Australian Government

Department of Health

Medicare Benefits Schedule Book

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Title: Medicare Benefits Schedule Book

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

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GUIDE TO SUMMARY OF CHANGES INCLUDED IN THIS EDITION

INCREASE IN MAXIMUM PATIENT GAP

The maximum patient gap between the Medicare Benefits Schedule (MBS) fee and the benefits payable for out-of-hospital services increases to $84.70 as at 1 November 2019. The 85% benefit level will apply for all fees up to $564.70, after which benefits are calculated at the Schedule fee less $84.70.

Heart Health Assessment 1 November 2019 update

From 1 November 2019 an administrative amendment will be made to items 699 and 177 to make all health assessment items have a 100% benefit. The fees will be adjusted for items 699 and 177 so there is no change to the Medicare rebate patients will receive for a heart health assessment service.

Amendment to eight A2 services

Amends the descriptor of eight A2 services (items 52, 53, 54, 57, 58, 59, 60 and 65) by omitting reference to clause 2.3.1.

Remove gender specific text from professional attendance items

Gender specific text has been removed from Professional Attendance items in Groups: A3, A4, A8, A21, A24, A6, A12, A26, A29, A31, A15, A28, and A32.

GP Telehealth items (MMM 6-7)

Twelve new video conferencing items for patients in rural and remote areas (as defined by Modified Monash areas 6 to 7) to assist with access to general practice services.

Amendment to items 90092, 90093, 90095 and 90096

This amends the descriptor of four attendance items provided by omitting the rendering cohort of doctors in paragraphs (a) and (b) and substituting with “by a medical practitioner who is not a general practitioner”.

Sleep study items 12205 and 12207

From 1 November 2019, minor amendments will be made to items 12205 and 12207 to provide more clarity on the clinical circumstances to which these items apply.

Sleep study item 12208

On 1 November 2019, a minor update will be made to improve the readability of the item descriptor.

Anaesthesia MBS Changes from 1 November 2019

MBS items for anaesthesia services are changing to reflect contemporary anaesthesia practice. These changes are a result of the MBS Review Taskforce recommendations and consultation with stakeholders. The revised structure contains twenty eight amended items, proposes ten new items and deletes thirty one items.

New Items for Colonoscopy

Amending existing colonoscopy services to distinguish eligible patient cohorts by appropriate interval screenings, as recommended by the Taskforce.

Minor amendments to items 30075, 30078, 30275, 30329, 30330, 35551, 35664, 35670 and 52027

Terminology for these items has been improved by replacing references to "lymph gland/s” with the term “lymph node/s”.

Split of item 45626 to delineate between trachomatous and non-trachomatous cause

Splitting MBS item 45626 into two items to be able to identify utilisation of this procedure to treat delineating ectropion / entropion repair for trachoma and non-trachomatous causes

Minor amendments to spinal surgery items from 1 November 2019

Items 51051, 51052 and 51053
The term ‘motion segment’ will be replaced with the appropriate clinical term ‘vertebra’ or ‘vertebrae’.

Items 51061 to 51066
The term 'spine fusion' will be replaced with the appropriate clinical term “spinal fusion”.

Items 51113 and 51114
The co-claiming restrictions for items 51113 and 51114 will be revised to enable appropriate co-claiming of these items with the paediatric scoliosis or kyphosis items (50600 to 50644).

Item 51145
The item will enable a second medical practitioner to be remunerated for providing assistance at the operation through the inclusion of the term (Assist.) in the item descriptor.

New item for mobile x-ray at residential aged care facilities

One new item providing a flagafall fee for the provision of skeletal x-ray (following a fall), chest x-ray (for suspected pneumonia or heart failure) and abdominal X-ray (for suspected acute abdomen or bowel obstruction) to patients within a residential aged care facility.

New items for Whole body 18F-FDG PET study for breast cancer

New items for: whole body 18F-FDG positron emission tomography (PET) study for: staging of locally advanced breast cancer; or evaluation of suspected metastatic or suspected locally or regionally recurrent breast carcinoma.

New MBS items for Breast MRI for specified populations

This change will introduce four new interim items for magnetic resonance imaging for breast cancer. These new items are for the diagnosis of breast cancer where other imaging is inconclusive, and for treatment planning for breast cancer.

Amendment to Pathology Services Table Item 73832

Item 73832 has been amended to ensure that the same requirements that apply for performance of item 73805 also apply to item 73832.

Amendment to Pathology Services Table Item 72860

This item has been amended to clarify that the retrieval and review of archived formalin fixed paraffin embedded block(s) to determine the appropriate sample(s) for the purposes of further genetic testing does not apply if the subsequent genetic test(s) is performed in the same laboratory. The item will apply if the subsequent genetic test(s) is performed in a different laboratory, including laboratories within the same laboratory network provided the laboratories are at separate locations.

New MBS items for Eating Disorders

This change will introduce, a suite of 64 Eating Disorder items to support a model of best practice evidence based care for patients with anorexia nervosa and other eligible patients with eating disorders.

SUMMARY OF CHANGES FROM 01/11/2019

The 01/11/2019 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

Deleted Items

20705	20805	20953	21927	22001	22018	22040	22045	22050	22070	23021	23022	23023
23031	23032	23033	23041	23042	23043	23051	23052	23053	23061	23062	23063	23071
23072	23073	23081	23082	23083	32088	32089	32090	32093	41846			

New Items

2461	2463	2464	2465	2471	2472	2475	2478	2480	2481	2482	2483	18297
22041	22042	23025	23035	23045	23055	23065	23075	23085	32222	32223	32224	32225
32226	32227	32228	32229	41501	45627	57541	61524	61525	63531	63532	63533	63534
82350	82351	82352	82353	82354	82355	82356	82357	82358	82359	82360	82361	82362
82363	82364	82365	82366	82367	82368	82369	82370	82371	82372	82373	82374	82375
82376	82377	82378	82379	82380	82381	82382	82383	90250	90251	90252	90253	90254
90255	90256	90257	90260	90261	90262	90263	90264	90265	90266	90267	90268	90269
90271	90272	90273	90274	90275	90276	90277	90278	90279	90280	90281	90282	

Description Amended

52	53	54	57	58	59	60	65	99	104	105	106	107
108	109	110	111	112	113	114	116	117	119	120	122	128
131	132	133	135	141	143	145	147	149	170	171	172	177
288	289	291	293	296	297	299	300	302	304	306	308	310
312	314	316	318	319	320	322	324	326	328	330	332	334
336	338	342	344	346	348	350	352	353	355	356	357	358
359	361	364	366	367	369	370	384	385	386	387	388	389
501	503	507	511	515	519	520	530	532	534	536	699	820
822	823	825	826	828	830	832	834	835	837	838	855	857
858	861	864	866	880	2799	2801	2806	2814	2820	2824	2832	2840
2946	2949	2954	2958	2972	2974	2978	2984	2988	2992	2996	3000	3003
3005	3010	3014	3015	3018	3023	3028	3032	3040	3044	3051	3055	3062
3069	3074	3078	3083	3088	3093	6007	6009	6011	6013	6015	6016	6018
6019	6023	6024	6025	6026	6028	6029	6031	6032	6034	6035	6037	6038
6042	6051	6052	6057	6058	6059	6060	6062	6063	6064	6065	6067	6068
6071	6072	6074	6075	11507	11508	11512	12205	12207	12208	18216	18219	18226
18227	20160	20162	20706	20745	20750	20790	20840	20902	21952	22002	22012	22014
22025	22031	25015	30075	30078	30275	30329	30330	32084	32087	35551	35664	35670
45626	51051	51052	51053	51061	51062	51063	51064	51065	51066	52027	73832	90092
90093	90095	90096										

Fee Amended

177	699	20142	20144	20145	20410	20745	20750	21922	21926	21936	21952

GENERAL EXPLANATORY NOTES

GENERAL EXPLANATORY NOTES

GN.1.1 The Medicare Benefits Schedule - Introduction

Schedules of Services

Each professional service contained in the Schedule has been allocated a unique item number. Located with the item number and description for each service is the Schedule fee and Medicare benefit, together with a reference to an explanatory note relating to the item (if applicable).

If the service attracts an anaesthetic, the word (Anaes.) appears following the description. Where an operation qualifies for the payment of benefits for an assistant, the relevant items are identified by the inclusion of the word (Assist.) in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

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

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

Explanatory Notes

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

GN.1.2 Medicare - an outline

The Medicare Program ('Medicare') provides access to medical and hospital services for all Australian residents and certain categories of visitors to Australia. The Department of Human Services administers Medicare and the payment of Medicare benefits. The major elements of Medicare are contained in the Health Insurance Act 1973, as amended, and include the following:

a. Free treatment for public patients in public hospitals.
b. The payment of 'benefits', or rebates, for professional services listed in the Medicare Benefits Schedule (MBS). In general, the Medicare benefit is 85% of the Schedule fee, otherwise the benefits are
    i. 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients;
    ii. 100% of the Schedule fee for services provided on behalf of a general practitioner by a practice nurse or Aboriginal and Torres Strait Islander health practitioner;
    iii. 75% of the Schedule fee for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients);
    iv. 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment.

Medicare benefits are claimable only for 'clinically relevant' services rendered by an appropriate health practitioner. A 'clinically relevant' service is one which is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient.

When a service is not clinically relevant, the fee and payment arrangements are a private matter between the practitioner and the patient.

Services listed in the MBS must be rendered according to the provisions of the relevant Commonwealth, State and Territory laws. For example, medical practitioners must ensure that the medicines and medical devices they use have been supplied to them in strict accordance with the provisions of the Therapeutic Goods Act 1989.

Where a Medicare benefit has been inappropriately paid, the Department of Human Services may request its return from the practitioner concerned.

GN.1.3 Medicare benefits and billing practices

Key information on Medicare benefits and billing practices

The *Health Insurance Act 1973* stipulates that Medicare benefits are payable for professional services. A professional service is a clinically relevant service which is listed in the MBS. A medical service is clinically relevant if it is generally accepted in the medical profession as necessary for the appropriate treatment of the patient.

Medical practitioners are free to set their fees for their professional service. However, the amount specified in the patient's account must be the amount charged for the service specified. The fee may not include a cost of goods or services which are not part of the MBS service specified on the account.

Billing practices contrary to the Act

A *non-clinically relevant service* must not be included in the charge for a Medicare item. The non-clinically relevant service must be separately listed on the account and not billed to Medicare.

Goods supplied for the patient's home use (such as wheelchairs, oxygen tanks, continence pads) must not be included in the consultation charge. Medicare benefits are limited to services which the medical practitioner provides at the time of the consultation - any other services must be separately listed on the account and must not be billed to Medicare.

Charging part of all of an episode of hospital treatment or a hospital substitute treatment to a non-admitted consultation is prohibited. This would constitute a false or misleading statement on behalf of the medical practitioner and no Medicare benefits would be payable.

An account may not be re-issued to include charges and out-of-pocket expenses excluded in the original account. The account can only be reissued to correct a genuine error.

Potential consequence of improperly issuing an account

The potential consequences for improperly issuing an account are

(a) No Medicare benefits will be paid for the service;

(b) The medical practitioner who issued the account, or authorised its issue, may face charges under sections 128A or 128B of the *Health Insurance Act 1973*.

(c) Medicare benefits paid as a result of a false or misleading statement will be recoverable from the doctor under section 129AC of the *Health Insurance Act 1973*.

Providers should be aware that the Department of Human Services is legally obliged to investigate doctors suspected of making false or misleading statements, and may refer them for prosecution if the evidence indicates fraudulent charging to Medicare. If Medicare benefits have been paid inappropriately or incorrectly, the Department of Human Services will take recovery action.

The Department of Human Services (DHS) has developed a Health Practitioner Guideline for responding to a request to substantiate that a patient attended a service. There is also a Health Practitioner Guideline for substantiating that a specific treatment was performed. These guidelines are located on the DHS website.

GN.2.4 Provider eligibility for Medicare

To be eligible to provide medical service which will attract Medicare benefits, or to provide services for or on behalf of another practitioner, practitioners must meet one of the following criteria:

(a) be a recognised specialist, consultant physician or general practitioner; or

(b) be in an approved placement under section 3GA of the *Health Insurance Act 1973*; or

(c) be a temporary resident doctor with an exemption under section 19AB of the *Health Insurance Act 1973*, and working in accord with that exemption.

Any practitioner who does not satisfy the requirements outlined above may still practice medicine but their services will not be eligible for Medicare benefits.

NOTE: New Zealand citizens entering Australia do so under a special temporary entry visa and are regarded as temporary resident doctors.

NOTE: It is an offence under Section 19CC of the *Health Insurance Act 1973* to provide a service without first informing a patient where a Medicare benefit is not payable for that service (i.e. the service is not listed in the MBS).

Non-medical practitioners

To be eligible to provide services which will attract Medicare benefits under MBS items 10950-10977 and MBS items 80000-88000 and 82100-82140 and 82200-82215, allied health professionals, dentists, and dental specialists, participating midwives and participating nurse practitioners must be

(a) registered according to State or Territory law or, absent such law, be members of a professional association with uniform national registration requirements; and

(b) registered with the Department of Human Services to provide these services.

GN.2.5 Provider Numbers

Practitioners eligible to have Medicare benefits payable for their services and/or who for Medicare purposes wish to raise referrals for specialist services and requests for pathology or diagnostic imaging services, may apply ***in writing*** to the Department of Human Services for a Medicare provider number for the locations where these services/referrals/requests will be provided. The form may be downloaded from the Department of Human Services website.

For Medicare purposes, an account/receipt issued by a practitioner must include the practitioner's name and ***either*** the provider number for the location where the service was provided ***or*** the address where the services were provided.

Medicare provider number information is released in accord with the secrecy provisions of the *Health Insurance Act 1973* (section 130) to authorized external organizations including private health insurers, the Department of Veterans' Affairs and the Department of Health.

When a practitioner ceases to practice at a given location they must inform Medicare promptly. Failure to do so can lead to the misdirection of Medicare cheques and Medicare information.

Practitioners at practices participating in the Practice Incentives Program (PIP) should use a provider number linked to that practice. Under PIP, only services rendered by a practitioner whose provider number is linked to the PIP will be considered for PIP payments.

GN.2.6 Locum tenens

Where a locum tenens will be in a practice for more than two weeks ***or*** in a practice for less than two weeks but on a regular basis, the locum should apply for a provider number for the relevant location. If the locum will be in a practice for less than two weeks and will not be returning there, they should contact the Department of Human Services (provider liaison - 132 150) to discuss their options (for example, use one of the locum's other provider numbers).

A locum must use the provider number allocated to the location if

(a) they are an approved general practice or specialist trainee with a provider number issued for an approved training placement; or

(b) they are associated with an approved rural placement under Section 3GA of the *Health Insurance Act 1973*; or

(c) they have access to Medicare benefits as a result of the issue of an exemption under section 19AB of the *Health Insurance Act 1973* (i.e. they have access to Medicare benefits at specific practice locations); or

(d) they will be at a practice which is participating in the Practice Incentives Program; or

(e) they are associated with a placement on the MedicarePlus for Other Medical Practitioners (OMPs) program, the After Hours OMPs program, the Rural OMPs program or Outer Metropolitan OMPs program.

GN.2.7 Overseas trained doctor

Ten year moratorium

Section 19AB of the Health Insurance Act 1973 states that services provided by overseas trained doctors (including New Zealand trained doctors) and former overseas medical students trained in Australia, will not attract Medicare benefits for 10 years from either

a. their date of registration as a medical practitioner for the purposes of the Health Insurance Act 1973; or
b. their date of permanent residency (the reference date will vary from case to case).

Exclusions - Practitioners who before 1 January 1997 had

a. registered with a State or Territory medical board and retained a continuing right to remain in Australia; or
b. lodged a valid application with the Australian Medical Council (AMC) to undertake examinations whose successful completion would normally entitle the candidate to become a medical practitioner.

The Minister of Health and Ageing may grant an overseas trained doctor (OTD) or occupational trainee (OT) an exemption to the requirements of the ten year moratorium, with or without conditions. When applying for a Medicare provider number, the OTD or OT must

a. demonstrate that they need a provider number and that their employer supports their request; and
b. provide the following documentation:
    i. Australian medical registration papers; and
    ii. a copy of their personal details in their passport and all Australian visas and entry stamps; and
    iii. a letter from the employer stating why the person requires a Medicare provider number and/or prescriber number is required; and
    iv. a copy of the employment contract.

GN.2.8 Contact details for the Department of Human Services

Changes to Provider Contact Details

It is important that you contact the Department of Human Services promptly of any changes to your preferred contact details. Your preferred mailing address is used to contact you about Medicare provider matters. We require requests for changes to your preferred contact details to be made by the provider in writing to the Department of Human Services at:

Medicare

GPO Box 9822

in your capital city

or

By email: medicare.prov@medicareaustralia.gov.au

You may also be able to update some provider details through HPOS
http://www.medicareaustralia.gov.au/hpos/index.jsp

MBS Interpretations

The day-to-day administration and payment of benefits under the Medicare arrangements is the responsibility of the Department of Human Services. Inquiries concerning matters of interpretation of MBS items should be directed to the Department of Health at Email: askmbs@health.gov.au

or by phone on 132 150

GN.3.9 Patient eligibility for Medicare

An "eligible person" is a person who resides permanently in Australia. This includes New Zealand citizens and holders of permanent residence visas. Applicants for permanent residence may also be eligible persons, depending on circumstances. Eligible persons must enrol with Medicare before they can receive Medicare benefits.

Medicare covers services provided only in Australia. It does not refund treatment or evacuation expenses overseas.

GN.3.10 Medicare cards

The **green** Medicare card is for people permanently in Australia. Cards may be issued for individuals or families.

The **blue** Medicare card bearing the words "INTERIM CARD" is for people who have applied for permanent residence.

Visitors from countries with which Australia has a Reciprocal Health Care Agreement receive a card bearing the words "RECIPROCAL HEALTH CARE"

GN.3.11 Visitors to Australia and temporary residents

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

GN.3.12 Reciprocal Health Care Agreements

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

Visitors from these countries are entitled to medically necessary treatment while they are in Australia, comprising public hospital care (as public patients), Medicare benefits and drugs under the Pharmaceutical Benefits Scheme (PBS). Visitors must enroll with the Department of Human Services to receive benefits. A passport is sufficient for public hospital care and PBS drugs.

Exceptions:

· Visitors from Ireland and New Zealand are entitled to public hospital care and PBS drugs, and should present their passports before treatment as they are not issued with Medicare cards.

· Visitors from Italy and Malta are covered for a period of six months only.

The Agreements do not cover treatment as a private patient in a public or private hospital. People visiting Australia for the purpose of receiving treatment are not covered.

GN.4.13 General Practice

Some MBS items may only be used by general practitioners. For MBS purposes a general practitioner is a medical practitioner who is

(a) vocationally registered under section 3F of the *Health Insurance Act 1973* (see General Explanatory Note below); or

(b) a Fellow of the Royal Australian College of General Practitioners (FRACGP), who participates in, and meets the requirements for the RACGP Quality Assurance and Continuing Medical Education Program; or

(c) a Fellow of the Australian College of Rural and Remote Medicine (FACRRM) who participates in, and meets the requirements for the ACRRM Quality Assurance and Continuing Medical Education Program; or

(d) is undertaking an approved general practice placement in a training program for ***either*** the award of FRACGP ***or*** a training program recognised by the RACGP being of an equivalent standard; or

(e) is undertaking an approved general practice placement in a training program for ***either*** the award of FACRRM ***or*** a training program recognised by ACRRM as being of an equivalent standard.

A medical practitioner seeking recognition as an FRACGP should apply to the Department of Human Services, having completed an application form available from the Department of Human Services's website. A general practice trainee should apply to General Practice Education and Training Limited (GPET) for a general practitioner trainee placement. GPET will advise the Department of Human Services when a placement is approved. General practitioner trainees need to apply for a provider number using the appropriate provider number application form available on the Department of Human Services's website.

Vocational recognition of general practitioners

The only qualifications leading to vocational recognition are FRACGP and FACRRM. The criteria for recognition as a GP are:

(a) certification by the RACGP that the practitioner

· is a Fellow of the RACGP; and

· practice is, or will be within 28 days, predominantly in general practice; and

· has met the minimum requirements of the RACGP for taking part in continuing medical education and quality assurance programs.

(b) certification by the General Practice Recognition Eligibility Committee (GPREC) that the practitioner

· is a Fellow of the RACGP; and

· practice is, or will be within 28, predominantly in general practice; and

· has met minimum requirements of the RACGP for taking part in continuing medical education and quality assurance programs.

(c) certification by ACRRM that the practitioner

· is a Fellow of ACRRM; and

· has met the minimum requirements of the ACRRM for taking part in continuing medical education and quality assurance programs.

In assessing whether a practitioner's medical practice is predominantly in general practice, the practitioner must have at least 50% of clinical time and services claimed against Medicare. Regard will also be given as to whether the

practitioner provides a comprehensive primary medical service, including treating a wide range of patients and conditions using a variety of accepted medical skills and techniques, providing services away from the practitioner's surgery on request, for example, home visits and making appropriate provision for the practitioner's patients to have access to after hours medical care.

Further information on eligibility for recognition should be directed to:

QI&CPD Program Administrator, RACGP

Tel: 1800 472 247 Email at: qicpd@racgp.org.au

Secretary, General Practice Recognition Eligibility Committee:

Email at gprec@health.gov.au

Executive Assistant, ACRRM:

Tel: (07) 3105 8200 Email at acrrm@acrrm.org.au

How to apply for vocational recognition

Medical practitioners seeking vocational recognition should apply to the Department of Human Services using the approved Application Form available on the the Department of Human Services website: www.humanservices.gov.au. Applicants should forward their applications, as appropriate, to

The Secretariat

The General Practice Recognition Eligibility Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

GPO Box 9848

CANBERRA ACT 2601

email address: gprec@health.gov.au

The Secretariat

The General Practice Recognition Appeal Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

GPO Box 9848

CANBERRA ACT 2601

email address: gprac@health.gov.au

The relevant body will forward the application together with its certification of eligibility to the Department of Human Services CEO for processing.

Continued vocational recognition is dependent upon:

(a) the practitioner's practice continuing to be predominantly in general practice (for medical practitioners in the Register only); and

(b) the practitioner continuing to meet minimum requirements for participation in continuing professional development programs approved by the RACGP or the ACRRM.

Further information on continuing medical education and quality assurance requirements should be directed to the RACGP or the ACRRM depending on the college through which the practitioner is pursuing, or is intending to pursue, continuing medical education.

Medical practitioners refused certification by the RACGP, the ACRRM or GPREC may appeal in writing to The Secretariat, General Practice Recognition Appeal Committee (GPRAC), National Registration and Accreditation Scheme Policy Section, MDP 152, Department of Health, GPO Box 9848, Canberra, ACT, 2601.

Removal of vocational recognition status

A medical practitioner may at any time request the Department of Human Services to remove their name from the Vocational Register of General Practitioners.

Vocational recognition status can also be revoked if the RACGP, the ACRRM or GPREC certifies to the Department of Human Services that it is no longer satisfied that the practitioner should remain vocationally recognised. Appeals of the decision to revoke vocational recognition may be made in writing to GPRAC, at the above address.

A practitioner whose name has been removed from the register, or whose determination has been revoked for any reason must make a formal application to re-register, or for a new determination.

GN.5.14 Recognition as a Specialist or Consultant Physician

A medical practitioner who:

· is registered as a specialist under State or Territory law; or

· holds a fellowship of a specified specialist College and has obtained, after successfully completing an appropriate course of study, a relevant qualification from a relevant College

and has formally applied and paid the prescribed fee, may be recognised by the Minister as a specialist or consultant physician for the purposes of the *Health Insurance Act 1973*.

A relevant specialist College may also give the Department of Human Services' Chief Executive Officer a written notice stating that a medical practitioner meets the criteria for recognition.

A medical practitioner who is training for a fellowship of a specified specialist College and is undertaking training placements in a private hospital or in general practice, may provide services which attract Medicare rebates. Specialist trainees should consult the information available at the Department of Human Services' Medicare website.

Once the practitioner is recognised as a specialist or consultant physician for the purposes of the *Health Insurance Act 1973*, Medicare benefits will be payable at the appropriate higher rate for services rendered in the relevant speciality, provided the patient has been appropriately referred to them.

Further information about applying for recognition is available at the Department of Human Services' Medicare website.

The Department of Human Services (DHS) has developed an Health Practitioner Guideline to substantiate that a valid referral existed (specialist or consultant physician) which is located on the DHS website.

GN.5.15 Emergency Medicine

A practitioner will be acting as an emergency medicine specialist when treating a patient within 30 minutes of the patient's presentation, and that patient is

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

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

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

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

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

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

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

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

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

GN.6.16 Referral Of Patients To Specialists Or Consultant Physicians

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

A reference to a referral in this Section does not refer to written requests made for pathology services or diagnostic imaging services. Information about the form of a diagnostic imaging request can be found in **Note IN.0.1** of the Diagnostic Imaging Services Table (Category 5) and information about the form of a pathology request can be found in **Note PN.2.1** of the Pathology Services Table (Category 6).

What is a Referral?

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

Subject to the exceptions in the paragraph below, for a valid "referral" to take place

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

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

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

The exceptions to the requirements in paragraph above are that

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

- a pre-anaesthesia consultation by a specialist anaesthetist (items 16710-17625);

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

- a referral generated during an episode of hospital treatment, for a service provided or arranged by that hospital, where the hospital records provide evidence of a referral (including the referring practitioner's signature); or

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

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

Examination by Specialist Anaesthetists

A referral is not required in the case of pre-anaesthesia consultation items 17610-17625. However, for benefits to be payable at the specialist rate for consultations, other than pre-anaesthesia consultations by specialist anaesthetists (items 17640 -17655) a referral is required.

Who can Refer?

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

Referrals by Dentists or Optometrists or Participating Midwives or Participating Nurse Practitioners

For Medicare benefit purposes, a referral may be made to

(i) a recognised specialist:

(a) by a registered dental practitioner, where the referral arises from a dental service; or

(b) by a registered optometrist where the specialist is an ophthalmologist; or

(c) by a participating midwife where the specialist is an obstetrician or a paediatrician, as clinical needs dictate. A referral given by a participating midwife is valid until 12 months after the first service given in accordance with the referral and for I pregnancy only or

(d) by a participating nurse practitioner to specialists and consultant physicians. A referral given by a participating nurse practitioner is valid until 12 months after the first service given in accordance with the referral.

(ii) a consultant physician, by an approved dental practitioner (oral surgeon), where the referral arises out of a dental service.

In any other circumstances (i.e. a referral to a consultant physician by a dentist, other than an approved oral surgeon, or an optometrist, or a referral by an optometrist to a specialist other than a specialist ophthalmologist), it is <u>not</u> a valid referral. Any resulting consultant physician or specialist attendances will attract Medicare benefits at unreferred rates.

Registered dentists and registered optometrists may refer themselves to specialists in accordance with the criteria above, and Medicare benefits are payable at the levels which apply to their referred patients.

Billing

Routine Referrals

In addition to providing the usual information required to be shown on accounts, receipts or assignment forms, specialists and consultant physicians must provide the following details (unless there are special circumstances as indicated in paragraph below):-

- name and either practice address or provider number of the referring practitioner;

- date of referral; and

- period of referral (when other than for 12 months) expressed in months, eg "3", "6" or "18" months, or "indefinitely" should be shown.

Special Circumstances

(i) Lost, stolen or destroyed referrals.

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

(ii) Emergencies

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

(iii) Hospital referrals.

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

Public Hospital Patients

State and Territory Governments are responsible for the provision of public hospital services to eligible persons in accordance with the National Healthcare Agreement.

Bulk Billing

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

Period for which Referral is Valid

The referral is valid for the period specified in the referral which is taken to commence on the date of the specialist's or consultant physician's first service covered by that referral.

Specialist Referrals

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

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

Referrals by other Practitioners

Where the referral originates from a practitioner other than those listed in *Specialist Referrals*, the referral is valid for a period of 12 months, unless the referring practitioner indicates that the referral is for a period more or less than 12 months (eg. 3, 6 or 18 months or valid indefinitely). Referrals for longer than 12 months should only be used where the patient's clinical condition requires continuing care and management of a specialist or a consultant physician for a specific condition or specific conditions.

Definition of a Single Course of Treatment

A single course of treatment involves an initial attendance by a specialist or consultant physician and the continuing management/treatment up to the stage where the patient is referred back to the care of the referring practitioner. It also includes any subsequent review of the patient's condition by the specialist or the consultant physician that may be necessary. Such a review may be initiated by either the referring practitioner or the specialist/consultant physician.

The presentation of an unrelated illness, requiring the referral of the patient to the specialist's or the consultant physician's care would initiate a new course of treatment in which case a new referral would be required.

The receipt by a specialist or consultant physician of a new referral following the expiration of a previous referral for the same condition(s) does not necessarily indicate the commencement of a new course of treatment involving the itemisation of an initial consultation. In the continuing management/treatment situation the new referral is to facilitate the payment of benefits at the specialist or the consultant physician referred rates rather than the unreferred rates.

However, where the referring practitioner:-

(a) deems it necessary for the patient's condition to be reviewed; and

(b) the patient is seen by the specialist or the consultant physician outside the currency of the last referral; and

(c) the patient was last seen by the specialist or the consultant physician more than 9 months earlier

the attendance following the new referral initiates a new course of treatment for which Medicare benefit would be payable at the initial consultation rates.

Retention of Referral Letters

The prima facie evidence that a valid referral exists is the provision of the referral particulars on the specialist's or the consultant physician's account.

A specialist or a consultant physician is required to retain the instrument of referral (and a hospital is required to retain the patient's hospital records which show evidence of a referral) for 2 years from the date the service was rendered.

A specialist or a consultant physician is required, if requested by the Department of Human Services CEO, to produce to a medical practitioner who is an employee of the Department of Human Services, the instrument of referral within seven days after the request is received. Where the referral originates in an emergency situation or in a hospital, the specialist or consultant physician is required to produce such information as is in his or her possession or control relating to whether the patient was so treated.

Attendance for Issuing of a Referral

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

Locum-tenens Arrangements

It should be noted that where a non-specialist medical practitioner acts as a locum-tenens for a specialist or consultant physician, or where a specialist acts as a locum-tenens for a consultant physician, Medicare benefit is only payable at the level appropriate for the particular locum-tenens, eg, general practitioner level for a general practitioner locum-tenens and specialist level for a referred service rendered by a specialist locum tenens.

Medicare benefits are not payable where a practitioner is not eligible to provide services attracting Medicare benefits acts as a locum-tenens for any practitioner who is eligible to provide services attracting Medicare benefits.

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

Self Referral

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

GN.7.17 Billing procedures

The Department of Human Services website contains information on Medicare billing and claiming options. Please visit the Department of Human Services website for further information.

Bulk billing

Under the *Health Insurance Act 1973*, a bulk billing facility for professional services is available to all persons in Australia who are eligible for a benefit under the Medicare program. If a practitioner bulk bills for a service the practitioner undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service cannot be raised. This includes but is not limited to:

- any consumables that would be reasonably necessary to perform the service, including bandages and/or dressings;
- record keeping fees;
- a booking fee to be paid before each service, or;
- an annual administration or registration fee.

Where the patient is bulk billed, an additional charge can **only** be raised against the patient by the practitioner where the patient is provided with a vaccine or vaccines from the practitioner's own supply held on the practitioner's premises. This exemption only applies to general practitioners and other non-specialist practitioners in association with attendance items **3 to 96**, **179 to 212**, **733 to 789** and **5000 to 5267** (inclusive) and only relates to vaccines that

are not available to the patient free of charge through Commonwealth or State funding arrangements or available through the Pharmaceutical Benefits Scheme. The additional charge must only be to cover the supply of the vaccine.

Where a practitioner provides a number of services (excluding operations) on the one occasion, they can choose to bulk bill some or all of those services and privately charge a fee for the other service (or services), in excess of the Medicare rebate. The privately charged fee can only be charged in relation to said service (or services). Where two or more operations are provided on the one occasion, all services must be either bulk billed or privately charged.

It should be noted that, where a service is not bulk billed, a practitioner may privately raise an additional charge against a patient, such as for a consumable. An additional charge can also be raised where a practitioner does not bulk bill a patient but instead charges a fee that is equal to the rebate for the Medicare service. For example, where a general practitioner provides a professional service to which item 23 relates the practitioner could, in place of bulk billing the patient, charge the rebate for the service and then also raise an additional charge (such as for a consumable).

GN.8.18 Provision for review of individual health professionals

The Professional Services Review (PSR) reviews and investigates service provision by health practitioners to determine if they have engaged in inappropriate practice when rendering or initiating Medicare services, or when prescribing or dispensing under the PBS.

Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude that it would be unacceptable to the general body of the members of the profession in which the practitioner was practicing when they rendered or initiated the services under review. It is also an offence under Section 82 for a person or officer of a body corporate to knowingly, recklessly or negligently cause or permit a practitioner employed by the person to engage in such conduct.

The Department of Human Services monitors health practitioners' claiming patterns. Where the Department of Human Services detects an anomaly, it may request the Director of PSR to review the practitioner's service provision. On receiving the request, the Director must decide whether to a conduct a review and in which manner the review will be conducted. The Director is authorized to require that documents and information be provided.

Following a review, the Director must:

decide to take no further action; or

enter into an agreement with the person under review (which must then be ratified by an independent Determining Authority); or

refer the matter to a PSR Committee.

A PSR Committee normally comprises three medically qualified members, two of whom must be members of the same profession as the practitioner under review. However, up to two additional Committee members may be appointed to provide wider range of clinical expertise.

The Committee is authorized to:

investigate any aspect of the provision of the referred services, and without being limited by the reasons given in the review request or by a Director's report following the review;

hold hearings and require the person under review to attend and give evidence;

require the production of documents (including clinical notes).

The methods available to a PSR Committee to investigate and quantify inappropriate practice are specified in legislation:

(a) Patterns of Services - The *Health Insurance (Professional Services Review) Regulations 1999* specify that when a general practitioner or other medical practitioner reaches or exceeds 80 or more attendances on each of 20 or more days in a 12-month period, they are deemed to have practiced inappropriately.

A professional attendance means a service of a kind mentioned in group A1, A2, A5, A6, A7, A9, A11, A13, A14, A15, A16, A17, A18, A19, A20, A21, A22 or A23 of Part 3 of the General Medical Services Table.

If the practitioner can satisfy the PSR Committee that their pattern of service was as a result of exceptional circumstances, the quantum of inappropriate practice is reduce accordingly. Exceptional circumstances include, but are not limited to, those set out in the *Regulations*. These include:

an unusual occurrence;

the absence of other medical services for the practitioner's patients (having regard to the practice location); and

the characteristics of the patients.

(b) Sampling - A PSR Committee may use statistically valid methods to sample the clinical or practice records.

(c) Generic findings - If a PSR Committee cannot use patterns of service or sampling (for example, there are insufficient medical records), it can make a 'generic' finding of inappropriate practice.

Additional Information

A PSR Committee may not make a finding of inappropriate practice unless it has given the person under review notice of its intention to review them, the reasons for its findings, and an opportunity to respond. In reaching their decision, a PSR Committee is required to consider whether or not the practitioner has kept adequate and contemporaneous patient records (See general explanatory note G15.1 for more information on adequate and contemporaneous patient records).

The practitioner under review is permitted to make submissions to the PSR Committee before key decisions or a final report is made.

If a PSR Committee finds that the person under review has engaged in inappropriate practice, the findings will be reported to the Determining Authority to decide what action should be taken:

(i) a reprimand;

(ii) counselling;

(iii) repayment of Medicare benefits; and/or

(iv) complete or partial disqualification from Medicare benefit arrangements for up to three years.

Further information is available from the PSR website - www.psr.gov.au

GN.8.19 Medicare Participation Review Committee

The Medicare Participation Review Committee determines what administrative action should be taken against a practitioner who:

(a) has been successfully prosecuted for relevant criminal offences;

(b) has breached an Approved Pathology Practitioner undertaking;

(c) has engaged in prohibited diagnostic imaging practices; or

(d) has been found to have engaged in inappropriate practice under the Professional Services Review scheme and has received Final Determinations on two (or more) occasions.

The Committee can take no further action, counsel or reprimand the practitioner, or determine that the practitioner be disqualified from Medicare for a particular period or in relation to particular services for up to five years.

Medicare benefits are not payable in respect of services rendered by a practitioner who has been fully disqualified, or partly disqualified in relation to relevant services under the *Health Insurance Act 1973* (Section 19B applies).

GN.8.20 Referral of professional issues to regulatory and other bodies

The *Health Insurance Act 1973* provides for the following referral, to an appropriate regulatory body:

i. a significant threat to a person's life or health, when caused or is being caused or is likely to be caused by the conduct of the practitioner under review; or
ii. a statement of concerns of non-compliance by a practitioner with 'professional standards'.

GN.8.21 Comprehensive Management Framework for the MBS

The Government announced the Comprehensive Management Framework for the MBS in the 2011-12 Budget to improve MBS management and governance into the future. As part of this framework, the Medical Services Advisory Committee (MSAC) Terms of Reference and membership have been expanded to provide the Government with independent expert advice on all new proposed services to be funded through the MBS, as well as on all proposed amendments to existing MBS items. Processes developed under the previously funded MBS Quality Framework are now being integrated with MSAC processes under the Comprehensive Management Framework for the MBS.

GN.8.22 Medical Services Advisory Committee

The Medical Services Advisory Committee (MSAC) advises the Minister on the strength of evidence relating to the safety, effectiveness and cost effectiveness of new and emerging medical services and technologies and under what circumstances public funding, including listing on the MBS, should be supported.

MSAC members are appointed by the Minister and include specialist practitioners, general practitioners, health economists, a health consumer representative, health planning and administration experts and epidemiologists.

For more information on the MSAC refer to their website - www.msac.gov.au or email on msac.secretariat@health.gov.au or by phoning the MSAC secretariat on (02) 6289 7550.

GN.8.23 Pathology Services Table Committee

This Pathology Services Table Committee comprises six representatives from the interested professions and six from the Australian Government. Its primary role is to advise the Minister on the need for changes to the structure and content of the Pathology Services Table (except new medical services and technologies) including the level of fees.

GN.9.25 Penalties and Liabilities

Penalties of up to $10,000 or imprisonment for up to five years, or both, may be imposed on any person who makes a statement (oral or written) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used with a claim for benefits. In addition, any practitioner who is found guilty of such offences by a court shall be subject to examination by a Medicare Participation Review Committee and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.

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

GN.10.26 Schedule fees and Medicare benefits

Medicare benefits are based on fees determined for each medical service. The fee is referred to in these notes as the "Schedule fee". The fee for any item listed in the MBS is that which is regarded as being reasonable on average for that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered.

The Schedule fee and Medicare benefit levels for the medical services contained in the MBS are located with the item descriptions. Where appropriate, the calculated benefit has been rounded to the nearest higher 5 cents. However, in no circumstances will the Medicare benefit payable exceed the fee actually charged.

There are presently three levels of Medicare benefit payable:

a. 75% of the Schedule fee:
    i. for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients). Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '*' or the letter 'H' directly after an item number where used; or a description of the professional service and an indication the service was rendered as an episode of hospital treatment (for example, 'in hospital', 'admitted' or 'in patient');
    ii. for professional services rendered as part of an episode of hospital-substitute treatment, and the patient who receives the treatment chooses to receive a benefit from a private health insurer. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service, preceded by the words 'hospital-substitute treatment'.
b. 100% of the Schedule fee for non-referred attendances by general practitioners to non-admitted patients and services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a general practitioner.
c. 85% of the Schedule fee, or the Schedule fee less $84.70 (indexed annually in November), whichever is the greater, for all other professional services.

Public hospital services are to be provided free of charge to eligible persons who choose to be treated as public patients in accordance with the National Healthcare Agreement.

A medical service rendered to a patient on the day of admission to, or day of discharge from hospital, but prior to admission or subsequent to discharge, will attract benefits at the 85% or 100% level, not 75%. This also applies to a pathology service rendered to a patient prior to admission. Attendances on patients at a hospital (other than patients covered by paragraph (i) above) attract benefits at the 85% level.

The 75% benefit level applies even though a portion of the service (eg. aftercare) may be rendered outside the hospital. With regard to obstetric items, benefits would be attracted at the 75% level where the confinement takes place in hospital.

Pathology tests performed after discharge from hospital on bodily specimens taken during hospitalisation also attract the 75% level of benefits.

It should be noted that private health insurers can cover the "patient gap" (that is, the difference between the Medicare rebate and the Schedule fee) for services attracting benefits at the 75% level. Patient's may insure with private health insurers for the gap between the 75% Medicare benefits and the Schedule fee or for amounts in excess of the Schedule fee where the doctor has an arrangement with their health insurer.

GN.10.27 Medicare safety nets

The Medicare Safety Nets provide families and singles with an additional rebate for out-of-hospital Medicare services, once annual thresholds are reached. There are two safety nets: the original Medicare safety net and the extended Medicare safety net.

Original Medicare Safety Net:

Under the original Medicare safety net, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee. The threshold from 1 January 2019 is $470.00. This threshold applies to all Medicare-eligible singles and families.

Extended Medicare Safety Net:

Under the extended Medicare safety net (EMSN), once an annual threshold in out-of-pocket costs for out-of-hospital Medicare services is reached, Medicare will pay for 80% of any future out-of-pocket costs for out-of-hospital Medicare services for the remainder of the calendar year. However, where the item has an EMSN benefit cap, there is a maximum limit on the EMSN benefit that will be paid for that item. Further explanation about EMSN benefit caps is provided below. Out-of-pocket costs refer to the difference between the Medicare benefit and the fee charged by the practitioner.

In 2019, the threshold for singles and families that hold Commonwealth concession card, families that received Family Tax Benefit Part (A) (FTB(A)) and families that qualify for notional FTB (A) is $680.70. The threshold for all other singles and families in 2019 is $2,133.00.

The thresholds for both safety nets are usually indexed on 1 January each year.

Individuals are automatically registered with the Department of Human Services for the safety nets; however couples and families are required to register in order to be recognised as a family for the purposes on the safety nets. In most cases, registered families have their expenses combined to reach the safety net thresholds. This may help to qualify for safety net benefits more quickly. Registration forms can be obtained from the Department of Human Services offices, or completed online at http://www.humanservices.gov.au/customer/services/medicare/medicare-safety-net.

EMSN Benefit Caps:

The EMSN benefit cap is the maximum EMSN benefit payable for that item and is paid in addition to the standard Medicare rebate. Where there is an EMSN benefit cap in place for the item, the amount of the EMSN cap is displayed in the item descriptor.

Once the EMSN threshold is reached, each time the item is claimed the patient is eligible to receive up to the EMSN benefit cap. As with the safety nets, the EMSN benefit cap only applies to out-of-hospital services.

Where the item has an EMSN benefit cap, the EMSN benefit is calculated as 80% of the out-of-pocket cost for the service. If the calculated EMSN benefit is less than the EMSN benefit cap; then calculated EMSN rebate is paid. If the calculated EMSN benefit is greater than the EMSN benefit cap; the EMSN benefit cap is paid.

For example: Item A has a Schedule fee of $100, the out-of-hospital benefit is $85 (85% of the Schedule fee). The EMSN benefit cap is $30. Assuming that the patient has reached the EMSN threshold:

o If the fee charged by the doctor for Item A is $125, the standard Medicare rebate is $85, with an out-of-pocket cost of $40. The EMSN benefit is calculated as $40 x 80% = $32. However, as the EMSN benefit cap is $30, only $30 will be paid.

o If the fee charged by the doctor for Item A is $110, the standard Medicare rebate is $85, with an out-of-pocket cost of $25. The EMSN benefit is calculated as $25 x 80% = $20. As this is less than the EMSN benefit cap, the full $20 is paid.

GN.11.28 Services not listed in the MBS

Benefits are not generally payable for services not listed in the MBS. However, there are some procedural services which are not specifically listed because they are regarded as forming part of a consultation or else attract benefits on an attendance basis. For example, intramuscular injections, aspiration needle biopsy, treatment of sebhorreic

keratoses and less than 10 solar keratoses by ablative techniques and closed reduction of the toe (other than the great toe).

Enquiries about services not listed or on matters of interpretation should be directed to the Department of Human Services on 132 150.

GN.11.29 Ministerial Determinations

Section 3C of the *Health Insurance Act 1973* empowers the Minister to determine an item and Schedule fee (for the purposes of the Medicare benefits arrangements) for a service not included in the health insurance legislation. This provision may be used to facilitate payment of benefits for new developed procedures or techniques where close monitoring is desirable. Services which have received section 3C approval are located in their relevant Groups in the MBS with the notation "**(Ministerial Determination)**".

GN.12.30 Professional services

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

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

(a) Category 1 (Professional Attendances) items except 170-172, 342-346, 820-880, 6029–6042, 6064-6075;

(b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11304, 11600, 11627, 11701, 11712, 11722, 11724, 11728, 11921, 12000, 12003;

(c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13709, 13750-13760, 13915-13948, 14050, 14053, 14218, 14221 and 14245);

(d) Item 15600 in Group T2 (Radiation Oncology);

(e) All Group T3 (Therapeutic Nuclear Medicine) items;

(f) All Group T4 (Obstetrics) items (except 16400 and 16514);

(g) All Group T6 (Anaesthetics) items;

(h) All Group T7 (Regional or Field Nerve Block) items;

(i) All Group T8 (Operations) items;

(j) All Group T9 (Assistance at Operations) items;

(k) All Group T10 (Relative Value Guide for Anaesthetics) items.

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

Medicare benefits are not payable for these group items or any of the items listed in (a) - (k) above when the service is rendered by a medical practitioner employed by the proprietor of a hospital (not being a private hospital), except where the practitioner is exercising their right of private practice, or is performing a medical service outside the hospital. For example, benefits are not paid when a hospital intern or registrar performs a service at the request of a staff specialist or visiting medical officer.

Medicare benefits are only payable for items 12306 - 12322 (Bone Densitometry) when the service is performed by a specialist or consultant physician in the practice of his or her specialty where the patient is referred by another medical practitioner.

GN.12.31 Services rendered on behalf of medical practitioners

Medical services in Categories 2 and 3 not included in GN.12.30 and Category 5 (Diagnostic Imaging) services continue to attract Medicare benefits if the service is rendered by:-

(a) the medical practitioner in whose name the service is being claimed;

(b) a person, other than a medical practitioner, who is employed by a medical practitioner or, in accordance with accepted medical practice, acts under the supervision of a medical practitioner.

See Category 6 Notes for Guidance for arrangements relating to Pathology services.

So that a service rendered by an employee or under the supervision of a medical practitioner may attract a Medicare rebate, the service must be billed in the name of the practitioner who must accept full responsibility for the service. All practitioners should ensure they maintain adequate and contemporaneous records. All elements of the service must be performed in accordance with accepted medical practice.

Supervision from outside of Australia is not acceptable.

While the supervising medical practitioner need not be present for the entire service, they must have a direct involvement in at least part of the service. Although the supervision requirements will vary according to the service in question, they will, as a general rule, be satisfied where the medical practitioner has:-

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

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

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

GN.12.32 Medicare benefits and vaccinations

Where a medical practitioner administers an injection for immunisation purposes on his or her own patient, Medicare benefits for that service would be payable on a consultation basis, that is, for the attendance at which the injection is given. However, the cost of the vaccine itself does not attract a Medicare rebate. The Medicare benefits arrangements cover only the professional component of the medical practitioner's service. There are some circumstances where a Medicare benefit is not payable when a medical practitioner administers an injection for immunisation purposes – please refer to example 3 below for further details.

Example 1

A patient presents to a GP to receive the influenza vaccination. The patient is not in the cohort of patients which is covered for the influenza vaccine under the NIP.

After taking a short patient history, the GP administers the vaccine to the patient. The GP has met the requirements of a level A consultation and claims item 3. The GP can bulk bill the patient for the cost of the MBS service and can charge a separate amount for the cost of the vaccine, which is not covered under the NIP.

If a patient presented to a GP to receive a vaccine and to enquire about a medical condition, the GP may claim the appropriate item (such as item 23).

Example 2

A patient presents to a GP to receive the influenza vaccination. The patient is in the cohort of patients which is covered for the influenza vaccine under the NIP.

After taking a short patient history, the GP administers the vaccine to the patient. The GP has met the requirements of a level A consultation and claims item 3. The GP can bulk bill the patient but does not need to charge a separate amount for the cost of the vaccine, which is covered under the NIP.

If a patient presented to a GP to receive a vaccine and to enquire about a medical condition, the GP may claim the appropriate item (such as item 23).

Example 3

A GP is employed by a State or Territory community health centre to administer vaccines and provides no additional medical services.

A Medicare benefit is not payable as the GP is providing the service under an arrangement with the State or Territory, which is prohibited under subsection 19(2) of the Health Insurance Act 1973. The service is also prohibited on the basis that it is a mass immunisation which is prohibited under subsection 19(4).

A mass immunisation is a program to inoculate people that is funded by the Commonwealth or State Government, or through an international or private organisation.

GN.13.33 Services which do not attract Medicare benefits

Services not attracting benefits

(a) telephone consultations;

(b) issue of repeat prescriptions when the patient does not attend the surgery in person;

(c) group attendances (unless otherwise specified in the item, such as items 170, 171, 172, 342, 344 and 346);

(d) non-therapeutic cosmetic surgery;

(e) euthanasia and any service directly related to the procedure. However, services rendered for counselling/assessment about euthanasia will attract benefits.

Medicare benefits are not payable where the medical expenses for the service

(a) are paid/payable to a public hospital;

(b) are for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability. (Please note that if the medical expenses relate to a compensable injury/illness for which the insurer/compensation agency is disputing liability, then Medicare benefits are payable until the liability is accepted.);

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

(d) are incurred in mass immunisation (see General Explanatory Note 12.3 for further explanation).

Unless the Minister otherwise directs

Medicare benefits are not payable where:

(a) the service is rendered by or on behalf of, or under an arrangement with the Australian Government, a State or Territory, a local government body or an authority established under Commonwealth, State or Territory law;

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

(c) the person to whom the service is rendered is employed in an industrial undertaking and that service is rendered for the purposes related to the operation of the undertaking; or

(d) the service is a health screening service.

(e) the service is a pre-employment screening service

Current regulations preclude the payment of Medicare benefits for professional services rendered in relation to or in association with:

(a) chelation therapy (that is, the intravenous administration of ethylenediamine tetra-acetic acid or any of its salts) other than for the treatment of heavy-metal poisoning;

(b) the injection of human chorionic gonadotrophin in the management of obesity;

(c) the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;

(d) the removal of tattoos;

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

(f) the removal from a cadaver of kidneys for transplantation;

(g) the administration of microwave (UHF radio wave) cancer therapy, including the intravenous injection of drugs used in the therapy.

Pain pumps for post-operative pain management

The cannulation and/or catheterisation of surgical sites associated with pain pumps for post-operative pain management cannot be billed under any MBS item.

The filling or re-filling of drug reservoirs of ambulatory pain pumps for post-operative pain management cannot be billed under any MBS items.

Non Medicare Services

No MBS item applies to a service mentioned in the item if the service is provided to a patient at the same time as, or in connection with, an injection of blood or a blood product that is autologous.

No MBS item applies to a service mentioned in the item if the service is provided to a patient at the same time as, or in connection with, the harvesting, storage, in vitro processing or injection of non-haematopoietic stem cells.

An item in the range 1 to 10943 does not apply to the service described in that item if the service is provided at the same time as, or in connection with, any of the services specified below:

(a) endoluminal gastroplication, for the treatment of gastro-oesophageal reflux disease;

(b) gamma knife surgery;

(c) intradiscal electro thermal arthroplasty;

(d) intravascular ultrasound (except where used in conjunction with intravascular brachytherapy);

(e) intro-articular viscosupplementation, for the treatment of osteoarthritis of the knee;

(f) low intensity ultrasound treatment, for the acceleration of bone fracture healing, using a bone growth stimulator;

(g) lung volume reduction surgery, for advanced emphysema;

(h) photodynamic therapy, for skin and mucosal cancer;

(i) placement of artificial bowel sphincters, in the management of faecal incontinence;

(j) selective internal radiation therapy for any condition other than hepatic metastases that are secondary to colorectal cancer;

(k) specific mass measurement of bone alkaline phosphatase;

(l) transmyocardial laser revascularisation;

(m) vertebral axial decompression therapy, for chronic back pain;

(n) autologous chondrocyte implantation and matrix-induced autologous chondrocyte implantation;

(o) vertebroplasty;

(p) extracorporeal magnetic innervation.

Health Screening Services

Unless the Minister otherwise directs Medicare benefits are not payable for health screening services. A health screening service is defined as a medical examination or test that is not reasonably required for the management of the medical condition of the patient. Services covered by this proscription include such items as:

(a) multiphasic health screening;

(b) mammography screening (except as provided for in Items 59300/59303);

(c) testing of fitness to undergo physical training program, vocational activities or weight reduction programs;

(d) compulsory examinations and tests to obtain a flying, commercial driving or other licence;

(e) entrance to schools and other educational facilities;

(f) for the purposes of legal proceedings;

(g) compulsory examinations for admission to aged persons' accommodation and pathology services associated with clinical ecology.

The Minister has directed that Medicare benefits be paid for the following categories of health screening:

(a) a medical examination or test on a symptomless patient by that patient's own medical practitioner in the course of normal medical practice, to ensure the patient receives any medical advice or treatment necessary to maintain their state of health. Benefits would be payable for the attendance and tests which are considered reasonably necessary according to patients individual circumstances (such as age, physical condition, past personal and family history). For example, a cervical screening test in a person (see General Explanatory note 12.3 for more information), blood lipid estimation where a person has a family history of lipid disorder. However, such routine check-up should not necessarily be accompanied by an extensive battery of diagnostic investigations;

(b) a pathology service requested by the National Heart Foundation of Australia, Risk Evaluation Service;

(c) age or health related medical examinations to obtain or renew a licence to drive a private motor vehicle;

(d) a medical examination of, and/or blood collection from persons occupationally exposed to sexual transmission of disease, in line with conditions determined by the relevant State or Territory health authority, (one examination or collection per person per week). Benefits are not paid for pathology tests resulting from the examination or collection;

(e) a medical examination for a person as a prerequisite of that person becoming eligible to foster a child or children;

(f) a medical examination being a requisite for Social Security benefits or allowances;

(g) a medical or optometrical examination provided to a person who is an unemployed person (as defined by the Social Security Act 1991), as the request of a prospective employer.

The National Policy for the National Cervical Screening Program (NCSP) is as follows:

(a) Cervical screening should be undertaken every five years in asymptomatic persons, using a primary human papillomavirus (HPV) test with partial genotyping and reflex liquid based cytology (LBC) triage;

(b) Persons who have ever been sexually active should commence cervical screening at 25 years of age;

(c) Persons aged 25 years or older and less than 70 years will receive invitations and reminders to participate in the program;

(d) Persons will be invited to exit the program by having a HPV test between 70 years or older and less than 75 years of age and may cease cervical screening if their test result is low risk;

(e) Persons 75 years of age or older who have either never had a cervical screening test or have not had one in the previous five years, may request a cervical screening test and can be screened;

(f) All persons, both HPV vaccinated and unvaccinated, are included in the program;

(g) Self collection of a sample for testing is available for persons who are aged 30 years and over and has never participated in the NCSP; or is overdue for cervical screening by two years or longer.

· Self collection must be facilitated and requested by a healthcare professional who also routinely offers cervical screening services;

· The self collection device and the HPV test, when used together, must meet the requirements of the National Pathology Accreditation Advisory Council (NPAAC) Requirements for Laboratories Reporting Tests for the NCSP; and

(h) Persons with intermediate and higher risk screening test results should be followed up in accordance with the cervical screening pathway and the NCSP: Guidelines for the management of screen detected abnormalities, screening women in specific populations and investigation of women with abnormal vaginal bleeding (2016 Guidelines) – endorsed by the Royal Australian College of General Practitioners, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Royal College of Pathologists of Australasia, the Australian Society of Gynaecologic Oncologists and the Australian Society for Colposcopy and Cervical Pathology.

Note 1: As separate items exist for routine screening, screening in specific population and investigation of persons with abnormal vaginal bleeding, treating practitioners are asked to clearly identify on the request form, if the sample is collected as part of routine screening or for another purpose (see paragraph PP.16.11 of Pathology Services Explanatory Notes in Category 6).

Note 2: Where reflex cytology is performed following the detection of HPV in routine screening, the HPV test and the LBC test results must be issued as a combined report with the overall risk rating.

Note 3: See items 2501 to 2509, and 2600 to 2616 in Group A18 and A19 of Category 1 - Professional Attendances and the associated explanatory notes for these items in Category 1 - Professional Attendances.

Services rendered to a doctor's dependants, practice partner, or practice partner's dependants

Medicare benefits are not paid for professional services rendered by a medical practitioner to dependants or partners or a partner's dependants.

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

(a) a spouse, in relation to a dependant person means:

a. a person who is legally married to, and is not living, on a permanent basis, separately and apart from, that person; and

b. a de facto spouse of that person.

(b) a child, in relation to a dependant person means:

a. a child under the age of 16 years who is in the custody, care and control of the person or the spouse of the person; and

b. a person who:

(i) has attained the age of 16 years who is in the custody, care and control of the person of the spouse of the person; or

(ii) is receiving full time education at a school, college or university; and

(iii) is not being paid a disability support pension under the Social Security Act 1991; and

(iv) is wholly or substantially dependent on the person or on the spouse of the person.

GN.14.34 Principles of interpretation of the MBS

Each professional service listed in the MBS is a complete medical service. Where a listed service is also a component of a more comprehensive service covered by another item, the benefit for the latter service will cover the former.

Where a service is rendered partly by one medical practitioner and partly by another, only the one amount of benefit is payable. For example, where a radiographic examination is started by one medical practitioner and finalised by another.

GN.14.35 Services attracting benefits on an attendance basis

Some services are not listed in the MBS because they are regarded as forming part of a consultation or they attract benefits on an attendance basis.

GN.14.36 Consultation and procedures rendered at the one attendance

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

Where the level of benefit for an attendance depends upon the consultation time (for example, in psychiatry), the time spent in carrying out a procedure which is covered by another item in the MBS, may not be included in the consultation time.

A consultation fee may only be charged if a consultation occurs; that is, it is not expected that consultation fee will be charged on every occasion a procedure is performed.

GN.14.37 Aggregate items

The MBS includes a number of items which apply only in conjunction with another specified service listed in the MBS. These items provide for the application of a fixed loading or factor to the fee and benefit for the service with which they are rendered.

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

GN.14.38 Residential aged care facility

A residential aged care facility is defined in the *Aged Care Act 1997*; the definition includes facilities formerly known as nursing homes and hostels.

GN.15.39 Practitioners should maintain adequate and contemporaneous records

All practitioners who provide, or initiate, a service for which a Medicare benefit is payable, should ensure they maintain **adequate** and **contemporaneous** records.

Note: 'Practitioner' is defined in Section 81 of the *Health Insurance Act 1973* and includes: medical practitioners, dentists, optometrists, chiropractors, physiotherapists, podiatrists and osteopaths.

Since 1 November 1999 PSR Committees determining issues of inappropriate practice have been obliged to consider if the practitioner kept adequate and contemporaneous records. It will be up to the peer judgement of the PSR Committee to decide if a practitioner's records meet the prescribed standards.

The standards which determine if a record is adequate and contemporaneous are prescribed in the *Health Insurance (Professional Services Review) Regulations 1999*.

To be ***adequate***, the patient or clinical record needs to:

clearly identify the name of the patient; and

contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated; and

each entry needs to provide clinical information adequate to explain the type of service rendered or initiated; and

each entry needs to be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient's ongoing care.

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

The Department of Human Services (DHS) has developed an Health Practitioner Guideline to substantiate that a specific treatment was performed which is located on the DHS website.

CATEGORY 1: PROFESSIONAL ATTENDANCES

SUMMARY OF CHANGES FROM 01/11/2019

The 01/11/2019 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a)	new item	New
(b)	amended description	Amend
(c)	fee amended	Fee
(d)	item number changed	Renum
(e)	EMSN changed	EMSN

New Items

2461	2463	2464	2465	2471	2472	2475	2478	2480	2481	2482	2483	90250
90251	90252	90253	90254	90255	90256	90257	90260	90261	90262	90263	90264	90265
90266	90267	90268	90269	90271	90272	90273	90274	90275	90276	90277	90278	90279
90280	90281	90282										

Description Amended

52	53	54	57	58	59	60	65	99	104	105	106	107
108	109	110	111	112	113	114	116	117	119	120	122	128
131	132	133	135	141	143	145	147	149	170	171	172	177
288	289	291	293	296	297	299	300	302	304	306	308	310
312	314	316	318	319	320	322	324	326	328	330	332	334
336	338	342	344	346	348	350	352	353	355	356	357	358
359	361	364	366	367	369	370	384	385	386	387	388	389
501	503	507	511	515	519	520	530	532	534	536	699	820
822	823	825	826	828	830	832	834	835	837	838	855	857
858	861	864	866	880	2799	2801	2806	2814	2820	2824	2832	2840
2946	2949	2954	2958	2972	2974	2978	2984	2988	2992	2996	3000	3003
3005	3010	3014	3015	3018	3023	3028	3032	3040	3044	3051	3055	3062
3069	3074	3078	3083	3088	3093	6007	6009	6011	6013	6015	6016	6018
6019	6023	6024	6025	6026	6028	6029	6031	6032	6034	6035	6037	6038
6042	6051	6052	6057	6058	6059	6060	6062	6063	6064	6065	6067	6068
6071	6072	6074	6075	90092	90093	90095	90096					

Fee Amended

177 699

Heart Health Assessment 1 November 2019 update

From 1 November 2019 an administrative amendment will be made to items 699 and 177 to make all health assessment items have a 100% benefit. The fees will be adjusted for items 699 and 177 so there is no change to the Medicare rebate patients will receive for a heart health assessment service.

Amendment to eight A2 services

Amends the descriptor of eight A2 services (items 52, 53, 54, 57, 58, 59, 60 and 65) by omitting reference to clause 2.3.1.

Remove gender specific text from professional attendance items

Gender specific text has been removed from Professional Attendance items in Groups: A3, A4, A8, A21, A24, A6, A12, A26, A29, A31, A15, A28, and A32.

GP Telehealth items (MMM 6-7)

Twelve new video conferencing items for patients in rural and remote areas (as defined by Modified Monash areas 6 to 7) to assist with access to general practice services.

Amendment to items 90092, 90093, 90095 and 90096

This amends the descriptor of four attendance items provided by omitting the rendering cohort of doctors in paragraphs (a) and (b) and substituting with “by a medical practitioner who is not a general practitioner”.

New MBS items for Eating Disorders

This change will introduce, a suite of 64 Eating Disorder items to support a model of best practice evidence based care for patients with anorexia nervosa and other eligible patients with eating disorders.

PROFESSIONAL ATTENDANCES NOTES

AN.0.1 Personal Attendance by Practitioner

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

AN.0.2 Benefits For Services

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

Responsibility for regulating the Medicare program lies with the Australian Government through the Department of Health. The Department of Human Services is responsible for consideration of applications and for the day to day operation of Medicare and the payment of benefits. Contact details of the Department of Health and the Department of Human Services are located at the end of these Notes.

AN.0.3 Professional Attendances

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

AN.0.4 Provider Numbers

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

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

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

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

Locum Tenens

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

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

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

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

· Check that they will be providing optometry services on behalf of a participating optometrist i.e. their employer has a current Undertaking.

· Complete the Schedule which is available on the Department of Human Services' website http://www.humanservices.gov.au/, before commencing the locum arrangement of the name and address of the participating optometrist on whose behalf they will be providing services.

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

AN.0.5 Services not Attracting Medicare Benefits

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

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

AN.0.6 Patient Eligibility

An "eligible person" is a person who resides permanently in Australia. This includes New Zealand citizens and holders of permanent residence visas. Applicants for permanent residence may also be eligible persons, depending on circumstances. Eligible persons must enrol with Medicare before they can receive Medicare benefits.

Medicare covers services provided only in Australia. It does not refund treatment or evacuation expenses overseas.

Medicare Cards

The ***green*** Medicare card is for people permanently in Australia. Cards may be issued for individuals or families.

The ***blue*** Medicare card bearing the words "INTERIM CARD" is for people who have applied for permanent residence.

Visitors from countries with which Australia has a Reciprocal Health Care Agreement (RHCA) receive a card bearing the words "RECIPROCAL HEALTH CARE".

Visitors to Australia and temporary residents

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

Reciprocal Health Care Agreements

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

Visitors from these countries are entitled to medical treatment while they are in Australia, comprising public hospital care (as public patients), Medicare benefits for out of hospital services and drugs under the Pharmaceutical Benefits Scheme (PBS). Visitors must enrol with the Department of Human Services to receive benefits. A passport is sufficient for public hospital care and PBS drugs.

Exceptions:

· Visitors from Ireland and New Zealand are entitled to public hospital care and PBS drugs only, and should present their passports before treatment as they are not issued with Medicare cards.

· Visitors from Italy and Malta are covered for a period of six months only.

The RHCAs do not cover treatment as a private patient in a public or private hospital. People visiting Australia for the purpose of receiving treatment are not covered. Visitors from New Zealand and the Republic of Ireland are NOT entitled to optometric treatment under a RHCA.

AN.0.7 Multiple Attendances on the Same Day

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

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

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

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

AN.0.8 Benefits For Optometrists

What services are covered?

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

From 1 January 2015, optometrists will be free to set their own fees for their professional service. However, the amount specified in the patient's account must be the amount charged for the service specified. The fee may not include a cost of goods or services which are not part of the MBS service specified on the account. A non-clinically relevant service must not be included in the charge for a Medicare item. The non-clinically relevant service must be separately listed on the account and not billed to Medicare. Where it is necessary for the optometrist to seek patient information from the Department of Human Services in order to determine appropriate itemisation of accounts, receipts or bulk-billed claims, the optometrist must ensure that:

(a) the patient is advised of the need to seek the information and the reason the information is required;

(b) the patient's informed consent to the release of information has been obtained; and

(c) the patient's records verify the patient's consent to the release of information.

Benefits may only be claimed when:

(a) a service has been performed and a clinical record of the service has been made;

(b) a significant consultation or examination procedure has been carried out;

(c) the service has been performed at premises to which the Undertaking relates;

(d) the service has involved the personal attendance of both the patient and the optometrist; and

(e) the service is "clinically relevant" (as defined in the *Health Insurance Act 1973*).

Where Medicare benefits are not payable

Medicare benefits may not be claimed for attendances for:

(a) delivery, dispensing, adjustment or repairs of visual aids;

(b) filling of prescriptions written by other practitioners.

Benefits are not payable for optometric services associated with:

(a) cosmetic surgery;

(b) refractive surgery;

(c) tests for fitness to undertake sporting, leisure or vocational activities;

(d) compulsory examinations or tests to obtain any commercial licence (e.g. flying or driving);

(e) entrance to schools or other educational facilities;

(f) compulsory examinations for admissions to aged care facilities;

(g) vision screening.

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

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

(b) an attendance on behalf of teaching institutions on patients of supervised students of optometry;

(c) where the service is not "clinically relevant" (as defined in the *Health Insurance Act 1973).*

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

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

(b) the service was rendered in one or more of the following circumstances -

(i) the employer arranges or requests the consultation

(ii) the results are provided to the employer by the optometrist

(iii) the employer requires that the employee have their eyes examined

(iv) the account for the consultation is sent to the employer

(v) the consultation takes place at the patient's workplace or in a mobile consulting room at the patient's

workplace.

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

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

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

a ***spouse***, in relation to a dependant person means:

(a) a person who is legally married to, and is not living, on a permanent basis, separately and apart from, that person; and

(b) a de facto spouse of that person.

a ***child***, in relation to a dependant person means:

(a) a child under the age of 16 years who is in the custody, care and control of the person or the spouse of the person; and

(b) a person who:

(i) has attained the age of 16 years who is in the custody, care and control of the person of the spouse of the person; or

(ii) is receiving full time education at a school, college or university; and

(iii) is not being paid a disability support pension under the *Social Security Act 1991*; and

(iv) is wholly or substantially dependent on the person or on the spouse of the person.

AN.0.9 Attendances by General Practitioners (Items 3-4, 23-24, 36-37, 44, 47, 193, 195, 197, 199, 585, 594, 599, 2095, 2144, 2180, 2193, 2497-2559, 5000-5067 and 90020-90051)

Attendances by General Practitioners (Items 3-4, 23-24, 36-37, 44, 47, 193, 195, 197, 199, 585, 594, 599, 2497-2559, 5000-5067 and 90020-90051)

Items 3-4, 23-24, 36-37, 44, 47, 193, 195, 197, 199, 585, 594, 599, 2095, 2144, 2180, 2193, 2497-2559, 5000-5067 and 90020-90051 relate to attendances rendered by medical practitioners who are:

- listed on the Vocational Register of General Practitioners maintained by the Department of Human Services; or

- holders of the Fellowship of the Royal Australian College of General Practitioners (FRACGP) who participate in, and meet the requirements of the RACGP for continuing medical education and quality assurance as defined in the RACGP Quality Assurance and Continuing Medical Education program; or

- holders of the Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) who participate in, and meet the requirements of the Australian College of Rural and Remote Medicine (ACRRM) for continuing medical education and quality assurance as defined in ACRRM's Professional Development Program; 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 training recognised by the RACGP as being of an equivalent standard; or

- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FACRRM or training recognised by ACRRM as being of an equivalent standard.

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

LEVEL A

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

LEVEL B

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

LEVEL C

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

LEVEL D

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

Creating and Updating a My Health Record

The time spent by a medical practitioner on the following activities may be counted towards the total consultation time:

· Reviewing a patient's clinical history, in the patient's file and/or the My Health Record, and preparing or updating a Shared Health Summary where it involves the exercise of clinical judgement about what aspects of the clinical history are relevant to inform ongoing management of the patient's care by other providers; or

· Preparing an Event Summary for the episode of care.

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

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

Counselling or Advice to Patients or Relatives

For items 23-24, 36-37, 44, 47 and 5020 to 5067 'implementation of a management plan' includes counselling services.

Items 3-4, 23-24, 36-37, 44, 47, 193, 195, 197, 199, 585, 594, 599, 2497-2559, 5000-5067 and 90020-90051 include advice to patients and/or relatives during the course of an attendance. The advising of relatives at a later time does not extend the time of attendance.

Recording Clinical Notes

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

Other Services at the Time of Attendance

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

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

AN.10.1 Schedule Fees and Medicare Benefits

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

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

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

Medicare Safety Nets

The Medicare safety net provides families and singles with an additional rebate for out-of-hospital Medicare services, once annual thresholds are reached. There are two safety nets: the original Medicare safety net and the extended Medicare safety net (EMSN).

Under the original Medicare safety net, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee.

Under the EMSN, once an annual threshold in out-of-pocket costs for out-of-hospital Medicare services is reached, Medicare will pay for 80% of any future out-of-pocket costs for out-of-hospital Medicare services for the remainder of the calendar year. However, where the item has an EMSN benefit cap, there is a maximum limit on the EMSN benefit that will be paid for that item. Further explanation about EMSN benefit caps is provided at www.mbsonline.gov.au.

The thresholds for the Medicare safety nets are indexed on 1 January each year.

Individuals are automatically registered with the Department of Human Services for the safety nets, however couples and families are required to register in order to be recognised as a family for the purposes of the safety nets. In most cases, registered families have their expenses combined to reach the safety net thresholds. This may help to qualify for safety net benefits more quickly. Registration forms can be obtained from the Department of Human Services offices, or completed at www.humanservices.gov.au. If you have already registered it is important to ensure your details are up to date.

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

Limiting rule for patient claims

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

Multiple attendances

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

Where two or more attendances are made on the one day by the same optometrist the time of each attendance should be stated on the account (e.g. 10.30 am and 3.15 pm) in order to assist in the payment of benefits. Times do not need to be specified where a perimetry item is performed in association with a consultation item.

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

Release of prescription

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

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

Reminder notices

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

Aftercare period following surgery

Medicare schedule items that apply to surgery include all professional attendances necessary for the post-operative treatment of the patient, other than attendances provided by vocationally or non-vocationally trained general practitioners. The aftercare period includes all post-operative treatment, when provided by a medical specialist, consultant physician or optometrist. The amount and duration of the aftercare may vary but includes all attendances until recovery from the operation. Attendances unrelated to the operation provided by a vocationally or non-vocationally registered general practitioner in the aftercare period can also attract Medicare benefits. Attendances provided by an optometrist in the aftercare period do not attract a Medicare benefit.

The rebate for cataract surgery includes payment for aftercare attendances so payment for aftercare services provided by an optometrist on behalf of a surgeon should be arranged with the surgeon. The optometrist should not charge the patient. In the case of cataract surgery, the first visit following surgery for which the optometrist can charge a rebatable fee is generally the attendance at which a prescription for spectacles or contact lenses is written.

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

Single Course of Attention

A reference to a single course of attention means:

(a) In the case of items 10905 to 10918, and old item 10900 - a course of attention by one or more optometrists in relation to a specific episode of optometric care.

(b) In relation to items 10921 to 10930 - a course of attention, including all associated attendances, by one or more optometrists for the purpose of prescribing and fitting of contact lenses. This includes those after-care visits necessary to ensure the satisfactory performance of the lenses.

Referred comprehensive initial consultations (item 10905) - Read in conjunction with 08 Referrals

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

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

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

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

Second comprehensive initial consultation, within 36 months for a patient who is less than 65 years of age and once every 12 months for a patient who is at least 65 years of age, of a previous comprehensive consultation (item 10907)

A patient can receive a comprehensive initial consultation by another optometrist within 36 months if the patient is less than 65 years of age, and once every 12 months if the patient is at least 65 years of age, if the patient has attended another optometrist for an attendance to which item 10905, 10907, 10910, 10911, 10912, 10913, 10914 or 10915 applies, or old item 10900 applied.

Comprehensive initial consultations (items 10910 and 10911)

There are two new MBS items for comprehensive initial consultation that have been introduced. Item 10910 has been introduced for a professional attendance of more than 15 minutes for a patient who is less than 65 years of age. This item is payable once only within a 36 month period, and if the patient has not received a service in this timeframe to which item 10905, 10907, 10910, 10912, 10913, 10914 or 10915 applies, or old item 10900 applied.

Item 10911 has been introduced for a professional attendance of more than 15 minutes for a patient who is at least 65 years of age. This item is payable once only within a 12 month period, and if the patient has not received a service in this timeframe to which item 10905, 10907, 10910, 10911, 10912, 10913, 10914 or 10915 applies, or old item 10900 applied.

However, a benefit is payable under item 10912, 10913, 10914 or 10915 where the patient has an ocular condition which necessitates a further course of attention being started within 36 months for a patient who is less than 65 years of age (item 10910) and within 12 months for a patient who is at least 65 years of age (item 10911) of the previous initial consultation. The conditions which qualify for a further course of attention are contained in the descriptions of these items.

Where an attendance would have been covered by item 10905, 10907, 10910, 10911, 10912, 10913, 10914, or 10915 but is of 15 minutes duration or less, item 10916 (Short consultation) applies.

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

Significant changes in visual function which justify the charging of item 10912 could include documented changes of:

· vision or visual acuity of 2 lines (0.2 logMAR) or more (corrected or uncorrected)

· visual fields or previously undetected field loss

· binocular vision

· contrast sensitivity or previously undetected contrast sensitivity loss.

New signs or symptoms requiring comprehensive re-evaluation (item 10913)

When charging item 10913 the optometrist should document the new signs or symptoms suffered by the patient on the patient's record card.

Progressive disorder requiring comprehensive re-evaluation (item 10914)

When charging item 10914, the optometrist should document the nature of the progressive disorder suffered by the patient on the patient's record card. Progressive disorders may include conditions such as maculopathy (including age related maculopathy) cataract, corneal dystrophies, glaucoma etc.

Examination of the eyes of a patient with diabetes mellitus (item 10915)

Where an examination of the eyes, with the instillation of a mydriatic, of a patient with diabetes mellitus is being conducted, where possible this item should be billed rather than item 10914 to assist in identifying whether such patients are receiving appropriate eye care.

Second or subsequent consultations (item 10918)

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

Contact lens consultations (items 10921 to 10930)

In the case of contact lens consultations, benefit is payable only where the patient is one of the prescribed classes of patient entitled to benefit for contact lens consultations as described in items 10921 to 10929.

For claims under items 10921,10922,10923,10925 and 10930, eligibility is based on the patient's distance spectacle prescription, determining the spherical equivalent by adding to the spherical prescription, half the cylindrical correction.

Medicare benefits are not payable for item 10929 in circumstances where a patient wants contact lenses for:

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

(b) sporting purposes;

(c) work purposes; or

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

All attendances subsequent to the initial consultation in a course of attention involving the prescription and fitting of contact lenses are collectively regarded as a single service under items 10921 to 10930, as appropriate. The date of service is deemed to be the date on which the contact lenses are delivered to the patient. In some cases, where the patient decides not to proceed with contact lenses, no Medicare fee is payable because the patient has not taken delivery of the lenses. In such instances, the patient may be charged a non-rebatable (private) fee for a 'part' service.

Any visits related to the prescribing and fitting of lenses are regarded to be covered by the relevant item in the range 10921 to 10930. The bulk item includes those aftercare visits necessary to ensure the satisfactory performance of the lenses. This interpretation is unaltered by the frequency of aftercare visits associated with various lens types including extended wear lenses.

Consultations during the aftercare period that are unrelated to the prescription and fitting of contact lenses or that are not part of normal aftercare may be billed under other appropriate items (not items 10921 to 10930).

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

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

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

Benefit under items 10921 to 10929 is payable once only in any period of 36 consecutive months except where circumstances are met under item 10930 within a 36 month period.

Domiciliary visits (items 10931 - 10933)

Where patients are unable to travel to an optometrist's practice for treatment, and where the request for treatment is initiated by the patient, a domiciliary visit may be conducted, which involves the optometrist travelling to the patient's place of residence, and transporting the necessary equipment. Where possible, it is preferable that the patient travel to the practice so that the full range of equipment is available for the examination of the patient.

Benefits are payable under items 10931 - 10933 to provide some financial assistance in the form of a loading to the optometrist, in recompense for travel costs and packing and unpacking of equipment. The loading is in addition to the consultation item. For the purposes of the loading, acceptable places of residence for domiciliary visits are:

- the patient's home;

- a residential aged care facility as defined by the *Aged Care Act 1997;* or

- an institution which means a place (other than a residential aged care facility or hospital) at which residential accommodation and/or day care is made available to any of the following categories: disadvantaged children, juvenile offenders, aged persons, chronically ill psychiatric patients, homeless persons, unemployed persons, persons suffering from alcoholism, persons addicted to drugs, or physically or intellectually disabled persons.

Visits to a hospital at the patient's request are not covered by the loading and instead, an extra fee in addition to the Schedule fee can be charged, providing the service is not bulk-billed. Medicare benefits are not payable in respect of the private charge.

Items 10931 - 10933 may be used whether or not the optometrist chooses to bulk-bill but it is important that if the consultation is bulk-billed the loading is also, and no private charge can then be levied. If the consultation is not bulk-billed, the loading should also not be bulk-billed and a private charge may be levied. The usual requirement that the patient must have requested the domiciliary visit applies.

Domiciliary visit loading items cannot be claimed in conjunction with brief initial consultation item 10916, or with computerised perimetry items 10940 or 10941. The choice of appropriate item in the range 10931 - 10933 depends

on how many patients are seen at the one location. Benefits are payable under item 10931 where the optometrist travels to see one patient at a single location. Item 10931 can be billed in addition to the appropriate consultation item (excluding items 10916, 10932, 10933, 10940 or 10941). If the optometrist goes on to see another single patient **at a different location**, that patient can also be billed an item 10931 plus the appropriate consultation. However, if two patients are visited at a single location on the same occasion, each of the two patients should be billed item 10932 as well as the appropriate consultation item applying to each patient. Similarly, if three patients are visited at a single location on the same occasion, each of the three patients should be billed item 10933 as well as the appropriate consultation item applying to each patient.

Where more than three patients are seen at the same location, additional benefits for domiciliary visits are not payable for the fourth, fifth etc patients. On such occasions, the first three patients should be billed item 10933 as well as the appropriate consultation item, and all subsequent patients may only be billed the appropriate consultation item. Where multiple patients are seen at one location on one occasion, there is no provision for patients to be 'grouped' into twos and threes for billing purposes.

Where a private charge is levied for a domiciliary visit, bulk-billing is precluded. Medicare benefits are not payable in respect of the private charge and the patient should be informed of this. Private charges should be shown separately on accounts issued by optometrists and must not be included in the fees for the service.

Computerised Perimetry Services (items 10940 and 10941)

Benefit under items 10940 and 10941 is payable where full quantitative computerised perimetry (automated absolute static threshold but not including multifocal multichannel objective perimetry) has been performed by an optometrist on both eyes (item 10940) or one eye (item 10941) where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain. Item 10940 for bilateral procedures cannot be claimed for patients who are totally blind in one eye. In this instance, item 10941 for unilateral procedures should be claimed, where appropriate.

These items can be billed either in association with comprehensive consultation items 10905, 10907, 10910, 10911, 10912, 10913, 10914, or 10915, or independently, but they cannot be billed with items 10916, 10918, 10931, 10932 or 10933. An assessment and report is required and, where referral to an ophthalmologist for further treatment is required, the printed results of the perimetry should be provided to the ophthalmologist to discourage repetition of perimetry unless clinically necessary. If Medicare benefits are to be claimed, a maximum of two perimetry services in any twelve month period may be provided.

Low Vision Assessment (item 10942)

A benefit is payable under item 10942 where one or more of the tests outlined in the item description are carried out on a patient who has already been established during a comprehensive consultation as having low vision, as specifically defined in the item. This item is not intended for patients expected to undergo cataract surgery in the near future who may temporarily meet the criteria for having low vision.

Item 10942 may be claimed on the same day as either a comprehensive initial consultation (items 10905 - 10915) or a subsequent consultation (item 10918), but only where the additional low vision testing has been carried out on an eligible patient. Item 10942 is not intended to be claimed with a brief initial consultation (item 10916), or with any of the contact lens items (items 10921-10930).

Children's vision assessment (item 10943)

Children aged 0 to 2 years, and 15 years and over, are not eligible for item 10943 and may be treated under appropriate attendance items.

A benefit is payable under item 10943 where one or more of the assessment and testing procedures outlined in the item description are carried out on a patient aged 3 - 14 years inclusive, and where a finding of significant binocular or accommodative dysfunction is the outcome of the consultation and assessment/testing. The conditions to be assessed under this item are primarily amblyopia and strabismus, but dysfunctions relating to vergences are also covered, providing well established and evidence based optometry practice is observed.

A benefit is not payable under item 10943 for the assessment of learning difficulties or learning disabilities.

Item 10943 may be claimed on the same day as either a comprehensive consultation (items 10905 - 10915) or a subsequent consultation (item 10918), but only where the additional assessment/testing has been carried out on an eligible child. Item 10943 is not intended to be claimed with a brief initial consultation (item 10916), or with any of the contact lens items (items 10921-10930).

Removal of an embedded corneal foreign body (item 10944)

Item 10944 has been introduced for the complete removal of an embedded corneal foreign body that is sub-epithelial or intra-epithelial and the removal of rust rings from the cornea.

The removal of an embedded foreign body should be performed using a hypodermic needle, foreign body gouge or similar surgical instrument, with magnification provided by a slit lamp biomicroscope, loupe or similar device.

The optometrist should document the nature of the embedded foreign body (sub-epithelial or intra-epithelial), method of removal and the magnification. Similarly, with rust ring removal, the optometrist should document the method of removal and the magnification.

Where complexity of the procedure is beyond the skill of the optometrist, or if other complications are present (e.g. globe perforation, penetration >25%, or patient unable to hold still due to pathological anxiety, nystagmus, or tremor etc, without some form of systemic medication), the patient should be referred to an ophthalmologist.

This item cannot be billed on the same occasion as items 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915, 10916 or 10918. If the embedded foreign body or rust ring has not been completely removed, benefits are only payable under item 10916.

AN.0.11 Professional Attendances at an Institution (Items 4, 24, 37, 47, 58, 59, 60, 65, 5003, 5023, 5043, 5063, 5220, 5223, 5227 and 5228)

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

(a) disadvantaged children;

(b) juvenile offenders;

(c) aged persons;

(d) chronically ill psychiatric patients;

(e) homeless persons;

(f) unemployed persons;

(g) persons suffering from alcoholism;

(h) persons addicted to drugs; or

(i) physically or intellectually disabled persons.

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 facility on the one occasion, each account, receipt or assignment form would show "Item 4 - 1 of 10 patients" for a general practitioner.

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

AN.0.12 Billing Procedures

There are three ways benefits may be paid for optometric services:

(a) the claimant may pay the optometrist's account in full and then claim benefits from the Department of Human Services office by submitting the account and the receipt;

(b) the claimant may submit the unpaid account to the Department of Human Services who will then send a cheque in favour of the optometrist, to the claimant; or

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

Claiming of benefits

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

Paid accounts

If the account has been paid in full a claimant can claim Medicare benefits in a number of ways:

- Electronically if the claimant's doctor offers this service and the claimant has completed and lodged a Bank account details collection form with Medicare.
- Online through Medicare Online Services.
- At the claimant's local Department of Human Services Service Centre.
- By mail by sending a completed Medicare claim form with the original accounts and/or receipts to:

Department of Human Services

GPO Box 9822

In the claimant's capital city

- Over the phone by calling 132 011 and giving the claim details and then sending the accounts and/or receipts to:

Telephone Claiming

Department of Human Services

GPO Box 9847

In the claimant's capital city

Practitioners seeking information regarding registration to allow EFT payments and other E-Business transactions, can do so by viewing the Health Professionals section at the Department of Human Services at www.humanservices.gov.au.

Unpaid accounts

Where the patient has not paid the account in full, the unpaid account may be presented to the Department of Human Services with a completed Medicare claim form. In this case the Department of Human Services will forward to the claimant a benefit cheque made payable to the optometrist.

It is the patient's responsibility to forward the cheque to the optometrist and make arrangements for payment of the balance of the account, if any. "Pay optometrist" cheques involving Medicare benefits must (by law), not be sent direct to optometrists, or to the claimant at an optometrist's address (even if requested by the claimant to do so). "Pay optometrist" cheques are required to be forwarded to the claimant's last known address as recorded with the Department of Human Services.

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

Itemised accounts

When an optometrist bills a patient for a service, the patient should be issued with a correctly itemised account and receipt to enable the patient to claim Medicare benefits. Where both a consultation and another service, for example computerised perimetry occur, these may be itemised on the same account.

Medicare benefits are only payable in respect of optometric services where it is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of each service to each patient, the following information:

(a) patient's name;

(b) date on which the service(s) was rendered;

(c) a description of the service(s) (e.g. "initial consultation," "subsequent consultation" or "contact lens consultation"and/or "computerised perimetry" in those cases where it is performed);

(d) Medicare Benefits Schedule item number(s);

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

(f) the fee charged for the service(s); and

(g) the time each service began if the optometrist attended the patient on more than one occasion on the same day and on each occasion rendered a professional service relating to an optometric item, except where a perimetry item is performed in association with a consultation item, where times do not need to be specified.

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

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

Details of any charges made other than for services, e.g. a dispensing charge, a charge for a domiciliary visit, should be shown separately either on the same account or on a separate account.

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

Duplicate accounts

Only one original itemised account per service should be issued, except in circumstances where both a consultation and computerised perimetry occur, in which case these may be itemised on the same original account. Duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

Assignment of benefit (bulk billed) arrangements

Under the *Health Insurance Act 1973* an Assignment of Benefit (bulk-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need.

If an optometrist bulk-bills, they undertake to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:

· the patient's Medicare number must be quoted on all bulk-bill assignment of benefit forms for that patient;

· the assignment of benefit forms provided are loose leaf to enable the patient details to be imprinted from the Medicare Card;

· the forms include information required by Regulations under Section 19(6) of the *Health Insurance Act 1973*; and

· the optometrist must cause the particulars relating to the professional service to be set out on the assignment of benefit form, before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it.

Where a patient is unable to sign the assignment of benefit form, the signature of the patient's parent, guardian or other responsible person (other than the optometrist, optometrist's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff)) is acceptable.

Where the signature space is either left blank or another person signs on the patient's behalf, the form **must** include:

- the notation "Patient unable to sign" and
- in the section headed 'Practitioner's Use', an explanation should be given as to why the patient was unable to sign (e.g. unconscious, injured hand etc.) and this note should be signed or initialled by the optometrist. If in the opinion of the optometrist the reason is of such a "sensitive" nature that revealing it would constitute an unacceptable breach of patient confidentiality or unduly embarrass or distress the recipient of the patient's copy of the assignment of benefits form, a concessional reason "due to medical condition" to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific.

Use of Medicare cards in bulk-billing

Where a patient presents without a Medicare card and indicates that they have been issued with a card but does not know the details, the optometrist may contact the Department of Human Services on 132 150 to obtain the number.

It is important for the optometrist to check the eligibility of their patients for Medicare benefits by reference to the card, as entitlement is limited to the "valid to" date shown on the bottom of the card. Additionally the card will show if a person is enrolled through a Reciprocal Health Care Agreement.

Assignment of benefit forms

Only the approved assignment of benefit forms available from the Department of Human Services website, www.humanservices.gov.au, can be used to bulk-bill patients for optometric services and no other form can be used without its approval.

(a) **Form DB2-OP**
This form is designed for the use of optical scanning equipment and is used to assign benefits for optometrical services. It is loose leaf to enable imprinting of patient details from the Medicare card and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Practitioner copy and a Patient copy.

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

The Claim for Assigned Benefits (Form DB1N, DB1H)

Optometrists who accept assigned benefits must claim from the Department of Human Services using either Claim for Assigned Benefits form DB1N or DB1H. The DB1N form should be used where services are rendered to persons for treatment provided out of hospital or day hospital treatment. The DB1H form should be used where services are rendered to persons while hospital treatment is provided in a hospital or day hospital facility (other than public patients). Both forms have been designed to enable benefit for a claim to be directed to an optometrist other than the one who rendered the services. The facility is intended for use in situations such as where a short term locum is acting on behalf of the principal optometrist and setting the locum up with a provider number and pay-group link for the principal optometrist's practice is impractical. Optometrists should note that this facility cannot be used to generate payments to or through a person who does not have a provider number.

Each claim form must be accompanied by the assignment of benefit forms to which the claim relates.

Time limits applicable to lodgement of bulk bill claims for benefits

A time limit of two years applies to the lodgement of claims with the Department of Human Services under the bulk billed (assignment of benefits) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than two years earlier than the date the claim was lodged with the Department of Human Services.

Provision exists whereby in certain circumstances (e.g. hardship cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the Department of Human Services website at www.humanservices.gov.au or the processing centre to which bulk-bill claims are directed.

AN.0.13 Attendances at a Hospital (Items 4, 24, 37, 47, 58, 59, 60, 65)

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

AN.0.14 Referrals (Read in Connection with the Relevant Paragraphs at O.6)

General

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

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

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

A referral letter or note must have been issued by the optometrist for all such services provided by specialist ophthalmologists or optometrists in order for patients to be eligible for Medicare benefits at the referred rate. Unless such a letter or note has been provided, benefits will be paid at the non-referred attendance rate, which has a lower rebate..

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

What is a referral?

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

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

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

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

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

The exceptions to the requirements in the above paragraph are that:

(a) sub-paragraphs (b) and (c) do not apply to an emergency situation where the specialist ophthalmologist was of the opinion that the service be rendered as quickly as possible (see paragraph below on emergency situations); and

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

Period for which referral is valid

A referral from an optometrist to an ophthalmologist is valid for twelve months unless the optometrist specifies on the referral that the referral is for a different period (e.g. three, six or eighteen months or valid indefinitely).

The referral applies for the period specified in the referral from the date that the ophthalmologist provides the first service to the patient. If there is no period specified in the referral then the referral is valid for twelve months from the date of the first service provided by the ophthalmologist.

Referrals for longer than twelve months should be made only when the patient's clinical condition requires continuing care and management.

An optometrist may write a new referral when a patient presents with a condition unrelated to the condition for which the previous referral to an ophthalmologist was written. In these circumstances Medicare benefits for the consultation with the ophthalmologist would be payable at initial consultation rates.

A new course of treatment for which Medicare benefits would be payable at the initial consultation rates will also be paid where the referring optometrist:

(a) deems it necessary for the patient's condition to be reviewed; and

(b) the patient is seen by the ophthalmologist outside the currency of the previous referral; and

(c) the patient was last seen by the specialist ophthalmologist more than nine months earlier than the attendance following a new referral.

Self referral

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

Lost, stolen or destroyed referrals

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

Emergency situations

Medicare benefits are payable even though there is no written referral in an emergency situation (as defined in the *Health Insurance Regulations 2018*). The specialist or the consultant physician should be of the opinion that the service must be rendered as quickly as possible and endorses the account, receipt or assignment form as an "Emergency referral".

A referral must be obtained from a medical practitioner or, in the case of a specialist ophthalmologist, a medical practitioner or an optometrist if attendances subsequent to the emergency attendance are to attract Medicare benefits at the referred rate.

AN.0.15 Residential Aged Care Facility Attendances (Items 5010, 5028, 5049, 5067, 5260, 5263, 5265, 5267)

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

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

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

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

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 two patients were visited (for a brief consultation) in the one facility on the one occasion, each account, receipt or assignment form would show "Item 5010 - 1 of 2 patients" for a general practitioner.

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

AN.0.16 Provision for Review of the Schedule
Optometric Benefits Consultative Committee (OBCC)

The OBCC is an advisory committee established in 1990 by arrangement between the Minister and Optometry Australia.

The OBCC's functions are:

(a) to discuss the appropriateness of existing Medicare Benefits Schedule items for the purposes of considering whether an approach to the Medical Services Advisory Committee may be needed;

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

(c) to consider and advise on the appropriateness of the participating optometrists' arrangements and the Common Form of Undertaking (as specified in the *Health Insurance Act 1973* and related legislation) and the administrative rules and interpretations which determine the payment of benefits for optometric services or the level of benefits;

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

The OBCC comprises two representatives from the Department of Health, two representatives from the Department of Human Services, and three representatives from Optometry Australia.

AN.0.18 Provision for Review of Practitioner Behaviour
Professional Services Review (PSR) Scheme

The Professional Services Review (PSR) Scheme is a scheme for reviewing and investigating the provision of services by a health practitioner to determine whether the practitioner has engaged in inappropriate practice in the rendering or initiating of Medicare services or in prescribing under the Pharmaceutical Benefits Scheme (PBS). 'Practitioner' is defined in Section 81 of the *Health Insurance Act 1973* and includes: medical practitioners, dentists, optometrists, chiropractors, midwives, nurse practitioners, physiotherapists, podiatrists and osteopaths.

Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude that it would be unacceptable to the general body of the members of the profession in which the practitioner was practising when he or she rendered or initiated the services. It is also an offence under Section 82 for a person who is an officer of a body corporate to knowingly, recklessly or negligently cause or permit a practitioner employed by the person to engage in such conduct.

The Department of Human Services monitors health practitioners' claiming patterns. Where an anomaly is detected, for which a satisfactory explanation cannot be provided, the Department of Human Services can request that the Director of PSR review the provision of services by the practitioner. On receiving the request, the Director must decide whether to conduct a review and in which manner the review will be conducted. The Director is authorised to require that documents and information be provided.

Following a review, the Director must:

(a) decide to take no further action; or

(b) enter into an agreement with the person under review (which must then be ratified by an independent Determining Authority); or

(c) refer the matter to a PSR Committee.

A PSR Committee consists of the Chairperson and two other panel members who must be members of the same profession as the practitioner under review. However, up to two additional Committee members may be appointed to provide a wider range of clinical expertise.

The Committee is authorised to:

(a) investigate any aspect of the provision of the referred services, and without being limited by the reasons given in the review request or by a Director's report following the review;

(b) hold hearings and require the person under review to attend and give evidence; and

(c) require the production of documents (including clinical notes).

A PSR Committee may not make a finding of inappropriate practice unless it has given the person under review notice of its intention to review them, the reasons for its findings, and an opportunity to respond. In reaching their decision, a PSR Committee is required to consider whether or not the practitioner has kept adequate and contemporaneous patient records. It will be up to the peer judgement of the PSR Committee to decide if a practitioner's records meet the prescribed standards.

The standards which determine if a record is adequate and contemporaneous are prescribed in the *Health Insurance (Professional Services Review) Regulations 1999*.

To be ***adequate***, the patient or clinical record needs to:

clearly identify the name of the patient; and

contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated; and

each entry needs to provide clinical information adequate to explain the type of service rendered or initiated; and

each entry needs to be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient's ongoing care.

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

The practitioner under review is permitted to make submissions to the PSR Committee before key decisions or a final report is made.

If a PSR Committee finds that the person under review has engaged in inappropriate practice, the findings will be reported to the Determining Authority to decide what action should be taken:

(i) a reprimand;

(ii) counselling;

(iii) repayment of Medicare benefits; and/or

(iv) complete or partial disqualification from Medicare benefit arrangements for up to three years.

Further information on the Professional Services Review is available at www.psr.gov.au and information on Medicare compliance is available at http://www.humanservices.gov.au/health-professionals/subjects/compliance?utm_id=9.

Penalties

Penalties of up to $10,000 or imprisonment for up to five years, or both may be imposed on any person who makes a statement (either orally or in writing) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used with a claim for benefits. In addition, any practitioner who is found guilty of such offences shall be subject to examination by a Medicare Participation Review Committee (MPRC) and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.

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

Medicare Participation Review Committee (MPRC)

The Medicare Participation Review Committee determines what administrative action should be taken against a practitioner who:

(a) has been successfully prosecuted for relevant criminal offences; or

(b) has been found to have engaged in inappropriate practice under the Professional Services Review scheme.

The Committee can take no further action, counsel or reprimand the practitioner, or determine that the practitioner be disqualified from Medicare for a particular period or in relation to particular services for up to five years.

Medicare benefits are not payable in respect of services rendered by a practitioner who has been fully disqualified, or partly disqualified in relation to relevant services under the *Health Insurance Act 1973* (Section 19B applies).

AN.0.19 After-Hours Attendances (Items 585, 588, 591, 594, 599, 600, 5000, 5003, 5010, 5020, 5023, 5028, 5040, 5043, 5049, 5060, 5063, 5067, 5200, 5203, 5207, 5208, 5220, 5223, 5227, 5228, 5260, 5263, 5265 and 5267)

After-Hours Attendances (Items 585, 588, 591, 594, 599, 600, 5000, 5003, 5010, 5020, 5023, 5028, 5040, 5043, 5049, 5060, 5063, 5067, 5200, 5203, 5207, 5208, 5220, 5223, 5227, 5228, 5260, 5263, 5265 and 5267)

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

After-hours attendance items may be claimed as follows:

Items 585, 588, 591, 594, 599, 600 apply only to a professional attendance that is provided:

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

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

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

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

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

Urgent After-Hours Attendances (Items 585 - 600)

Items 585, 588, 591, 594, 599 and 600 can be used for urgent after-hours services.

Urgent After-Hours Attendances (Items 585, 588, 591, and 594) allow for urgent attendances (other than an attendance between 11pm and 7am) in an after-hours period.

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

The attendance for all these items must be requested by the patient or a responsible person during the same unbroken urgent after-hours period in which the medical service is provided. The medical practitioner must first determine that the patient requires urgent medical assessment.

In considering the need for an urgent assessment of a patient's condition, the practitioner may rely on information conveyed by the patient or patient's carer, other health professionals or emergency services personnel. A record of the assessment must be completed and included in the patient's medical record.

The MBS urgent after-hours items may be used when, on the information available to the medical practitioner, the patient's condition requires urgent medical assessment during the after-hours period to prevent deterioration or potential deterioration in their health. Specifically the patient's assessment:

- cannot be delayed until the next in-hours period; and
- the medical practitioner must attend the patient at the patient's location or reopen the practice rooms.

Appendix B of the Approved Medical Deputising Service (AMDS) Program Guidelines offers a useful protocol to determine whether prospective after-hours patients should be seen by a deputising medical practitioner or see their regular medical practitioner. The AMDS Program Guidelines are available at http://www.health.gov.au/internet/main/publishing.nsf/Content/approved-medical-deputising-service

If the attendance is undertaken at consulting rooms, it is necessary for the practitioner to return to and specially open the consulting rooms for the attendance.

MBS Item 585 is available to medical practitioners who are:

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

- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FACRRM or training recognised by ACRRM as being of an equivalent standard.

NOTE: MBS incentives continue to be available through the After-Hours Other Medical Practitioners (AHOMPs) Program to non-vocationally recognised medical practitioners who perform after-hours attendances. MBS item 585 will be available to AHOMPs Program participants if they perform an urgent after-hours attendance as part of their employment with a full-time general practice.

AHOMPs will not extend access to item 585 to non-vocationally recognised medical practitioners who work with an after-hours only practice or a medical deputising service (including an AMDS).

MBS Item 588 is available to non-vocationally recognised medical practitioners who are providing services (as a contractor, employee, member or otherwise) for a general practice or clinic or as part of medical deputising arrangements in Modified Monash Model Areas 2 to 7.

A locator map to identify a medical practice's Modified Monash Model Area location is available at the DoctorConnect website at http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator

MBS item 591 is available to non-vocationally recognised medical practitioners who perform attendances for after-hours clinics or as part of deputising arrangements in Modified Monash Model Area 1.

If more than one patient is seen on the same occasion (that is, the second and any further services are consequential to the first service) using either MBS items 585, 588 or 591, **MBS item 594** must be used in respect of the second and subsequent services to patients attended on the same occasion.

Medical practitioners who routinely provide services to patients in the after-hours periods at consulting rooms, or who provide the services (as a contractor, employee, member or otherwise) for a general practice or clinic that routinely provides services to patients in after-hours periods at consulting rooms, will not be able to bill urgent after-hours items 585, 588, 591, 594, 599 and 600.

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

There is no change to the types of providers who can render services under the *Urgent After-Hours Attendances during Unsociable Hours items* (MBS items 599 and 600). Attendances using these items must be booked during the same unbroken urgent after-hours period.

MBS item 599 continues to be available to medical practitioners who are:

- listed on the Vocational Register of General Practitioners maintained by the Department of Human Services or;

- holders of the Fellowship of the Royal Australian College of General Practitioners (FRACGP) who participate in, and meet the requirements of the RACGP for continuing medical education and quality assurance as defined in the RACGP Quality Assurance and Continuing Medical Education Program; or

- holders of the Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) who participate in, and meet the requirements of the Australian College of Rural and Remote Medicine (ACRRM) for continuing medical education and quality assurance as defined in ACRRM's Professional Development Program; 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 training recognised by the RACGP as being of an equivalent standard; or

- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FACRRM or training recognised by ACRRM as being of an equivalent standard non-vocationally recognised medical practitioners through the AHOMPs Program; or

- non-vocationally recognised medical practitioners participating in the AHOMPs Program.

MBS item 600 continues to be available to non-vocationally recognised medical practitioners.

Non-Urgent After-Hours Attendances (5000 - 5067 and 5200 - 5267)

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

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

Attendance Period	**Applicable Time**			**Items**
	Monday to Friday	**Saturday***	**Sunday and/or public holiday**	
Urgent after-hours attendance	Between 7am - 8am and 6pm - 11pm	Between 7am - 8am and 12 noon - 11pm	Between 7am - 11pm	585, 588, 591, 594
Urgent after-hours in unsociable hours	Between 11pm - 7am	Between 11pm - 7am	Between 11pm - 7am	599, 600
Non-urgent After hours In consulting rooms	Before 8am or after 8pm	Before 8am or after 1pm	24 hours	5000, 5020, 5040, 5060 5200, 5203, 5207, 5208
Non-urgent after-hours at a place other than consulting rooms (other than a hospital or Residential Aged Care Facility)	Before 8am or after 6pm	Before 8am or after 12 noon	24 hours	5003, 5023,5043, 5063, 5220, 5223, 5227, 5228
Non-urgent after-hours in a Residential Aged Care Facility	Before 8am or after 6pm	Before 8am or after 12 noon	24 hours	5010, 5028, 5049, 5067 5260, 5263, 5265, 5267

*with the exception of public holidays which fall on a Saturday

AN.0.20 Visiting Optometrists Scheme (VOS)

Special arrangements exist under the provisions of Section 129A of the Health Insurance Act 1973 to ensure that people in rural and remote locations have access to optometry services. Optometrists are encouraged to provide outreach services to national priority locations, particularly remote and very remote locations, Aboriginal and Torres Strait Islander communities and rural locations with an identified need for optometry services.

Under these arrangements, financial assistance may be provided to cover costs associated with delivering outreach services, including travel, accommodation and meals and facility fees.

Funding agreements are currently in place with optometrists for the delivery of services until 30 June 2015. Enquiries can be directed to vos@health.gov.au.

AN.0.21 Minor Attendance by a Consultant Physician (Items 119, 120, 131)

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.

AN.0.22 Telehealth Patient-end Support Services by Optometrists

These notes provide information on the telehealth MBS attendance items for optometrists to provide clinical support to their patients, when clinically relevant, during video consultations with ophthalmologists under items 10945, 10946, 10947 and 10948 in Group A10.

Telehealth patient-end support services can only be claimed where:

- a Medicare eligible specialist service is claimed;

- the service is rendered in Australia; and

- this is necessary for the provision of the specialist service.

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

Clinical indications

The ophthalmologist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the ophthalmologist.

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

Collaborative Consultation

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

Restrictions

The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes Hospital in the Home patients). Benefits are not payable for telephone or email consultations. In order to fulfil the

item descriptor there must be a visual and audio link between the patient and the ophthalmologist. If the ophthalmologist is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Eligible Geographical Areas

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

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference. This rule will not apply to specialist video consultations with patients who are a care recipient in an eligible residential care service; or at an eligible Aboriginal Medical Service or Aboriginal Community Controlled Health Service for which a direction, made under subsection 19(2) of the *Health Insurance Act 1973*, as these patients are able to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at:
http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/connectinghealthservices-eligible-geo.

Record Keeping

Telehealth optometrists must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

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

Multiple attendances on the same day

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

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

Also, if a patient has an initial consultation via telehealth, they cannot also claim an initial face-to-face consultation as part of the same course of treatment.

Aftercare Rule

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

Referrals

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

Technical requirements

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

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

Duration of attendance

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

AN.0.23 Referred Patient Consultant Physician Treatment and Management Plan (Items 132 and 133)

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

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

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

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

Preparation of the consultant physician treatment and management plan should be in consultation with the patient. If appropriate, a written copy of the consultant physician treatment and management plan should be provided to the patient. A written copy of the consultant physician treatment and management plan should be provided to the referring medical practitioner, usually within two weeks of the consultant physician consultation. In more serious cases, more prompt provision of the plan and verbal communication with the referring medical practitioner may be appropriate. A guide to the content of such consultant physician treatment and management plans which are to be provided under this item is included within this Schedule.

(Note: This information is provided as a guide only and each case should be addressed according to a patient's individual needs.)

REFERRED PATIENT CONSULTANT PHYSICIAN TREATMENT AND MANAGEMENT PLAN

- The following content outline is indicative of what would normally be sent back to the referring practitioner.

- The consultant physician treatment and management plan should address the specific questions and issues raised by the referring practitioner.

History

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

Examination

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

Diagnosis

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

Management plan

Treatment options/Treatment plan

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

Medication recommendations

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

Social measures

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

Other non medication measures

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

Indications for review

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

Longer term management

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

The Department of Human Services (DHS) has developed an Health Practitioner Guideline to substantiate that a valid referral existed (specialist or consultant physician) which is located on the DHS website.

AN.0.24 Referred patient assessment, diagnosis and treatment and management plan for autism or any other pervasive developmental disorder (items 135 and 289)

These items are for consultant paediatricians (item 135) or psychiatrists (item 289), on referral from a medical practitioner, to provide early diagnosis and treatment of autism or any other pervasive development disorder (PDD)

for children aged under 13 years. The items are for assessment, diagnosis and the creation of a treatment and management plan, and are claimable only once per patient per lifetime.

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

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

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

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

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

Items 135 or 289 also provide a referral pathway for access to services provided through Childhood Autism Advisors by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). For further information on assistance available through FaHCSIA, phone 1800 778 581 or emailASD.Support@fahcsia.gov.au. TTY users - phone 1800 555 677 then ask for the 1800 toll-free number you wish to contact.

Referral requirements

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

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

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

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

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

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

Allied health assistance with diagnosis/assessment and treatment

Helping Children with Autism Program - Allied Health Items

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

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

Assessment services

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

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

An allied health professional can provide these services when:

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

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

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

Treatment services

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

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

An eligible allied health professional can provide these services when:

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

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

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

Existing patients or patients with an existing diagnosis

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

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

AN.0.25 Patient Assessment, Diagnosis and Treatment and Management Plan for a Child with Disability (Items 137 and 139)

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

(a) sight impairment that results in vision of less than or equal to 6/18 vision or equivalent field loss in the better eye, with

correction.

(b) hearing impairment that results in:

(i) a hearing loss of 40 decibels or greater in the better ear, across 4 frequencies; or

(ii) permanent conductive hearing loss and auditory neuropathy.

(c) deafblindness

(d) cerebral palsy

(e) Down syndrome

(f) Fragile X syndrome

(g) Prader-Willi syndrome

(h) Williams syndrome

(i) Angelman syndrome

(j) Kabuki syndrome

(k) Smith-Magenis syndrome

(l) CHARGE syndrome

(m) Cri du Chat syndrome

(n) Cornelia de Lange syndrome

(o) microcephaly if a child has:

(i) a head circumference less than the third percentile for age and sex; and

(ii) a functional level at or below 2 standard deviations below the mean for age on a standard developmental test, or an IQ score of less than 70 on a standardised test of intelligence.

(p) Rett's disorder

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

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

AN.0.26 Geriatrician Referred Patient Assessment and Management Plan (Items 141-147)

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

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

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

· current active medical problems

· past medical history;

· medication review;

· immunisation status;

· advance care planning arrangements;

· current and previous physical function including personal, domestic and community activities of daily living;

· psychological function including cognition and mood; and

· social function including living arrangements, financial arrangements, community services, social support and carer issues.

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

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

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

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

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

The Patient Assessment and Management plans must be kept for 2 years after the date of service.

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

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

AN.0.27 Prolonged Attendance in Treatment of a Critical Condition (Items 160 164)

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

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

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

(iii) if personal attendance on a single patient is provided by 1 or more general practitioners, specialists or consultant physicians concurrently, each general practitioner, specialist or consultant physician may claim an attendance fee.

AN.0.28 Family Group Therapy (Items 170, 171, 172)

These items refer to family group therapy supervised by general practitioner, specialist or consultant physician (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.

AN.0.29 Acupuncture (Item 173, 193, 195, 197 and 199)

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

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

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

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

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

AN.0.30 Consultant Psychiatrist - Initial consultations for NEW PATIENTS (Items 296 to 299 and 361) Referred Patient Assessment and Management Plan (Items 291, 293 and 359) and referral to Allied Mental Health Professionals

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

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

- Kessler Psychological Distress Scale (K10)

- Short Form Health Survey (SF12)

- Health of the Nation Outcome Scales (HoNOS)

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

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

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

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

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

REFERRED PATIENT ASSESSMENT AND MANAGEMENT PLAN

Preliminary

- The following content outline is indicative of what would usually be sent back to GPs or participating nurse practitioner.

- The Management plan should address the specific questions and issues raised by the GP or participating nurse practitioner

- In most cases the patient is usually well known by the GP or participating nurse practitioner

History and Examination

This should focus on the presenting symptoms and current difficulties, including precipitating and ongoing stresses; and only briefly mention any relevant aspects of the patient's family history, developmental history, personality features, past psychiatric history and past medical history.

It should contain a comprehensive relevant Mental Status Examination and any relevant pathology results if performed.

It should summarise any psychological tests that were performed as part of the assessment.

Diagnosis

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

Psychiatric formulation

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

Management plan

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

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

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

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

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

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

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

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

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

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

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

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

Use of items 296 - 299 and 361 by one consultant psychiatrist does not preclude them being used by another consultant psychiatrist for the same patient. The use of items 296-299 and 361 are identical except for the location of where the service is rendered. That is item 296 is only available for consultations rendered in consulting rooms, item 297 is only available for consultations rendered at a hospital, item 299 is only available for consultations rendered at a place other than consulting rooms or a hospital (such as in a patient's home) and item 361 is for consultation rendered by telepsychiatry when a patient is located in a regional, rural or remote area.

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

Referral to Allied Mental Health Professionals (for new and continuing patients)

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

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

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

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

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

AN.0.31 Psychiatric Attendances (Item 319)

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

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

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

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

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

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

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

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

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

AN.0.32 Interview of Person other than a Patient by Consultant Psychiatrist (Items 348, 350, 352)

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

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

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

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

AN.0.33 Consultant Occupational Physician Attendances (Items 385 to 388)

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

(i) evaluation and assessment of a patient's rehabilitation requirements where the patient presents with an accepted medical condition(s) which may be affected by the consultant occupational physician's 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.

AN.0.34 Contact Lenses (Items 10801-10809)

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

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

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

(b) sporting purposes;

(c) work purposes; or

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

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

AN.0.35 Refitting of Contact Lenses (Item 10816)

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

AN.0.36 Health Assessments (Items 701, 703, 705, 707)

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

Brief Health Assessment (MBS Item 701)

A brief health assessment is used to undertake simple health assessments. The health assessment should take no more than 30 minutes to complete.

Standard Health Assessment (MBS Item 703)

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

Long Health Assessment (MBS Item 705)

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

Prolonged Health Assessment (MBS Item 707)

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

General practitioners may select one of the MBS health assessment items to provide a health assessment service to a member of any of the target groups listed in the table below. The health assessment item that is selected will depend on the time taken to complete the health assessment service. This is determined by the complexity of the patient's presentation and the specific requirements that have been established for each target group eligible for health assessments.

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

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

A health assessment for former serving members of the Australian Defence Force	Once only to an eligible patient

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

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

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

A health assessment must include the following elements:

a. information collection, including taking a patient history and undertaking or arranging examinations and investigations as required;
b. making an overall assessment of the patient;
c. recommending appropriate interventions;
d. providing advice and information to the patient;
e. keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and
f. offering the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

A health assessment may only be claimed by a general practitioner.

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

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

A copy of the Health Assessment must be retained for a period of 2 years after the date of service.

MBS health assessment items 701, 703, 705, 707 must be provided by a general practitioner personally attending upon a patient. Suitably qualified health professionals, such as practice nurses or Aboriginal and Torres Strait Islander health practitioners, employed and/or otherwise engaged by a general practice or health service, may assist general practitioners in performing health assessments. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the general practitioner. This may include activities associated with:

- information collection; and

- providing patients with information about recommended interventions at the direction of the general practitioner.

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

General practitioners should not conduct a separate consultation for another health-related issue in conjunction with a health assessment unless it is clinically necessary (ie. the patient has an acute problem that needs to be managed separately from the assessment). The only exception is the comprehensive medical assessment, where, if this health

assessment is undertaken during the course of a consultation for another purpose, the health assessment item and the relevant item for the other consultation may both be claimed.

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

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

AN.0.37 Health Assessment provided as a type 2 diabetes risk evaluation for people aged 40-49 years with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool

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

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

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

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

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

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

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

(c) any relevant recent diagnostic test results; and

(d) a family history of chronic disease.

The health assessment must include the following:

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

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

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

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

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

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

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

AN.0.38 Health Assessment provided for people aged 45-49 years who are at risk of developing chronic disease

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

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

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

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

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

(c) family history of a chronic disease.

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

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

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

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

AN.0.39 Health Assessment provided for people aged 75 years and older

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

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

This health assessment must include:

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

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

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

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

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

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

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

(h) A health assessment for people aged 75 years and older may be claimed once every twelve months by an eligible patient.

AN.0.40 Health Assessment provided as a comprehensive medical assessment for residents of residential aged care facilities

Items 701, 703, 705 and 707 may be used to undertake a comprehensive medical assessment of a resident of a residential aged care facility

This health assessment requires assessment of the resident's health and physical and psychological function, and must include:

(a) making a written summary of the comprehensive medical assessment;

(b) developing a list of diagnoses and medical problems based on the medical history and examination;

(c) providing a copy of the summary to the residential aged care facility; and

(d) offering the resident a copy of the summary.

A residential aged care facility is a facility in which residential care services, as defined in the *Aged Care Act 1997*, are provided. This includes facilities that were formerly known as nursing homes and hostels. A person is a resident of a residential aged care facility if the person has been admitted as a permanent resident of that facility.

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

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

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

(b) at 12 month intervals thereafter.

AN.0.41 Health Assessment provided for people with an intellectual disability

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

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

to practice in Australia or from a government-provided or funded disability service that has assessed the patient's intellectual function.

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

(a) Check dental health (including dentition);

(b) Conduct aural examination (arrange formal audiometry if audiometry has not been conducted within 5 years);

(c) Assess ocular health (arrange review by an ophthalmologist or optometrist if a comprehensive eye examination has not been conducted within 5 years);

(d) Assess nutritional status (including weight and height measurements) and a review of growth and development;

(e) Assess bowel and bladder function (particularly for incontinence or chronic constipation);

(f) Assess medications (including non-prescription medicines taken by the patient, prescriptions from other doctors, medications prescribed but not taken, interactions, side effects and review of indications);

- Advise carers of the common side effects and interactions.

- Consider the need for a formal medication review.

(g) Check immunisation status, including influenza, tetanus, hepatitis A and B, Measles, Mumps and Rubella (MMR) and pneumococcal vaccinations;

(h) Check exercise opportunities (with the aim of moderate exercise for at least 30 minutes per day);

(i) Check whether the support provided for activities of daily living adequately and appropriately meets the patient's needs, and consider formal review if required;

(j) Consider the need for breast examination, mammography, cervical screening, testicular examination, lipid measurement and prostate assessment as for the general population;

(k) Check for dysphagia and gastro-oesophageal disease (especially for patients with cerebral palsy), and arrange for investigation or treatment as required;

(l) Assess risk factors for osteoporosis (including diet, exercise, Vitamin D deficiency, hormonal status, family history, medication fracture history) and arrange for investigation or treatment as required;

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

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

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

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

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

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

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

AN.0.42 Health Assessment provided for refugees and other humanitarian entrants

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

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

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

Offshore Refugee Category including:

(a) 200 Refugee

(b) 201 In Country Special Humanitarian

(c) 203 Emergency rescue

(d) 204 Women at Risk

(e) Offshore - Special Humanitarian Program

(f) 202 Global Special Humanitarian

Offshore - Temporary Humanitarian Visas (THV) including:

(g) Subclass 695 (Return Pending)

(h) Subclass 070 (Removal Pending Bridging)

Onshore Protection Program including:

(i) 866 Permanent Protection Visa (PPV)

(j) 785 Temporary Protection Visa (TPV)

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

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

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

AN.0.43 Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715)

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

· An Aboriginal or Torres Strait Islander child who is less than 15 years.

· An Aboriginal or Torres Strait Islander person who is aged between 15 years and 54 years.

· An Aboriginal or Torres Strait Islander older person who is aged 55 years and over.

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

MBS item 715 must include the following elements:

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

(b) making an overall assessment of the patient;

(c) recommending appropriate interventions;

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

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

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

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

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

A health assessment may only be claimed by a general practitioner.

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

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

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

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

- information collection; and

- providing patients with information about recommended interventions at the direction of the general practitioner.

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

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

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

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

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

AN.0.44 A Health Assessment for an Aboriginal and Torres Strait Islander child (less than 15 years of age)

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

a. a personal attendance by a general practitioner;
b. taking the patient's medical history, including the following:
    i. mother's pregnancy history;
    ii. birth and neo-natal history:
    iii. breastfeeding history;
    iv. weaning, food access and dietary history;
    v. physical activity;
    vi. previous presentations, hospital admissions and medication usage;
    vii. relevant family medical history;
    viii. immunisation status;
    ix. vision and hearing (including neonatal hearing screening);
    x. development (including achievement of age appropriate milestones);
    xi. family relationships, social circumstances and whether the person is cared for by another person;
    xii. exposure to environmental factors (including tobacco smoke);
    xiii. environmental and living conditions;
    xiv. educational progress;
    xv. stressful life events;
    xvi. mood (including incidence of depression and risk of self-harm);
    xvii. substance use;
    xviii. sexual and reproductive health; and
    xix. dental hygiene (including access to dental services).
c. examination of the patient, including the following:
    i. measurement of height and weight to calculate body mass index and position on the growth curve;
    ii. newborn baby check (if not previously completed);
    iii. vision (including red reflex in a newborn);
    iv. ear examination (including otoscopy);
    v. oral examination (including gums and dentition);
    vi. trachoma check, if indicated;
    vii. skin examination, if indicated;
    viii. respiratory examination, if indicated;
    ix. cardiac auscultation, if indicated;
    x. development assessment, if indicated, to determine whether age appropriate milestones have been achieved;
    xi. assessment of parent and child interaction, if indicated; and
    xii. other examinations in accordance with national or regional guidelines or specific regional needs, or as indicated by a previous child health assessment.
d. undertaking or arranging any required investigation, considering the need for the following tests, in particular:
    i. haemoglobin testing for those at a high risk of anaemia; and
    ii. audiometry, if required, especially for those of school age

e. assessing the patient using the information gained in the child health check; and
f. making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

AN.0.45 A health assessment for an Aboriginal and Torres Strait Islander adult (aged between 15 years and 54 years)

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

a. a personal attendance by a general practitioner;
b. taking the patient's medical history, including the following:
    i. current health problems and risk factors;
    ii. relevant family medical history;
    iii. medication usage (including medication obtained without prescription or from other doctors);
    iv. immunisation status, by reference to the appropriate current age and sex immunisation schedule;
    v. sexual and reproductive health;
    vi. physical activity, nutrition and alcohol, tobacco or other substance use;
    vii. hearing loss;
    viii. mood(including incidence of depression and risk of self-harm); and
    ix. family relationships and whether the patient is a carer, or is cared for by another person;
    x. vision
c. examination of the patient, including the following:
    i. measurement of the patient's blood pressure, pulse rate and rhythm;
    ii. measurement of height and weight to calculate body mass index and, if indicated, measurement of waist circumference for central obesity;
    iii. oral examination (including gums and dentition);
    iv. ear and hearing examination (including otoscopy and, if indicated, a whisper test); and
    v. urinalysis (by dipstick) for proteinurea;
    vi. eye examination; and
d. undertaking or arranging any required investigation, considering the need for the following tests, in particular, (in accordance with national or regional guidelines or specific regional needs):
    i. fasting blood sugar and lipids (by laboratory based test on venous sample) or, if necessary, random blood glucose levels;
    ii. cervical screening;
    iii. examination for sexually transmitted infection (by urine or endocervical swab for chlamydia and gonorrhoea, especially for those aged from 15 to 35years); and
    iv. mammography, if eligible (by scheduling appointments with visiting services or facilitating direct referral).
e. assessing the patient using the information gained in the adult health assessment; and
f. making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

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

a. keeping a record of the health assessment; and
b. offering the patient a written report on the health assessment, with recommendations on matters covered by the health assessment;

AN.0.46 A health assessment for an Aboriginal and Torres Strait Islander older person (aged 55 years and over)

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

a. a personal attendance by the general practitioner;
b. measurement of the patient's blood pressure, pulse rate and rhythm;
c. an assessment of the patient's medication;
d. an assessment of the patient's continence;

e. an assessment of the patient's immunisation status for influenza, tetanus and pneumococcus;
f. an assessment of the patient's physical functions, including the patient's activities of daily living and whether or not the patient has had a fall in the last 3months;
g. an assessment of the patient's psychological function, including the patient's cognition and mood;
h. an assessment of the patient's social function, including:
    i. the availability and adequacy of paid, and unpaid, help;
    ii. whether the patient is responsible for caring for another person;
i. an eye examination

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

a. keeping a record of the health assessment; and
b. offering the patient a written report on the health assessment, with
c. recommendations on matters covered by the health assessment; and
d. offering the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

AN.0.47 Chronic Disease Management Items (Items 721 to 732)

Description	*Item No*	*Minimum claiming period**
Preparation of a GP Management Plan (GPMP)	721	12 months
Coordination of Team Care Arrangements (TCAs)	723	12 months
Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	729	3 months
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	731	3 months
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	732	3 months

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

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

Regulatory requirements

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

Restriction of Co-claiming of Chronic Disease and General Consultation Items

Co-claiming of consultation items 3, 4, 23, 24, 36, 37, 44, 47, 52, 53, 54, 57, 58, 59, 60, 65, 585, 588, 591, 594, 599, 600, 5000, 5003, 5020, 5023, 5040, 5043, 5060, 5063, 5200, 5203, 5207, 5208, 5220, 5223, 5227 and 5228 with chronic disease management items 721, 723, or 732 is not permitted for the same patient, on the same day.

Patient eligibility

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

CDM items 721, 723 and 732

These are:

· available to:

i. patients in the community; and
ii. private in-patients of a hospital (including private in-patients who are residents of aged care facilities) being discharged from hospital.

· not available to:

i. public in-patients of a hospital; or
ii. care recipients in a residential aged care facility.

CDM item 729

This is:

· available to:

i. patients in the community;
ii. both private and public in-patients being discharged from hospital.

· not available to care recipients in a residential aged care facility.

CDM item 731

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

Item 721

A comprehensive written plan must be prepared describing:

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

In preparing the plan, the provider must:

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

A copy of the written plan must be retained for 2 years.

Item 723

When coordinating the development of Team Care Arrangements (TCAs), the general practitioner must:

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

The document described above must be retained for 2 years.

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

Item 729

A multidisciplinary care plan means a written plan that:

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

When contributing to a multidisciplinary care plan or to a review of the care plan, the general practitioner must:

a. prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or
b. give advice to a person who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided to such a person.

A copy of the written plan must be retained for 2 years.

Item 731

A multidisciplinary care plan in a Residential Aged Care Facility (RACF) means a written plan that:

a. is prepared for a patient by a collaborating provider (other than a general practitioner, e.g. a RACF), in consultation with at least two other collaborating providers, each of whom provides a different kind of treatment or services to the patient; and
b. describes, at least, treatment and services to be provided to the patient by the collaborating providers.

When contributing to a multidisciplinary care plan or to a review of the care plan, the general practitioner must:

a. prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or

b. give advice to a person who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided to such a person.

Item 731 can also be used for contribution to a multidisciplinary care plan prepared for a resident by another provider before the resident is discharged from a hospital or an approved day-hospital facility, or to a review of such a plan prepared by another provider (not being a service associated with a service to which items 735 to 758 apply).

Item 732

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

When reviewing a GP Management Plan, the general practitioner must:

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

When coordinating a review of Team Care Arrangements, a multidisciplinary community care plan or a multidisciplinary discharge care plan, the general practitioner must:

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

A copy of the amended plan must be retained for 2 years.

Item 732 can also be used to COORDINATE A REVIEW OF a Multidisciplinary Community Care Plan (former item 720) or to COORDINATE REVIEW OF A Discharge Care Plan (former item 722), where these services were coordinated or prepared by that general practitioner (or an associated general practitioner), and not being a service associated with a service to which items 735-758 apply.

Claiming of benefits

Each service to which item 732 applies (i.e. Review of a GP Management Plan and Review of Team Care Arrangements) may be claimed once in a three-month period, except where there are exceptional circumstances arising from a significant change in the patient's clinical condition or care circumstances that necessitates earlier performance of the service for the patient.

Where a service is provided in exceptional circumstances, the patient's invoice or Medicare voucher should be annotated to indicate the reason why the service was required earlier than the minimum time interval for the relevant item. Payment can then be made.

Item 732 can be claimed twice on the same day providing an item 732 for reviewing a GP Management Plan and another 732 for reviewing Team Care Arrangements (TCAs) are both delivered on the same day as per the MBS item descriptors and explanatory notes.

Medicare requirements when item 732 is claimed twice on the same day

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

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

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

Items 721, 723 and 732

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

Additional information

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

Items 721-732 should generally be undertaken by the patient's **usual general practitioner**. The patient's "usual GP" means the GP, or a GP working in the medical practice, who has provided the majority of care to the patient over the previous twelve months and/or will be providing the majority of GP services to the patient over the next twelve months. The term "usual GP" would not generally apply to a practice that provides only one specific CDM service.

A **practice nurse, Aboriginal and Torres Strait Islander health practitioner, Aboriginal health worker or other health professional** may assist a GP with items 721, 723, and 732 (e.g. in patient assessment, identification of patient needs and making arrangements for services). However, the GP must meet all regulatory requirements, review and confirm all assessments and see the patient.

Patients being managed under the chronic disease management items may be eligible for:

· individual allied health services (items 10950 to 10970); and/or

· group allied health services (items 81100 to 81125).

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

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

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

AN.0.48 Medicare Dental Items For Patients With Chronic Conditions And Complex Care Needs - Services Provided By A Dental Practitioner On Referral From A GP [Items 85011-87777]

Closure of Medicare Dental Items 85011-87777

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

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

AN.0.49 Multidisciplinary Case Conferences by General Practitioners - (Items 735 to 758)

Items 735 to 758 provide rebates for general practitioners to organise and coordinate, or participate in, multidisciplinary case conferences for patients in the community or patients being discharged into the community from hospital or people living in residential aged care facilities.

REGULATORY REQUIREMENTS

To organise and coordinate case conference items **735, 739 and 743**, the provider must:

(a) explain to the patient the nature of a multidisciplinary case conference, and ask the patient for their agreement to the conference taking place; and

(b) record the patient's agreement to the conference; and

(c) record the day on which the conference was held, and the times at which the conference started and ended; and

(d) record the names of the participants; and

(e) offer the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a summary of the conference and provide this summary to other team members; and

(f) discuss the outcomes of the conference with the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and

(g) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

To participate in multidisciplinary case conference items **747, 750 and 758**, the provider must:

(a) explain to the patient the nature of a multidisciplinary case conference, and ask the patient whether they agree to the general practitioner's participation in the conference; and

(b) record the patient's agreement to the general practitioner's participation; and

(c) record the day on which the conference was held, and the times at which the conference started and ended; and

(d) record the names of the participants; and

(e) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

ADDITIONAL INFORMATION

Usual general practitioner

Items 735-758 should generally be undertaken by the patient's usual general practitioner. This is a general practitioner, or a general practitioner working in the medical practice, that has provided the majority of services to

the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

Multidisciplinary case conference team members

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

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

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

Discharge case conference

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

Further sources of information

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

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

AN.0.50 Public Health Medicine - (Items 410 to 417)

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

(i) management of a patient's vaccination requirements for accepted immunisation programs; or

(ii) prevention or management of sexually transmitted disease; or

(iii) prevention or management of disease due to environmental hazards or poisons; or

(iv) prevention or management of exotic diseases; or

(v) prevention or management of infection during outbreaks of infectious disease.

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

AN.0.51 Case Conferences by Consultant Physician - (Items 820 to 838, 6029 to 6034 and 6064 to 6075)

Items 820, 822, 823, 825, 826, 828, 6029, 6031, 6032, 6034, 6064, 6065, 6067, 6068, 6035, 6037, 6038, 6042, 6071, 6072, 6074 and 6075 apply to a community case conference (including a case conference conducted in a residential aged care facility) organised to discuss one patient in detail and applies only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and has complex needs requiring care from a multidisciplinary team. Community case conference items ie 820, 822, 823, 825, 826 and 828 do not apply to an in-patient of a hospital.

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

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

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

-discusses a patient's history;

-identifies the patient's multidisciplinary care needs;

- identifies outcomes to be achieved by members of the case conference team giving care and service to the patient;

-identifies tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and

-assesses whether previously identified outcomes (if any) have been achieved.

For the purposes of items 820, 822, 823, 830, 832, 834, 6029, 6031, 6032, 6034, 6064, 6065, 6067 and 6068 (that is, where a consultant physician organises a case conference) a multidisciplinary team requires the involvement of a minimum of four formal care providers from different disciplines. The consultant physician is counted toward the minimum of four. Although they may attend the case conference, neither the patient nor their informal carer, or any other medical practitioner (except where the medical practitioner is the patient's usual General Practitioner) can be counted toward the minimum of four.

For the purposes of items 825, 826, 828, 835, 837, 838, 6035, 6037, 6038, 6042, 6071, 6072, 6074 and 6075 (that is, where a consultant physician participates in a case conference) a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines. The consultant physician is counted toward the minimum of three. Although they may attend the case conference, neither the patient nor their informal carer, or any other medical practitioner (except where the medical practitioner is the patient's usual General Practitioner) can be counted toward the minimum of three.

For the purposes of items 820, 822, 823, 830, 832, 834, 6029, 6031, 6032, 6034, 6064, 6065, 6067 and 6068 (that is, where a consultant physician organises a case conference), and items 825, 826, 828, 835, 837, 838, 6035, 6037, 6038, 6042, 6071, 6072, 6074 and 6075 (that is, where a consultant physician participates in a case conference) "formal care providers" includes:

-the patient's usual General Practitioner;

-allied health professionals, being: registered nurse, physiotherapist, occupational therapist, podiatrist, speech pathologist, pharmacist; dietician; psychologist; orthoptist; orthotist and prosthetist, optometrist; audiologist, social worker, Aboriginal and Torres Strait Islander health practitioner, Aboriginal health worker, mental health worker, asthma educator, diabetes educator, dental therapist, dentist; and

-community service providers being: personal care worker, home and community care service provider, meals on wheels provider, education provider and probation officer.

Organisation of a case conference

For items 820, 822, 823, 830, 832, 834, 6029, 6031, 6032, 6034, 6064, 6065, 6067 and 6068, 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 they agree 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) putting a copy of that record in the patient's medical records; and

(f) giving the patient or the patient's agent, and each other member of the team a summary of the conference; and

(h) giving a copy of the summary of the conference to the patient's usual general practitioner; and

(i) discussing the outcomes of the patient or the patient's agent.

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

Participation in a case conference

For items 825, 826, 828, 835, 837, 838, 6035, 6037, 6038, 6042, 6071, 6072, 6074, 6075. 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 **Organisation of a case conference** 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.

See Health Insurance (General Medical Services Table) Regulation, Division 2.21.

General requirements

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

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

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

-Inform the patient that their 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 they want to be conveyed to, or withheld from, the other care providers;

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

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

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

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

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

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

AN.0.52 Medication Management Reviews - (Items 900 and 903)

Item 900 - Domiciliary Medication Management Review

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

Patient eligibility

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

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

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

DMMR's are targeted at patients who are:

· currently taking five or more regular medications;

· taking more than 12 doses of medication per day;

· have had significant changes made to medication treatment regimen in the last three months;

· taking medication with a narrow therapeutic index or medications requiring therapeutic monitoring;

· experiencing symptoms suggestive of an adverse drug reaction;

· displaying sub-optimal response to treatment with medicines;

· suspected of non-compliance or inability to manage medication related therapeutic devices;

· having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties;

· attending a number of different doctors, both general practitioners and specialists; and/or

· recently discharged from a facility / hospital (in the last four weeks).

In referring a patient for a DMMR, general practitioners should note that only patients meeting the following criteria will have the pharmacist portion funded through a Community Pharmacy Agreement program:

· Is a Medicare and/or Department of Veterans' Affairs (DVA) cardholder or a person who is eligible for a Medicare card;

· Is subject to a chronic condition and/or complex medication regimen; and

· Is failing to respond to treatment in the expected manner.

If the patient does not meet these criteria, the general practitioner can still issue a referral under this item. However, the remainder of the service will be on a “user pays” basis as determined by the accredited pharmacist.

REGULATORY REQUIREMENTS

In conducting a DMMR, a general practitioner must, with the patient’s consent:

(a) assess a patient is subject to a chronic medical condition and/or complex medication regimen but their therapeutic goals are not being met; and

(b) following that assessment, refer the patient to a community pharmacy or an accredited pharmacist for a DMMR and provide the relevant clinical information required for the review; and

(c) discuss with the reviewing pharmacist the result of that review including suggested medication management strategies; and

(d) develop a written medication management plan following discussion with the patient; and

(e) provide the written medication management plan to a community pharmacy chosen by the patient.

For any particular patient - applicable not more than once in each 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR.

Claiming

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

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

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

Provision of a subsequent DMMR must not be made solely by reaching an anniversary date, and the service is not intended to be undertaken on an ongoing review cycle.

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

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

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

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

FURTHER GUIDANCE

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

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

The process of **referral to a community pharmacy or an accredited pharmacist** includes:

· Obtaining consent from the patient, consistent with normal clinical practice, for a pharmacist to undertake the medication management review and for a charge to be incurred for the service for which a Medicare rebate is payable. The patient must be clearly informed of the purpose and possible outcomes of the DMMR, the process involved (including that the pharmacist will visit the patient at home, unless exceptional circumstances apply or they are an Aboriginal or Torres Strait Islander patient), what information will be provided to the pharmacist as part of the DMMR, and any additional costs that may be incurred; and

· Provision to the patient's preferred community pharmacy or accredited pharmacist, of relevant clinical information, by the general 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 general practitioner must provide patient details and relevant clinical information to the patient's preferred community pharmacy or accredited pharmacist.

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

· Receiving a written report from the reviewing pharmacist; and

· Discussing the relevant findings and suggested management strategies with the pharmacist (either by phone or face to face); and

· Developing a summary of the relevant review findings as part of the draft medication management plan.

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

· Developing a draft medication management plan and discussing this with the patient; and

· Once agreed, offering a copy of the written medication management plan to the patient and providing a copy to the community pharmacy or accredited pharmacist.

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

Item 903 - Residential Medication Management Review

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

Patient eligibility

RMMRs are available to:

new residents on admission into a RACF; and

existing residents on an 'as required' basis, where in the opinion of the resident's general practitioner, it is required because of a significant change in medical condition or medication regimen.

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

REGULATORY REQUIREMENTS

When conducting a RMMR, a GP must:

(a) discuss the proposed review with the resident and seek the resident's consent to the review; and

(b) collaborate with the reviewing pharmacist about the pharmacist's involvement in the review; and

(c) provide input from the resident's most recent comprehensive medical assessment or, if such an assessment has not been undertaken, provide relevant clinical information for the review and for the resident's records; and

(d) If recommended changes to the resident's medication management arise out of the review, participate in a post-review discussion (either face-to-face or by telephone) with the pharmacist to discuss the outcomes of the review including:

(i) the findings; and

(ii) medication management strategies; and

(iii) means to ensure that the strategies are implemented and reviewed, including any issues for implementation and follow-up; and

(iv) develop or revise the resident's medication management plan after discussion with the reviewing pharmacist; and

(v) finalise the plan after discussion with the resident.

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

(a) offering a copy of the medication management plan to the resident (or the resident's carer or representative if appropriate); and

(b) providing copies of the plan for the resident's records and for the nursing staff of the residential aged care facility; and

(c) discussing the plan with nursing staff if necessary.

A post-review discussion is not required if:

(a) there are no recommended changes to the resident's medication management arising out of the review; or

(b) any changes are minor in nature and do not require immediate discussion; or

(c) the pharmacist and general practitioner agree that issues arising out of the review should be considered in a case conference.

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

Claiming

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

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

· any immediate action required to be done at the time of completing the RMMR, based on and as a direct result of information gathered in the RMMR, should be treated as part of the RMMR item;

· any subsequent follow up should be treated as a separate consultation item;

· an additional consultation in conjunction with completing the RMMR should not be undertaken unless it is clinically indicated that a problem must be treated immediately.

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

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

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

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

FURTHER GUIDANCE

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

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

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

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

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

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

The general practitioner and reviewing pharmacist should agree on a preferred means for communicating issues and information relating to the provision of an RMMR service. This should include the method(s) of initiating the

RMMR, exceptions to the post review discussion, and the preferred method of communication. This can be done on a facility basis rather than on a case-by-case basis.

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

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

Related Items: **900 903**

AN.0.53 Taking a Cervical Screen from a Person who is Unscreened or Significantly Under-screened - (Items 2497 - 2509 and 2598 - 2616)

The item numbers 2497, 2501, 2503, 2504, 2506, 2507, 2509, 2598, 2600, 2603, 2606, 2610, 2613 and 2616 should be used in place of the usual attendance item where as part of a consultation, a sample for cervical screening is collected from a person between the ages of 24 years and 9 months and 74 years inclusive who has not had a cervical smear in the last four years. Cervical Screening in accordance with the National Cervical Screening Policy at P.16.11.

Self collection of a sample for screening is only available for women between the ages of 30 and 74 years of age who are overdue for screening by two or more years (i.e. being 4 years since their last Pap test). Self collection should only be offered to an eligible person who refuses to have a sample collected by their requesting practitioner.

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

(a) asking the person if they can remember having a cervical screening test in the last four years;

(b) checking their own practice's medical records; and

(c) checking the National Cancer Screening Register.

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

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

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

A PIP Cervical Screening SIP is available for taking a cervical screen from a person who has not been screened in the last for four years. The SIP will be paid to the medical practitioner who provided the service if the service was provided in a general practice participating in the PIP Cervical Screening Incentive. A further PIP Cervical Screening Incentive payment is paid to practices which reach target levels of cervical screening for their patients aged 24 years and 9 months of age to 74 years inclusive. More detailed information on the PIP Cervical Screening Incentive is available from the Department of Human Services PIP enquiry line on 1800 222 032 or from the Department of Human Services website.

AN.0.54 Completion of the Annual Diabetes Cycle of Care for Patients with Established Diabetes Mellitus - (Items 2517 - 2526 and 2620 - 2635)

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

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

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

* Not required if the patient is blind or does not have both eyes.

** Initial visit: measure height and weight and calculate BMI as part of the initial assessment.

Subsequent visits: measure weight.

*** Not required if the patient does not have both feet.

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

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

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

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

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

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

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

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

AN.0.55 Completion of the Asthma Cycle of Care - (Items 2546 - 2559 and 2664 - 2677)

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

At a minimum the Asthma Cycle of Care must include:

- At least 2 asthma related consultations within 12 months for a patient with moderate to severe asthma (at least 1 of which (the review consultation) is a consultation that was planned at a previous consultation),

- Documented diagnosis and assessment of level of asthma control and severity of asthma,

- Review of the patient's use of and access to asthma-related medication and devices,

- Provision to the patient of a written asthma action plan (if the patient is unable to use a written asthma action plan - discussion with the patient about an alternative method of providing an asthma action plan, and documentation of the discussion in the patient's medical records),

- Provision of asthma self-management education to the patient, and

- Review of the written or documented asthma action plan.

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

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

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

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

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

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

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

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

A PIP Asthma SIP is available for completing the minimum requirements of the Asthma Cycle of Care for individual patients as specified above. The SIP will be paid to the medical practitioner who provided the service if the service was provided in a general practice participating in the PIP Asthma Incentive. More detailed information on the PIP Asthma Incentive is available from the Department of Human Services PIP enquiry line on 1800222032 or from the Department of Human Services website.

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

Assessment of Severity

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

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

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

AN.0.56 GP Mental Health Treatment Items - (Items 2700 to 2717)

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

Overview

The GP Mental Health Treatment items define services for which Medicare rebates are payable where GPs undertake early intervention, assessment and management of patients with mental disorders. They include referral pathways for treatment by psychiatrists, clinical psychologists and other allied mental health workers. These items complement the mental health items for psychiatrists (items 296 - 299), clinical psychologists (items 80000 - 80021) and allied mental health providers (items 80100 - 80171).

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

· assess and plan;

· provide and/or refer for appropriate treatment and services;

· review and ongoing management as required.

Who can provide

The GP Mental Health Treatment Plan, Review and Consultation items are available for use in general practice by general practitioner. The term 'GP' is used in these notes as a generic reference to general practitioners able to claim these items.

Training Requirements (item 2715 and 2717)

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

What patients are eligible - Mental Disorder

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

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

PREPARING A GP MENTAL HEALTH TREATMENT PLAN - (Item 2700, 2701, 2715 or 2717)

What is involved - Assess and Plan

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

Assessment

An assessment of a patient must include:

· recording the patient's agreement for the GP Mental Health Treatment Plan service;

· taking relevant history (biological, psychological, social) including the presenting complaint;

· conducting a mental state examination;

· assessing associated risk and any co-morbidity;

· making a diagnosis and/or formulation; and

· administering an outcome measurement tool, except where it is considered clinically inappropriate.

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

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

Preparation of a GP Mental Health Treatment Plan

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

· discussing the assessment with the patient, including the mental health formulation and diagnosis or provisional diagnosis;

· identifying and discussing referral and treatment options with the patient, including appropriate support services;

· agreeing goals with the patient - what should be achieved by the treatment - and any actions the patient will take;

· provision of psycho-education;

· a plan for crisis intervention and/or for relapse prevention, if appropriate at this stage;

· making arrangements for required referrals, treatment, appropriate support services, review and follow-up; and

· documenting this (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP Mental Health Treatment Plan.

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

Once a GP Mental Health Treatment Plan has been completed and claimed on Medicare either through item 2700, 2701, 2715 or 2717 a patient is eligible to be referred for up to 10 Medicare rebateable allied mental health services per calendar year for psychological therapy or focussed psychological strategy services. Patients will also be eligible to claim up to 10 separate services for the provision of group therapy (either as part of psychological therapy or focussed psychological strategies).

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

On completion of a course of treatment provided through Medicare rebateable services, the service provider must provide a written report on the course of treatment to the GP. For the purposes of the Medicare rebateable allied mental health items, a course of treatment will consist of the number of services stated on the patient's referral (up to a maximum of six in any one referral). There may be two or more courses of treatment within a patient's entitlement of up to 10 services per calendar year. The number of services that the patient is being referred for is at the discretion of the referring practitioner (eg. GP).

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

or another Mental Health Treatment Plan item or within three months following a claim for a GP Mental Health Treatment Review (item 2712 or former item 2719).

REVIEWING A GP MENTAL HEALTH TREATMENT PLAN - (Item 2712)

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

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

The review must include:

· recording the patient's agreement for this service;

· a review of the patient's progress against the goals outlined in the GP Mental Health Treatment Plan;

· modification of the documented GP Mental Health Treatment Plan if required;

· checking, reinforcing and expanding education;

· a plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided; and

· re-administration of the outcome measurement tool used in the assessment stage, except where considered clinically inappropriate.

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

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

· an initial review, which should occur between four weeks to six months after the completion of a GP Mental Health Treatment Plan; and

· if required, a further review can occur three months after the first review.

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

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

GP MENTAL HEALTH TREATMENT CONSULTATION - (Item 2713)

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

A GP Mental Health Treatment Consultation must include:

· taking relevant history and identifying the patient's presenting problem(s) (if not previously documented);

· providing treatment, advice and/or referral for other services or treatment; and

· documenting the outcomes of the consultation in the patient's medical records and other relevant mental health plan (where applicable).

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

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

REFERRAL

Once a GP Mental Health Treatment Plan has been completed and claimed on Medicare, or a GP is managing a patient under a referred psychiatrist assessment and management plan (item 291), a patient is eligible for up to 10 Medicare rebateable allied mental health services per calendar year for services by:

· clinical psychologists providing psychological therapies; or

· appropriately trained GPs or allied mental health professionals providing focussed psychological strategy (FPS) services.

In addition to the above services, patients will also be eligible to claim up to 10 separate services for the provision of group therapy.

When referring patients, GPs should provide similar information as per normal GP referral arrangements, and specifically consider including both a statement identifying that a GP Mental Health Treatment Plan has been completed for the patient (including, where appropriate and with the patient's agreement, attaching a copy of the patient's GP Mental Health Treatment Plan) and clearly identifying the specific number of sessions the patient is being referred for. Referrals for patients with either a GP Mental Health Treatment Plan or referred psychiatrist assessment and management plan (item 291) should be provided, as required, for an initial course of treatment (a maximum of six services in any one referral but may be less depending on the referral and the patient's clinical need). There may be two or more courses of treatment within a patient's entitlement of up to 10 services per calendar year. The GP should consider the patient's clinical need for further sessions after the initial referral. This can be done using a GP Mental Health Treatment Plan Review, a GP Mental Health Treatment Consultation or a standard consultation item.

In the instance where a patient has received the 10 psychological therapy services (items 80000 to 80021), focussed psychological services-allied mental health services (items 80100 to 80171) or GP focussed psychological strategies services (items 2721 to 2727) available under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative per calendar year and is considered to clinically benefit from some additional services, the patient may be eligible for Primary Health Networks (PHNs) funded psychological therapies if they meet relevant eligibility criteria for the PHN commissioned services. It is recommended that providers refer to their PHN for further guidance.

ADDITIONAL CLAIMING INFORMATION

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

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

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

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

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

· if a GP Mental Health Treatment item is undertaken or initiated during the course of a consultation for another purpose, the GP Mental Health Treatment Plan, Review or Consultation item and the relevant item for the other consultation may both be claimed;

· if a GP Mental Health Treatment Plan is developed over more than one consultation, and those consultations are for the purposes of developing the plan, only the GP Mental Health Treatment Plan item should be claimed; and

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

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

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

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

Links to other Medicare Services

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

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

· Where a patient has a mental health condition only, it is anticipated that they will be managed under the new GP Mental Health Treatment items.

· Where a patient has a separate chronic medical condition, it may be appropriate to manage the patient's medical condition through a GP Management Plan, and to manage their mental health condition through a GP Mental Health Treatment Plan. In this case, both items can be used.

· Where a patient has a mental health condition as well as significant co-morbidities and complex needs requiring team-based care, the GP is able to use both the CDM items (for team-based care) and the GP Mental Health Treatment items.

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

AN.0.57 Provision of Focussed Psychological Strategies - (Items 2721 to 2731)

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

Minimum Requirements

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

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

Continued access to item numbers 2721 - 2731 will be dependent on the practitioner meeting the ongoing mental health education requirements as determined by the General Practice Mental Health Standards Collaboration.

Patients will be permitted to claim Medicare rebates for up to 10 allied mental health services under these item numbers per calendar year. The 10 services may consist of: GP focussed psychological strategies services (items 2721 to 2731 or non-specialist medical practitioner items 283 to 287, 371 and 372); and/or psychological therapy services (items 80000 to 80015); and/or focussed psychological strategies – allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165).

Out-of-Surgery Consultation

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

Telehealth Consultation

A **telehealth eligible area** means an area that is a Modified Monash 4 area, Modified Monash 5 area, Modified Monash 6 area or Modified Monash 7 area.

Specific Modified Monash locations can be looked up at DoctorConnect

Specific Focussed Psychological Strategies

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

1. Psycho-education
(including motivational interviewing)
2. Cognitive-behavioural therapy including:
· **Behavioural interventions**
- Behaviour modification
- Exposure techniques
- Activity scheduling
· **Cognitive interventions**
- Cognitive therapy
3. Relaxation strategies
- Progressive muscle relaxation
- Controlled breathing
4. Skills training
- Problem solving skills and training
- Anger management
- Social skills training
- Communication training

- Stress management
- Parent management training

5. Interpersonal therapy

Mental Disorder

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

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

AN.0.58 Pain and Palliative Medicine (Items 2801 to 3093)

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

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

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

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

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

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

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

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

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

AN.0.59 Telepsychiatry - (Items 353 to 370)

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

Support and Resourcing

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

Duration of Telepsychiatry Consultation

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

Number of Consultations in a Calendar Year

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

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

Documenting the Telepsychiatry Session

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

Geographical

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

Referred Patient Assessment and Management Plan review (Item 359)

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

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

Initial Consultations for NEW PATIENTS (Item 361)

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

is integral to the role of the psychiatrist. Referral for item 361 may be from a participating nurse practitioner, medical practitioner practising in general practice, a specialist or another consultant physician. It is intended that item 361 will apply once only for each new patient on the first occasion that the patient is seen by a consultant psychiatrist. It is not generally intended that item 361 will be used in conjunction with, or prior to, item 291.

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

AN.0.60 Attendances by Medical Practitioners who are Emergency Physicians - (Items 501 to 536)

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

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

The attendances for items 501 to 515 are divided into five categories relating to the level of complexity, namely:

(i) Level 1

(ii) Level 2

(iii) Level 3

(iv) Level 4

(v) Level 5

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

LEVEL 1

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

LEVEL 2

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

LEVEL 3

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

LEVEL 4

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

LEVEL 5

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

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

AN.0.61 Prolonged Attendance by an Emergency Physician in Treatment of a Critical Condition - (Items 519 to 536)

The conditions to be met before services covered by items 519 to 536 attract benefits are:

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

(ii) the times relate to the total time spent with a single patient, even if the time spent by the physician is not continuous.

AN.0.62 Case Conferences by Consultant Psychiatrists - (Items 855 to 866)

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

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

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

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

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

- discusses a patient's history;

- identifies the patient's multidisciplinary care needs;

- identifies outcomes to be achieved by members of the case conference team giving care and service to the patient;

- identifies tasks that need to be undertaken to achieve these outcomes, and allocates those tasks to members of the case conference team; and assesses whether previously identified outcomes (if any) have been achieved.

For the purposes of items 855 to 866, a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines, each of whom provides a different kind of care or service to the patient, and one of whom must be the patient's usual medical practitioner. The consultant psychiatrist and the medical practitioner are counted toward the minimum of three.

The patient's carer may be included as a member of the team (See A.49.8 below), in addition to the minimum of three health or care providers but do not count towards the minimum of three for Medicare purposes.

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

For the purposes of A.49.5, "formal care provider" includes in addition to the consultant psychiatrist and a medical practitioner (other than a specialist or consultant physician):

- allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dieticians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

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

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

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

Organisation of a case conference

Organise and coordinate a case conference means undertaking the following activities in relation to a case conference:

- explaining to the patient the nature of a case conference, and asking the patient whether the patient agrees to the case conference taking place; and

- recording the patient's agreement to the case conference; and

- recording the day on which the conference was held, and the times at which the conference started and ended; and

- recording the names of the participants; and

- recording the matters mentioned in A.49.4 and putting a copy of that record in the patient's medical records; and

- offering the patient (and the patient's carer, if appropriate and with the patient's agreement), and giving each other member of the team a summary of the conference; and

- discussing the outcomes of the case conference with the patient.

General requirements

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

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

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

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

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

- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to or withheld from the other case conference team members; and

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

- Inform the patient of any additional costs he or she will incur. The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided. (See General Notes 7.6)

AN.0.63 Case Conference by Consultant Physicians in Geriatric/Rehabilitation Medicine - (Item 880)

Item 880 applies only to a service provided by a consultant physician or a specialist in the specialty of Geriatric or Rehabilitation Medicine who has completed the additional requirements of the Royal Australasian College of Physicians for recognition in the subspecialty of geriatric medicine or rehabilitation medicine. The service must be in relation to an admitted patient in a hospital (not including a patient in a residential aged care facility) who is receiving one of the following types of specialist care:

· geriatric evaluation and management (GEM), in which the clinical intent is to maximise health status and/or optimise the living arrangements for a patient with multidimensional medical conditions with disabilities and psychosocial problems, who is usually (but not always) an older patient; or

· rehabilitation care, in which the clinical intent is to improve the functional status of a patient with an impairment or disability.

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

The specific responsibilities of the coordinating consultant physician or specialist are defined as:

- coordinating and facilitating the multidisciplinary team meeting;
- resolving any disagreement or conflict so that management consensus can be achieved;
- clarifying responsibilities; and
- ensuring that the input of participants and the outcome of the case conference is appropriately recorded.

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

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

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

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

AN.0.64 Neurosurgery Specialist Referred Consultation - (Items 6007 to 6015)

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

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

(i) Level 1 - 6009

(ii) Level 2 - 6011

(iii) Level 3 - 6013

(iv) Level 4 - 6015

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

(i) Initial consultation item 6007 will replace item 104.

(ii) Subsequent consultation items 6009-6015 will replace item 105

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

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

· the reviewing of neuroimaging for the monitoring of a tumour or lesion and discussion of the results with the patient (e.g. meningiomaglioma, spinal cord tumour);

· consultation on a patient to review imaging for spinal cord/cauda equina/ nerve root compression from a disc prolapse and discussion of results; or

· consultation on a patient prior to insertion of a ventriculo-peritoneal shunt)

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

· an attendance on a patient prior to a craniotomy for cerebral tumour;

· surgery for spinal tumour;

· revision of spinal surgery;

· epilepsy surgery; or

· for the treatment of cerebral aneurysm.

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

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

· managing adverse neurological outcomes;

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

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

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

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

· deterioration in neurologic function following cranial or spinal surgery;

· presentation with new neurologic signs/symptoms; multifocal spinal and cranial disease (e.g. neurofibromatosis); or

· chronic pain states following spinal surgery (including discussion of other treatment options and referral to pain management)

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

AN.0.65 Cancer Care Case Conference - (Items 871 and 872)

For the purposes of these items:

· private patients in public or private hospitals or the community with a malignancy of a solid organ or tissue or a systemic cancer such as a leukaemia or lymphoma are covered, with the exception of patients whose only cancer is a non-melanoma skin cancer;

· the billing general practitioner, specialist or consultant physician may be from any area of medical practice and must be a treating doctor of the patient discussed at the case conference. A treating doctor should generally have treated or provided a formal diagnosis of the patient's cancer in the past 12 months or expect to do so within the next 12 months. Attending non-treating clinicians, allied health providers or support staff are not eligible to bill the item.

· only one practitioner is eligible to claim item 871 for each patient case conference. This should be the doctor who assumes responsibility for leading and coordinating the case conference, ensures that records are kept and that the patient is informed of the outcome of the case conference. In most cases this will be the lead treating doctor.

· each billing practitioner must ensure that his or her patient is informed that a charge will be incurred for the case conference for which a Medicare rebate will be payable;

· participants must be in communication with each other throughout the case conference, either face-to-face, or by telephone or video link;

· suitable allied health practitioners would generally be from one of the following disciplines: aboriginal health care worker; asthma educator; audiologist; dental therapist; dentist; diabetes educator; dietician; mental health worker; occupational therapist; optometrist; orthoptist; orthotist or prosthetist; pharmacist; physiotherapist; podiatrist; psychologist; registered nurse; social worker; or, speech pathologist;

· in general, it is expected that no more than two case conferences per patient per year will be billed by a practitioner; and

· cancer care case conferences are for the purpose of developing a cancer treatment plan in a multidisciplinary team meeting and should not be billed against case conference items for other purposes eg community or discharge case conferences.

AN.0.66 Non-directive Pregnancy Support Counselling Service - (Item 4001)

Overview

The Pregnancy Support Counselling initiative provides for Medicare benefits to be paid for non-directive pregnancy support counselling services provided to a person who is:

· pregnant; or

· who has been pregnant in the 12 months preceding the first service to which this item, item 792 or item 81000, 81005 or 81010 applies in relation to that pregnancy.

There are five MBS items for the provision of non-directive pregnancy support counselling services:

Item 4001 - services provided by an eligible GP. The term 'GP' is used hereafter as a generic reference to general practitioners;

Item 792 – services provided by an eligible medical practitioner (not including a specialist or consultant physician)

Item 81000 - services provided by an eligible psychologist;

Item 81005 - services provided by an eligible social worker; and

Item 81010 - services provided by an eligible mental health nurse.

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

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

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

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

Patient eligibility

Medicare rebates for non-directive pregnancy support counselling services provided using item 4001 are available to a person who is:

- pregnant; or
- who has been pregnant in the 12 months preceding the first service to which this item, item 792 or item 81000, 81005 or 81010 applies in relation to that pregnancy.

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

Medicare benefits

Medicare benefits are payable for up to three non-directive pregnancy support counselling services per patient, per pregnancy, from any of the following items - 792, 4001, 81000, 81005 and 81010.

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

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

Minimum Requirements

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

AN.0.67 Telehealth Patient-end Support Services by Health Professionals

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

Telehealth patient-end support services can only be claimed where:

- a Medicare eligible specialist service is claimed;
- the service is rendered in Australia; and
- where this is necessary for the provision of the specialist service.

A video consultation will involve a single specialist or consultant physician attending to the patient, with the participation of another general practitioner, specialist or consultant physician, at the patient end. The above time-tiered items provide for patient-end support services in various settings including, consulting rooms, other than consulting rooms, eligible residential aged care services and Aboriginal Medical Services.

Clinical indications

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

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

Collaborative Consultation

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

Restrictions

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

Eligible Geographical Areas

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

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

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

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

Record Keeping

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

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

Multiple attendances on the same day

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

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

Extended Medicare Safety Net (EMSN)

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

Aftercare Rule

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

Referrals

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

Technical requirements

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

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

Bulk billing

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

Duration of attendance

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

AN.0.68 Telehealth Specialist Services

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

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

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

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

Clinical indications

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

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

Restrictions

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

Billing Requirements

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

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

Eligible Geographical Areas

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

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

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

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

Record Keeping

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

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

Extended Medicare Safety Net (EMSN)

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

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

Aftercare Rule

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

Multiple attendances on the same day

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

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

Referrals

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

Technical requirements

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

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

AN.0.69 Australian Defence Force Post-discharge GP Health Assessment

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

A health assessment for a former serving member of the Australian Defence Force is an assessment of:

a. a patient's physical and psychological health and social function; and
b. whether health care, education and other assistance should be offered to the patient to improve their physical, psychological health or social function.

This health assessment must include:

a. a personal attendance by a general practitioner; and

b. taking the patient's history, including the following:
    i. the patient's service with the Australian Defence Force, including service type, years of service, field of work, number of deployments and reason for discharge;
    ii. the patient's social history, including relationship status, number of children (if any) and current occupation;
    iii. the patient's current medical conditions;
    iv. whether the patient suffers from hearing loss or tinnitus;
    v. the patient's use of medication, including medication prescribed by another doctor and medication obtained without a prescription;
    vi. the patient's smoking, if applicable;
    vii. the patient's alcohol use, if applicable;
    viii. the patient's substance use, if applicable;
    ix. the patient's level of physical activity;
    x. whether the patient has bodily pain;
    xi. whether the patient has difficulty getting to sleep or staying asleep;
    xii. whether the patient has psychological distress;
    xiii. whether the patient has posttraumatic stress disorder;
    xiv. whether the patient is at risk of harm to self or others;
    xv. whether the patient has anger problems;
    xvi. the patient's sexual health;
    xvii. any other health concerns the patient has.

The assessment must also include the following:

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

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

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

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

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

AN.0.70 Limitation of items—certain attendances by specialists and consultant physicians

Medicare benefits are not payable for items 105, 116, 119, 386, 2806, 2814, 3010, 3014, 6019, 6052 and 16404 when claimed in association with an item in group T8 with a schedule fee of $304.80 or more.

The restriction applies when the procedure is performed by the same practitioner, on the same patient, on the same day.

AN.0.71 General practitioner attendances and Aftercare

Vocationally and non-vocationally registered general practitioners providing post-operative treatment to a patient during an aftercare period are eligible for Medicare benefits. This rule applies only in the circumstance whereby the vocationally or non-vocationally registered general practitioner did not perform the initial procedure requiring post-operative treatment.

Normal aftercare rules still apply when it is the vocationally or non-vocationally registered general practitioner who rendered the initial procedure requiring post-operative treatment.

AN.3.1 Subsequent attendance items

The current regulations prohibit the payment of Medicare benefits for subsequent attendance items 105, 116, 119, 386, 2806, 2814, 3010, 3014, 6019, 6052, and 16404 if a claim is made for any Group T8 item (30001-50952) with a schedule fee of equal to or greater than $304.80 on the same day. Non-compliance with the regulations can result in a referral to an appropriate regulatory body – such as the Professional Services Review.

Subsequent attendance items (111, 117, and 120) can only be claimed on the same day as Group T8 items with schedule fees of equal to or greater than $304.80, if the procedure is urgent and not able to be predicted prior to the commencement of the attendance. It is therefore expected that these items would be claimed only in exceptional circumstances.

Subsequent attendance item 115 can only be claimed, if the nature of the attendance was not able to be predicted prior to the procedure.

Item 115 should not be claimed if the consultation relates to the booked Group T8 procedure. Any consultation component related to the booked Group T8 procedure is considered to be covered under the fee for that procedure, if the Schedule fee is $304.80 or more.

Should a component of the consultation be unrelated to the booked T8 procedure and it is considered by the medical practitioner that it would be a clinical risk to defer this consultation then item could be claimable.

It would not be appropriate to claim item 115 if a patient attends for the booked operation, and prior to surgery an examination is conducted relevant to performing that procedure; together with a discussion of the outcomes and aftercare. If the consultation extends beyond this; including the development of a management plan involving a broader diagnosis, prognosis, associated treatments and follow-up; then it could be appropriate to claim item 115.

In claiming item 115, the specialist or consultant physician must be satisfied that it would be a clinical risk to defer the consultation for the patient at this time.

Where item 115 is claimed, the records for the consultation should clearly identify why the consultation is considered necessary for the patient including the clinical risk to defer the consultation.

AN.7.1 Attendances by Medical Practitioners

Items 179-181, 185-187, 189-197, 203-206, 215-287, 371, 372, 733-789, 792, 812-892, 90092-93, 90095-96, 90183, 90188, 90202, and 90212 relate to attendances rendered by a medical practitioner who is not a general practitioner, specialist or consultant physician, and who:

(a) is registered under section 3GA of the Act, to the extent that the person is practising during the period in respect of which, and in the location in respect of which, he or she is registered, and insofar as the circumstances specified for paragraph 19AA(3)(b) of the Act apply; or

(b) is covered by an exemption under subsection 19AB(3) of the Act; or

(c) first became a medical practitioner before 1 November 1996.

AN.7.2 Medical Practitioner Attendances To Which No Other Item Applies

Eligibility

Items 179 to 212 are available to medical practitioners providing services in eligible areas.

Eligible area means an area that is a Modified Monash 2 area, Modified Monash 3 area, Modified Monash 4 area, Modified Monash 5 area, Modified Monash 6 area or Modified Monash 7 area.

Medical practitioners providing services in a Modified Monash 1 area should use the items in Group A2.

A locator map to identify a medical practice's Modified Monash Model Area location is available at the DoctorConnect website at http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator

Guidance Notes

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

Professional consultation of not more than 5 minutes duration

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

Professional consultation of more than 5 minutes but not more than 25 minutes

The item will be used for a consultation lasting more than 5 minutes but less than 25 minutes for cases that are not obvious or straightforward in relation to one or more health related issues. This should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.

Professional consultation of more than 25 minutes but not more than 45 minutes

The item will be used for a consultation lasting more than 25 minutes but less than 45 minutes for cases in relation to one or more complex health related issues. This should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.

Professional consultation of more than 45 minutes

The item will be used for a consultation lasting at least 40 minutes for cases in relation to one or more very complex health related issues. This should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.

Creating and Updating a My Health Record

The time spent by a medical practitioner on the following activities may be counted towards the total consultation time:

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

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

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

Recording Clinical Notes

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

Other Services at the Time of Attendance

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

AN.7.3 Medical Practitioner Prolonged Attendance in Treatment of a Critical Condition (Items 214 to 220)

The conditions to be met before services covered by items 214-220 attract benefits are:-

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

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

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

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

AN.7.4 Medical Practitioner Family Group Therapy (Items 221, 222 and 223)

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.

Telephone consultations, letters of advice by medical practitioners, the issue of repeat prescriptions when the patient is not in attendance, post mortem examinations, the issue of death certificates, cremation certificates, counselling of relatives (note - items 348, 350 and 352 are not counselling services), group attendances (other than group attendances covered by items 170, 171, 172, 221, 222, 223, 342, 344 and 346) such as group counselling, health education, weight reduction or fitness classes do not qualify for benefit.

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

AN.7.5 Medical Practitioner Health Assessments (Items 224 to 227)

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

Brief Health Assessment (MBS Item 224)

A brief health assessment is used to undertake simple health assessments. The health assessment should take no more than 30 minutes to complete.

Standard Health Assessment (MBS Item 225)

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

Long Health Assessment (MBS Item 226)

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

Prolonged Health Assessment (MBS Item 227)

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

Medical practitioners may select one of the MBS health assessment items to provide a health assessment service to a member of any of the target groups listed in the table below. The health assessment item that is selected will depend on the time taken to complete the health assessment service. This is determined by the complexity of the patient's presentation and the specific requirements that have been established for each target group eligible for health assessments.

MBS Items 224, 225, 226 and 227 may be used to undertake a health assessment for the following target groups:

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

Frequency of service

The frequency with which patients in different population groups may receive a health assessment is described in the table above. Patients may not have more services than they are eligible for under the frequency provisions that apply to specific types of health assessment.

Important Note: patients may receive services using MBS items 224 to 227 and 701 to 707. However, once a patient has received a service using an MBS item from **either** group of MBS health assessment items, the patient may not receive another MBS health assessment until the appropriate time period has expired. In the case of health assessment services that are provided only once in a patient's lifetime, the patient would not be eligible for another health assessment.

The only exception is patients who are eligible for more than one type of health assessment (that is, the patient belongs to more than one eligible patient category). However, the frequency of service restrictions also apply to these services.

If a medical practitioner is not sure if a patient is eligible for an MBS health assessment service, they may telephone the Department of Human Services on 132011, with the patient present, to check eligibility.

Guidance Notes

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

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

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

A health assessment must include the following elements:

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

b. making an overall assessment of the patient;

c. recommending appropriate interventions;

d. providing advice and information to the patient;

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

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

Restrictions on billing the health assessment items

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

A health assessment should generally be undertaken by the patient's 'usual doctor'. For the purpose of the health assessment items, 'usual doctor' means the medical practitioner, or a medical practitioner working in the same

medical practice, which has provided the majority of primary health care to the patient over the previous twelve months and/or will be providing the majority of care to the patient over the next twelve months.

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

MBS health assessment items 224, 225, 226 and 227 must be provided by a medical practitioner personally attending upon a patient. Suitably qualified health professionals, such as practice nurses or Aboriginal and Torres Strait Islander health practitioners, employed and/or otherwise engaged by a medical practice or health service, may assist medical practitioners in performing health assessments. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the medical practitioner. This may include activities associated with:

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

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

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

Items 224, 225, 226 and 227 do not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, items 224, 225, 226 and 227 can be claimed for services provided by medical practitioners salaried by or contracted to, the Service or health clinic. All other requirements of the items must be met.

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

AN.7.6 Medical Practitioner Health Assessment Provided as a Type 2 Diabetes Risk Evaluation for People Aged 40-49 Years with a High Risk of Developing Type 2 Diabetes as Determined by the Australian Type 2 Diabetes Risk Assessment Tool

Items 224, 225, 226 and 227 may be used to undertake a type 2 diabetes risk evaluation for people aged 40-49 years (inclusive) with a high risk of developing type 2 diabetes, as determined by the Australian Type 2 Diabetes Risk Assessment Tool.

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

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

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

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

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

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

(c) any relevant recent diagnostic test results; and

(d) a family history of chronic disease.

The health assessment must include the following:

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

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

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

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

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

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

AN.7.7 Medical Practitioner Health Assessment Provided for People Aged 45-49 Years Who are at Risk of Developing Chronic Disease

Items 224, 225, 226 and 227 may be used to undertake a health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease.

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

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

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

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

(c) family history of a chronic disease.

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

If, after receiving this health assessment, a patient is identifed as having a high risk of type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool, the medical practitioner may refer that person to a

subsidised lifestyle modification program, along with other possible strategies to improve the health status of the patient (further information is available at http://www.health.gov.au/preventionoftype2diabetes).

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

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

AN.7.8 Medical Practitioner Health Assessment Provided for People Aged 75 Years and Older

Items 224, 225, 226 and 227 may be used to undertake a health assessment for people aged 75 years and older.

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

This health assessment must include:

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

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

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

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

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

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

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

(h) A health assessment for people aged 75 years and older may be claimed once every twelve months by an eligible patient.

AN.7.9 Medical Practitioner Health Assessment Provided as a Comprehensive Medical Assessment for Residents of Residential Aged Care Facilities

Items 224, 225, 226 and 227 may be used to undertake a comprehensive medical assessment of a resident of a residential aged care facility

This health assessment requires assessment of the resident's health and physical and psychological function, and must include:

(a) making a written summary of the comprehensive medical assessment;

(b) developing a list of diagnoses and medical problems based on the medical history and examination;

(c) providing a copy of the summary to the residential aged care facility; and

(d) offering the resident a copy of the summary.

A residential aged care facility is a facility in which residential care services, as defined in the Aged Care Act 1997, are provided. This includes facilities that were formerly known as nursing homes and hostels. A person is a resident of a residential aged care facility if the person has been admitted as a permanent resident of that facility.

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

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

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

(b) at 12 month intervals thereafter.

AN.7.10 Medical Practitioner Health Assessment Provided for People with an Intellectual Disability

Items 224, 225, 226 and 227 may be used to undertake a health assessment for people with an intellectual disability.

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

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

(a) Check dental health (including dentition);

(b) Conduct aural examination (arrange formal audiometry if audiometry has not been conducted within 5 years);

(c) Assess ocular health (arrange review by an ophthalmologist or optometrist if a comprehensive eye examination has not been conducted within 5 years);

(d) Assess nutritional status (including weight and height measurements) and a review of growth and development;

(e) Assess bowel and bladder function (particularly for incontinence or chronic constipation);

(f) Assess medications (including non-prescription medicines taken by the patient, prescriptions from other doctors, medications prescribed but not taken, interactions, side effects and review of indications);

- Advise carers of the common side effects and interactions.
- Consider the need for a formal medication review.

(g) Check immunisation status, including influenza, tetanus, hepatitis A and B, Measles, Mumps and Rubella (MMR) and pneumococcal vaccinations;

(h) Check exercise opportunities (with the aim of moderate exercise for at least 30 minutes per day);

(i) Check whether the support provided for activities of daily living adequately and appropriately meets the patient's needs, and consider formal review if required;

(j) Consider the need for breast examination, mammography, cervical screening, testicular examination, lipid measurement and prostate assessment as for the general population;

(k) Check for dysphagia and gastro-oesophageal disease (especially for patients with cerebral palsy), and arrange for investigation or treatment as required;

(l) Assess risk factors for osteoporosis (including diet, exercise, Vitamin D deficiency, hormonal status, family history, medication fracture history) and arrange for investigation or treatment as required;

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

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

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

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

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

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

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

AN.7.11 Medical Practitioner Health Assessment Provided for Refugees and Other Humanitarian Entrants

Items 224, 225, 226 and 227 may be used to undertake a health assessment for refugees and other humanitarian entrants.

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

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

Offshore Refugee Category including:

(a) 200 Refugee

(b) 201 In Country Special Humanitarian

(c) 203 Emergency rescue

(d) 204 Women at Risk

(e) Offshore - Special Humanitarian Program

(f) 202 Global Special Humanitarian

Offshore - Temporary Humanitarian Visas (THV) including:

(g) Subclass 695 (Return Pending)

(h) Subclass 070 (Removal Pending Bridging)

Onshore Protection Program including:

(i) 866 Permanent Protection Visa (PPV)

(j) 785 Temporary Protection Visa (TPV)

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

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

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

AN.7.12 Medical Practitioner Australian Defence Force Post-Discharge Health Assessment

Items 224, 225, 226 and 227 may be used to undertake a health assessment for a former serving member of the Australian Defence Force, including a former member of permanent and reserve forces.

A health assessment for a former serving member of the Australian Defence Force is an assessment of:

- a patient's physical and psychological health and social function; and
- whether health care, education and other assistance should be offered to the patient to improve their physical, psychological health or social function.

This health assessment must include:

1. a personal attendance by a medical practitioner; and

2. taking the patient's history, including the following:

i the patient's service with the Australian Defence Force, including service type, years of service, field of work, number of deployments and reason for discharge;

ii the patient's social history, including relationship status, number of children (if any) and current occupation;

iii the patient's current medical conditions;

iv whether the patient suffers from hearing loss or tinnitus;

v the patient's use of medication, including medication prescribed by another doctor and medication obtained without a prescription;

vi the patient's smoking, if applicable;

vii the patient's alcohol use, if applicable;

viii the patient's substance use, if applicable;

ix the patient's level of physical activity;

x whether the patient has bodily pain;

xi whether the patient has difficulty getting to sleep or staying asleep;

xii whether the patient has psychological distress;

xiii whether the patient has posttraumatic stress disorder;

xiv whether the patient is at risk of harm to self or others;

xv whether the patient has anger problems;

xvi the patient's sexual health;

xvii any other health concerns the patient has.

The assessment must also include the following:

1. measuring the patient's height;

2. weighing the patient and ascertaining, or asking the patient, whether the patient's weight has changed in the last 12 months;

3. measuring the patient's waist circumference;

4. taking the patient's blood pressure;

5. using information gained in the course of taking the patient's history to assess whether any further assessment of the patient's health is necessary;

6. either making the further assessment or referring the patient to another medical practitioner who can make the further assessment;

7. documenting a strategy for improving the patient's health;

8. offering to give the patient a written report of the assessment that makes recommendations for treating the patient including preventive health measures;

9. keeping a record of the assessment.

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

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

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

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

AN.7.13 Medical Practitioner Health Assessment for an Aboriginal and Torres Strait Islander People (Item 228)

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

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

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

MBS item 228 must include the following elements:

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

(b) making an overall assessment of the patient;

(c) recommending appropriate interventions;

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

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

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

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

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

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

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

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

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

MBS health assessment item 228 must be provided by a medical practitioner personally attending upon a patient. Suitably qualified health professionals, such as practice nurses, Aboriginal health workers or Aboriginal and Torres Strait Islander health practitioners employed and/or otherwise engaged by a general practice or health service, may assist medical practitioners in performing this health assessment. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the medical practitioner. This may include activities associated with:

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

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

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

Item 228 does not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, item 228 can be claimed for services provided by medical practitioners salaried by or contracted to, the Service or health clinic. All requirements of the item must be met.

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

An eligible patient may only receive the Health Assessment for Aboriginal and Torres Strait Islander People using either item 228 or item 715 once in a 9 month period.

AN.7.14 Medical Practitioner Health Assessment for an Aboriginal and Torres Strait Islander Child less than 15 years of age (Item 228)

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

a. a personal attendance by a medical practitioner;

b. taking the patient's medical history, including the following:

i. mother's pregnancy history;

ii. birth and neo-natal history:

iii. breastfeeding history;

iv. weaning, food access and dietary history;

v. physical activity;

vi. previous presentations, hospital admissions and medication usage;

vii. relevant family medical history;

viii. immunisation status;

ix. vision and hearing (including neonatal hearing screening);

x. development (including achievement of age appropriate milestones);

xi. family relationships, social circumstances and whether the person is cared for by another person;

xii. exposure to environmental factors (including tobacco smoke);

xiii. environmental and living conditions;

xiv. educational progress;

xv. stressful life events;

xvi. mood (including incidence of depression and risk of self-harm);

xvii.substance use;

xviii. sexual and reproductive health; and

xix. dental hygiene (including access to dental services).

c. examination of the patient, including the following:

i. measurement of height and weight to calculate body mass index and position on the growth curve;

ii. newborn baby check (if not previously completed);

iii. vision (including red reflex in a newborn);

iv. ear examination (including otoscopy);

v. oral examination (including gums and dentition);

vi. trachoma check, if indicated;

vii. skin examination, if indicated;

viii. respiratory examination, if indicated;

ix. cardiac auscultation, if indicated;

x. development assessment, if indicated, to determine whether age appropriate milestones have been achieved;

xi. assessment of parent and child interaction, if indicated; and

xii. other examinations in accordance with national or regional guidelines or specific regional needs, or as indicated by a previous child health assessment.

d. undertaking or arranging any required investigation, considering the need for the following tests, in particular:

i. haemoglobin testing for those at a high risk of anaemia; and

ii. audiometry, if required, especially for those of school age

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

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

AN.7.15 Medical Practitioner Health Assessment for an Aboriginal and Torres Strait Islander Adult Aged 15 Years to 54 Years (Item 228)

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

a. a personal attendance by a medical practitioner;

b. taking the patient's medical history, including the following:

i. current health problems and risk factors;

ii. relevant family medical history;

iii. medication usage (including medication obtained without prescription or from other doctors);

iv. immunisation status, by reference to the appropriate current age and sex immunisation schedule;

v. sexual and reproductive health;

vi. physical activity, nutrition and alcohol, tobacco or other substance use;

vii. hearing loss;

viii. mood(including incidence of depression and risk of self-harm);

ix. family relationships and whether the patient is a carer, or is cared for by another person; and

x. vision

c. examination of the patient, including the following:

i. measurement of the patient's blood pressure, pulse rate and rhythm;

ii. measurement of height and weight to calculate body mass index and, if indicated, measurement of waist circumference for central obesity;

iii. oral examination (including gums and dentition);

iv. ear and hearing examination (including otoscopy and, if indicated, a whisper test); and

v. urinalysis (by dipstick) for proteinurea;

vi. eye examination;

d. undertaking or arranging any required investigation, considering the need for the following tests, in particular, (in accordance with national or regional guidelines or specific regional needs):

i. fasting blood sugar and lipids (by laboratory based test on venous sample) or, if necessary, random blood glucose levels;

ii. cervical screening;

iii. examination for sexually transmitted infection (by urine or endocervical swab for chlamydia and gonorrhoea, especially for those aged from 15 to 35years); and

iv. mammography, if eligible (by scheduling appointments with visiting services or facilitating direct referral).

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

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

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

a. keeping a record of the health assessment; and

b. offering the patient a written report on the health assessment, with recommendations on matters covered by the health assessment.

AN.7.16 Medical Practitioner Health Assessment for an Aboriginal and Torres Strait Islander Older Person Aged 55 Years and Over (Item 228)

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

a. a personal attendance by the medical practitioner;

b. measurement of the patient's blood pressure, pulse rate and rhythm;

c. an assessment of the patient's medication;

d. an assessment of the patient's continence;

e. an assessment of the patient's immunisation status for influenza, tetanus and pneumococcus;

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

g. an assessment of the patient's psychological function, including the patient's cognition and mood;

h. an assessment of the patient's social function, including:

i. the availability and adequacy of paid, and unpaid, help;

ii. whether the patient is responsible for caring for another person;

i. an eye examination

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

a. keeping a record of the health assessment; and

b. offering the patient a written report on the health assessment, with

c. recommendations on matters covered by the health assessment; and

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

AN.7.17 Medical Practitioner Chronic Disease Management (Items 229 to 233)

Description	**Item No**	**Minimum claiming period***
Preparation of a GP Management Plan (GPMP)	229	12 months
Coordination of Team Care Arrangements (TCAs)	230	12 months
Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	231	3 months
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	232	3 months
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	233	3 months

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

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

Regulatory requirements

Items 229, 230, 231, 232 and 233 provide rebates for medical practitioners to manage chronic or terminal medical conditions by preparing, coordinating, reviewing or contributing to chronic disease management (CDM) plans. They apply for a patient who suffers from at least one medical condition that has been present (or is likely to be present) for at least six months or is terminal.

Restrictions on claiming multiple Chronic Disease Management Items

Patients may receive chronic disease management services using MBS items 229 to 223 and 721 to 732. However, once a patient has received a service using an MBS item from **either** group of MBS chronic disease management items, the patient may not receive another MBS chronic disease management service until the minimum claiming period has expired. The only exception is where there are exceptional circumstances necessitating an earlier performance of the service (see **Claiming of benefits** below).

If a medical practitioner is not sure if a patient is eligible for an MBS chronic disease management service, they may telephone the Department of Human Services on 132011, with the patient present, to check eligibility.

Restriction of Co-claiming of Chronic Disease and General Consultation Items

Co-claiming of MBS general consultation items 3, 4, 23, 24, 36, 37, 44, 47, 52, 53, 54, 57, 58, 59, 60, 65, 179, 181, 185, 187, 189, 191, 203, 206, 585, 588, 591, 594, 599, 600, 733, 737, 741, 745, 761, 763, 766, 769, 5000, 5003, 5020, 5023, 5040, 5043, 5060, 5063, 5200, 5203, 5207, 5208, 5220, 5223, 5227, 5228 with chronic disease management items 229, 230 and 233 is not permitted for the same patient, on the same day.

Patient eligibility

CDM items 229, 230 and 233 are available to:

i patients in the community; and

ii private in-patients of a hospital (including private in-patients who are residents of aged care facilities) being discharged from hospital.

CDM items 229, 230 and 233 are not available to:

i public in-patients of a hospital; or

ii care recipients in a residential aged care facility.

CDM item 231 is available to:

i patients in the community;

ii both private and public in-patients being discharged from hospital.

CDM item 231 is not available to:

i care recipients in a residential aged care facility.

CDM item 232 is available to care recipients in a residential aged care facility only.

Components of service

Item 229

A comprehensive written plan must be prepared describing:

a. the patient's health care needs, health problems and relevant conditions;

b. management goals with which the patient agrees;

c. actions to be taken by the patient;

d. treatment and services the patient is likely to need;

e. arrangements for providing this treatment and these services; and

f. arrangements to review the plan by a date specified in the plan.

In preparing the plan, the medical practitioner must:

a. explain to the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) the steps involved in preparing the plan; and

b. record the plan; and

c. record the patient's agreement to the preparation of the plan; and

d. offer a copy of the plan to the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees); and

e. add a copy of the plan to the patient's medical records.

Item 230

When coordinating the development of Team Care Arrangements (TCAs), the medical practitioner must:

a. consult with at least two collaborating providers, each of whom will provide a different kind of treatment or service to the patient, and one of whom may be another medical practitioner, when making arrangements for the multidisciplinary care of the patient; and

b. prepare a document that describes:

i treatment and service goals for the patient;

ii treatment and services that collaborating providers will provide to the patient; and

iii actions to be taken by the patient;

iv arrangements to review (i), (ii) and (iii) by a date specified in the document; and

c. explain the steps involved in the development of the arrangements to the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees);

d. discuss with the patient the collaborating providers who will contribute to the development of the TCAs and provide treatment and services to the patient under those arrangements; and

e. record the patient's agreement to the development of TCAs;

f. give copies of the relevant parts of the document to the collaborating providers;

g. offer a copy of the document to the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees); and

h. add a copy of the document to the patient's medical records.

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

Item 231

A multidisciplinary care plan means a written plan that:

a. is prepared for a patient by:

i a medical practitioner in consultation with two other collaborating providers, each of whom provides a different kind of treatment or service to the patient, and one of whom may be another medical practitioner; or

ii a collaborating provider (other than a medical practitioner) in consultation with at least two other collaborating providers, each of whom provides a different kind of treatment or services to the patient; and

b. describes, at least, treatment and services to be provided to the patient by the collaborating providers.

When contributing to a multidisciplinary care plan or to a review of the care plan, the medical practitioner must:

i. prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or

j. give advice to a person who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided to such a person.

Item 232

A multidisciplinary care plan in a Residential Aged Care Facility (RACF) means a written plan that:

a. is prepared for a patient by a collaborating provider (other than a medical practitioner, e.g. a RACF), in consultation with at least two other collaborating providers, each of whom provides a different kind of treatment or services to the patient; and

b. describes, at least, treatment and services to be provided to the patient by the collaborating providers.

When contributing to a multidisciplinary care plan or to a review of the care plan, the medical practitioner must:

a. prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or

b. give advice to a person who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided to such a person.

Item 232 can also be used for contribution to a multidisciplinary care plan prepared for a resident by another provider before the resident is discharged from a hospital or an approved day-hospital facility, or to a review of such a plan prepared by another provider (not being a service associated with a service to which items 235 to 240 apply).

Item 233

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

When reviewing a GP Management Plan, the medical practitioner must:

a. explain to the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) the steps involved in the review;

b. record the patient's agreement to the review of the plan;

c. review all the matters set out in the relevant plan;

d. make any required amendments to the patient's plan;

e. offer a copy of the amended document to the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees);

f. add a copy of the amended document to the patient's records; and

g. provide for further review of the amended plan by a date specified in the plan.

When coordinating a review of Team Care Arrangements, a multidisciplinary community care plan or a multidisciplinary discharge care plan, the medical practitioner must:

a. explain the steps involved in the review to the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees);

b. record the patient's agreement to the review of the TCAs or plan;

c. consult with at least two health or care providers (each of whom provides a service or treatment to the patient that is different from each other and different from the service or treatment provided by the medical practitioner who is coordinating the TCAs or plan) to review all the matters set out in the relevant plan;

d. make any required amendments to the patient's plan;

e. offer a copy of the amended document to the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees);

f. provide for further review of the amended plan by a date specified in the plan;

g. give copies of the relevant parts of the amended plan to the collaborating providers; and

h. add a copy of the amended document to the patient's records.

Item 233 can also be used to COORDINATE A REVIEW OF a Multidisciplinary Community Care Plan or to COORDINATE REVIEW OF A Discharge Care, where these services were coordinated or prepared by that medical practitioner (or an associated medical practitioner), and not being a service associated with a service to which items 235 to 240 apply.

Claiming of benefits

Each service to which item 233 applies (i.e. Review of a GP Management Plan and Review of Team Care Arrangements) may be claimed once in a three-month period, except where there are exceptional circumstances arising from a significant change in the patient's clinical condition or care circumstances that necessitates earlier performance of the service for the patient.

Where a service is provided in exceptional circumstances, the patient's invoice or Medicare voucher should be annotated to indicate the reason why the service was required earlier than the minimum time interval for the relevant item. Payment can then be made.

Item 233 can be claimed twice on the same day providing an item 233 for reviewing a GP Management Plan and another 233 for reviewing Team Care Arrangements (TCAs) are both delivered on the same day as per the MBS item descriptors and explanatory notes.

Medicare requirements when item 233 is claimed twice on the same day

If a GPMP and TCAs are both reviewed on the same date and item 233 is to be claimed twice on the same day, both electronic claims and manual claims need to indicate they were rendered at different times:

Non electronic Medicare claiming of items 233 on the same date

The time that each item 233 commenced should be indicated next to each item

Electronic Medicare claiming of item 233 on the same date

Medicare Easyclaim: use the 'ItemOverrideCde" set to 'AP', which flags the item as not duplicate services
Medicare Online/ECLIPSE: set the 'DuplicateServiceOverrideIND' to 'Y', which flags the item as not duplicate

Items 229, 230 233

The GP Management Plan items (229 and 233) and the Team Care Arrangement items (230 and 233) cannot be claimed by medical practitioners when they are a recognised specialist in the specialty of palliative medicine and treating a referred palliative care patient under items 3005-3093. The referring practitioner is able to provide the CDM services.

Additional information

Advice on the items and further guidance are available at http://www.health.gov.au/mbsprimarycareitems

Items 229-233 should generally be undertaken by the patient's usual medical practitioner. This means the medical practitioner, or a medical practitioner working in the same medical practice, who has provided the majority of care to the patient over the previous twelve months and/or will be providing the majority of medical services to the patient over the next twelve months. The term "usual medical practitioner" would not generally apply to a practice that provides only one specific CDM service.

A practice nurse, Aboriginal and Torres Strait Islander health practitioner, Aboriginal health worker or other health professional may assist with items 229, 230 and 233 (e.g. in patient assessment, identification of patient needs and making arrangements for services). However, the medical practitioner must meet all regulatory requirements, review and confirm all assessments and see the patient.

Patients being managed under the chronic disease management items may be eligible for:

- individual allied health services (items 10950 to 10970); and/or
- group allied health services (items 81100 to 81125).

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

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

AN.7.18 Medical Practitioner Medication Management Reviews (Items 245 and 249)

Item 245 - Domiciliary Medication Management Review

A Domiciliary Medication Management Review (DMMR) (Item 245), also known as Home Medicines Review, is intended to maximise an individual patient's benefit from their medication regimen, and prevent medication-related problems through a team approach, involving the patient's medical practitioner and preferred community pharmacy or accredited pharmacist.

Patient eligibility

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

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

DMMRs are targeted at patients who are likely to benefit from such a review:

- patients for whom quality use of medicines may be an issue or;

- patients who are at risk of medication misadventure because of factors such as their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or a lack of knowledge and skills to use medicines to their best effect.

DMMR’s are targeted at patients who are:

- currently taking five or more regular medications;
- taking more than 12 doses of medication per day;
- have had significant changes made to medication treatment regimen in the last three months;
- taking medication with a narrow therapeutic index or medications requiring therapeutic monitoring;
- experiencing symptoms suggestive of an adverse drug reaction;
- displaying sub-optimal response to treatment with medicines;

- suspected of non-compliance or inability to manage medication related therapeutic devices;
- having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties;
- attending a number of different doctors, both medical practitioners and specialists; and/or
- recently discharged from a facility / hospital (in the last four weeks).

In referring a patient for a DMMR, medical practitioners should note that only patients meeting the following criteria will have the pharmacist portion funded through a Community Pharmacy Agreement program:

- Is a Medicare and/or Department of Veterans' Affairs (DVA) cardholder or a person who is eligible for a Medicare card;
- Is subject to a chronic condition and/or complex medication regimen; and
- Is failing to respond to treatment in the expected manner.

If the patient does not meet these criteria, the medical practitioner can still issue a referral under this item. However, the remainder of the service will be on a "user pays" basis as determined by the accredited pharmacist.

REGULATORY REQUIREMENTS

In conducting a DMMR, a medical practitioner must, with the patient's consent:

(a) assess a patient is subject to a chronic medical condition and/or complex medication regimen but their therapeutic goals are not being met; and

(b) following that assessment, refer the patient to a community pharmacy or an accredited pharmacist for a DMMR and provide the relevant clinical information required for the review; and

(c) discuss with the reviewing pharmacist the result of that review including suggested medication management strategies; and

(d) develop a written medication management plan following discussion with the patient; and

(e) provide the written medication management plan to a community pharmacy chosen by the patient.

For any particular patient - applicable not more than once in each 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR.

Claiming

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

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

Benefits for a DMMR service under item 245 are payable only once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (e.g. diagnosis of a new condition or recent discharge from hospital involving significant changes in medication). In such cases the patient's invoice or Medicare voucher should be annotated to indicate that the DMMR service was required to be provided within 12 months of another DMMR service.

Provision of a subsequent DMMR must not be made solely by reaching an anniversary date, and the service is not intended to be undertaken on an ongoing review cycle.

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 245 may be claimed.

If the medical practitioner determines that a DMMR is not necessary, item 245 does not apply. In this case, normal consultation items should be used.

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

FURTHER GUIDANCE

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

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

The process of referral to a community pharmacy or an accredited pharmacist includes:

- Obtaining consent from the patient, consistent with normal clinical practice, for a pharmacist to undertake the medication management review and for a charge to be incurred for the service for which a Medicare rebate is payable. The patient must be clearly informed of the purpose and possible outcomes of the DMMR, the process involved (including that the pharmacist will visit the patient at home, unless exceptional circumstances apply or they are an Aboriginal or Torres Strait Islander patient), what information will be provided to the pharmacist as part of the DMMR, and any additional costs that may be incurred; and

- Provision to the patient's preferred community pharmacy or accredited pharmacist, of relevant clinical information, by the medical practitioner for each individual patient, covering the patient's diagnosis, relevant test results and medication history, and current prescribed medications.

A DMMR referral form is available for this purpose. If this form is not used, the medical practitioner must provide patient details and relevant clinical information to the patient's preferred community pharmacy or accredited pharmacist.

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

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

Development of a written medication management plan following discussion with the patient includes:

- Developing a draft medication management plan and discussing this with the patient; and

- Once agreed, offering a copy of the written medication management plan to the patient and providing a copy to the community pharmacy or accredited pharmacist.

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

Item 249 - Residential Medication Management Review

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

Patient eligibility

RMMRs are available to:

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

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

REGULATORY REQUIREMENTS

When conducting a RMMR, a medical practitioner must:

(a) discuss the proposed review with the resident and seek the resident's consent to the review; and

(b) collaborate with the reviewing pharmacist about the pharmacist's involvement in the review; and

(c) provide input from the resident's most recent comprehensive medical assessment or, if such an assessment has not been undertaken, provide relevant clinical information for the review and for the resident's records; and

(d) If recommended changes to the resident's medication management arise out of the review, participate in a post-review discussion (either face-to-face or by telephone) with the pharmacist to discuss the outcomes of the review including:

(i) the findings; and

(ii) medication management strategies; and

(iii) means to ensure that the strategies are implemented and reviewed, including any issues for implementation and follow-up; and

(iv) develop or revise the resident's medication management plan after discussion with the reviewing pharmacist; and

(v) finalise the plan after discussion with the resident.

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

(a) offering a copy of the medication management plan to the resident (or the resident's carer or representative if appropriate); and

(b) providing copies of the plan for the resident's records and for the nursing staff of the residential aged care facility; and

(c) discussing the plan with nursing staff if necessary.

A post-review discussion is not required if:

(a) there are no recommended changes to the resident's medication management arising out of the review; or

(b) any changes are minor in nature and do not require immediate discussion; or

(c) the pharmacist and medical practitioner agree that issues arising out of the review should be considered in a case conference.

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

Claiming

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

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

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

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

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

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

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

FURTHER GUIDANCE

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

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

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

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

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

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

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

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

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

AN.7.19 Medical Practitioner Cervical Screen from a Person Who is Unscreened or Significantly Under-Screened (Items 251 to 257)

Eligibility

Items 251 to 257 are available to medical practitioners providing services in eligible areas.

Eligible area means an area that is a Modified Monash 2 area, Modified Monash 3 area, Modified Monash 4 area, Modified Monash 5 area, Modified Monash 6 area or Modified Monash 7 area.

Medical practitioners providing services in a Modified Monash 1 area should use the items in Group A19, Subgroup 1.

A locator map to identify a medical practice's Modified Monash Model Area location is available at the DoctorConnect website at http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator

Guidance Notes

Item numbers 251, 252, 253, 254, 255, 256 and 257 should be used in place of the usual attendance item where as part of a consultation, a sample for cervical screening is collected from a person between the ages of 24 years and 9 months and 74 years inclusive who has not had a cervical smear in the last four years. Cervical Screening in accordance with the National Cervical Screening Policy at P.16.11.

Self-collection of a sample for screening is only available for women between the ages of 30 and 74 years of age who are overdue for screening by two or more years (i.e. being 4 years since their last Pap test). Self-collection should only be offered to an eligible person who refuses to have a sample collected by their requesting practitioner.

When providing this service, the medical practitioner must satisfy themselves that the person has not had a cervical screening test in the last four years by:

(a) asking the person if they can remember having a cervical screening test in the last four years;

(b) checking their own practice's medical records; and

(c) checking the National Cancer Screening Register.

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

Vault smears are not eligible for items 251 to 257.

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

A PIP Cervical Screening SIP is available for taking a cervical screen from a person who has not been screened in the last for four years. The SIP will be paid to the medical practitioner who provided the service if the service was provided in a medical practice participating in the PIP Cervical Screening Incentive. A further PIP Cervical Screening Incentive payment is paid to medical practices which reach target levels of cervical screening for their patients aged 24 years and 9 months of age to 74 years inclusive. More detailed information on the PIP Cervical Screening Incentive is available from the Department of Human Services PIP enquiry line on 1800 222 032 or from the Department of Human Services website.

AN.7.20 Medical Practitioner Completion of the Annual Diabetes Cycle of Care for Patients with Established Diabetes Mellitus (Items 259 to 264)

Eligibility

Items 259 to 264 are available to medical practitioners providing services in eligible areas.

Eligible area means an area that is a Modified Monash 2 area, Modified Monash 3 area, Modified Monash 4 area, Modified Monash 5 area, Modified Monash 6 area or Modified Monash 7 area.

Medical practitioners providing services in a Modified Monash 1 area should use the items in Group A19, Subgroup 2.

A locator map to identify a medical practice's Modified Monash Model Area location is available at the DoctorConnect website at http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator

Guidance Notes

Item numbers 259, 260, 261, 262, 263 and 264 should be used in place of the usual attendance item when a consultation completes the minimum requirements of the annual Diabetes Cycle of Care for a patient with established diabetes mellitus.

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

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

*Not required if the patient is blind or does not have both eyes.

**Initial visit: measure height and weight and calculate BMI as part of the initial assessment.

Subsequent visits: measure weight.

***Not required if the patient does not have both feet.

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

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

These items should only be used once per cycle per patient: A7 Subgroup 8, A18 Subgroup 2 or A19 Subgroup 2. For example, if item 259 is claimed for a patient then no other diabetes item in groups A18 or A19 can be used for this patient in the same cycle.

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

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

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

A PIP Diabetes SIP is available for completing the minimum requirements of the Diabetes Cycle of Care for individual patients as specified above. The Diabetes SIP is only paid once every 11-13 month period per patient. The SIP will be paid to the medical practitioner who provided the service if the service was provided in a medical practice participating in the PIP Diabetes Incentive. A further PIP Diabetes Incentive payment is paid to medical practices which reach target levels of care for their patients with diabetes mellitus. More detailed information on the PIP Diabetes Incentive is available from the Department of Human Services PIP enquiry line on 1800 222 032 or the Department of Human Services website.

AN.7.21 Medical Practitioner Completion of the Asthma Cycle of Care (Items 265 to 271)

Eligibility

Items 265 to 271 are available to medical practitioners providing services in eligible areas.

Eligible area means an area that is a Modified Monash 2 area, Modified Monash 3 area, Modified Monash 4 area, Modified Monash 5 area, Modified Monash 6 area or Modified Monash 7 area.

Medical practitioners providing services in a Modified Monash 1 area should use the items in Group A19, Subgroup 3.

A locator map to identify a medical practice's Modified Monash Model Area location is available at the DoctorConnect website at http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator

Guidance Notes

Item numbers 265, 266, 268, 269, 270 and 271 should be used in place of the usual attendance item when a consultation completes the minimum requirements of the Asthma Cycle of Care. The Practice Incentives Program

(PIP) Asthma Incentive is for patients with moderate to severe asthma who in the opinion of the medical practitioner could benefit from review, eg those whose asthma management could be improved.

At a minimum the Asthma Cycle of Care must include:

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

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

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

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

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

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

The visit that completes the Asthma Cycle of Care should be billed using the appropriate item listed in Group A7 Subgroup 8.

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

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

A PIP Asthma SIP is available for completing the minimum requirements of the Asthma Cycle of Care for individual patients as specified above. The SIP will be paid to the medical practitioner who provided the service if the service was provided in a medical practice participating in the PIP Asthma Incentive. More detailed information on the PIP Asthma Incentive is available from the Department of Human Services PIP enquiry line on 1800222032 or from the Department of Human Services website.

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

Assessment of Severity

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

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

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

AN.7.22 Medical Practitioner Mental Health Treatment (Items 272 to 282)

This note provides information on the Mental Health Treatment items 272, 276, 277, 279, 281 and 282. It includes an overview of the items, patient and provider eligibility, what activities are involved in providing services rebated by these items, links to other Medicare items and additional claiming information.

Overview

The Mental Health Treatment items define services for which Medicare rebates are payable where medical practitioners undertake early intervention, assessment and management of patients with mental disorders. They include referral pathways for treatment by psychiatrists, clinical psychologists and other allied mental health workers. These items complement the mental health items for psychiatrists (items 296 - 299), clinical psychologists (items 80000 - 80021) and allied mental health providers (items 80100 - 80171).

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

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

Who can provide

The GP Mental Health Treatment Plan, Review and Consultation items are available for use in general practice by medical practitioners, but excluding specialists or consultant physicians.

Training Requirements (item 281 and 282)

Medical practitioner providing GP Mental Health Treatment Plans, and who have undertaken mental health skills training recognised through the General Practice Mental Health Standards Collaboration, have access to items 281 and 282. For medical practitioners who have not undertaken training, items 272 and 276 are available. Items 272 provides for a GP Mental Health Treatment Plan lasting at least 20 minutes and item 276 provides for a GP Mental Health Treatment Plan lasting at least 40 minutes. It is strongly recommended that medical practitioners providing mental health treatment have appropriate mental health training. Medical professional organisations support the value of appropriate mental health training for medical practitioners using these items.

Which patients are eligible - Mental Disorder

These items are for patients with a mental disorder who would benefit from a structured approach to the management of their treatment needs. Mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities (Refer to the World

Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version). Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of the Mental Health Treatment items.

These services are available to eligible patients in the community. Mental Health Treatment Plan and Review services can also be provided to private in-patients (including private in-patients who are residents of aged care facilities) being discharged from hospital. Where the medical practitioner who provides the Mental Health Treatment item is providing in-patient treatment the item is claimed as an in-hospital service (at 75% MBS rebate). Medical practitioners are able to contribute to care plans for patients using item 231, Contribution to a Multidisciplinary Care Plan, and to care plans for residents of aged care facilities using item 232.

PREPARING A GP MENTAL HEALTH TREATMENT PLAN (Item 272, 276, 281 or 282)

What is involved - Assess and Plan

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

Assessment

An assessment of a patient must include:

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

The assessment can be part of the same consultation in which the GP Mental Health Treatment Plan is developed, or can be undertaken in different visits. Where separate visits are undertaken for the purpose of assessing the patient and developing the GP Mental Health Treatment Plan, they are part of the GP Mental Health Treatment Plan service and are included in item 272, 276, 281 or 282.

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

Preparation of a GP Mental Health Treatment Plan

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

- discussing the assessment with the patient, including the mental health formulation and diagnosis or provisional diagnosis;

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

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

Once a GP Mental Health Treatment Plan has been completed and claimed on Medicare either through items 272, 276, 281 or 282 or through GP items 2700, 2701, 2715 or2717, a patient is eligible to be referred for up to 10 Medicare rebateable allied mental health services per calendar year for psychological therapy or focussed psychological strategy services. Patients will also be eligible to claim up to 10 separate services for the provision of group therapy (either as part of psychological therapy or focussed psychological strategies).

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

On completion of a course of treatment provided through Medicare rebateable services, the service provider must provide a written report on the course of treatment to the medical practitioner. For the purposes of the Medicare rebateable allied mental health items, a course of treatment will consist of the number of services stated on the patient's referral (up to a maximum of six in any one referral). There may be two or more courses of treatment within a patient's entitlement of up to 10 services per calendar year. The number of services that the patient is being referred for is at the discretion of the referring medical practitioner.

Many patients will not require a new plan after their initial plan has been prepared. A new plan should not be prepared unless clinically required, and generally not within 12 months of a previous plan. Ongoing management can be provided through the GP Mental Health Treatment Consultation and standard consultation items, as required, and reviews of progress through the GP Mental Health Treatment Plan Review item. A rebate for preparation of a GP Mental Health Treatment Plan will not be paid within 12 months of a previous claim for the patient for the same or another Mental Health Treatment Plan item or within three months following a claim for a GP Mental Health Treatment Review (item 277 or GP item 2712).

REVIEWING A GP MENTAL HEALTH TREATMENT PLAN (Item 277)

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

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

The review must include:

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

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

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

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

In general, most patients should not require more than two reviews in a 12 month period, with ongoing management through the GP Mental Health Treatment Consultation and standard consultation items, as required.

A rebate will not be paid within three months of a previous claim for the same item/s or within four weeks following a claim for a GP Mental Health Treatment Plan item.

GP MENTAL HEALTH TREATMENT CONSULTATION (Item 279)

The GP Mental Health Treatment Consultation item is for an extended consultation with a patient where the primary treating problem is related to a mental disorder, including for a patient being managed under a GP Mental Health Treatment Plan. This item may be used for ongoing management of a patient with a mental disorder. This item should not be used for the development of a GP Mental Health Treatment Plan.

A GP Mental Health Treatment Consultation must include:

- taking relevant history and identifying the patient's presenting problem(s) (if not previously documented);
- providing treatment, advice and/or referral for other services or treatment; and
- documenting the outcomes of the consultation in the patient's medical records and other relevant mental health plan (where applicable).

A patient may be referred from a GP Mental Health Treatment Consultation for other treatment and services as per normal referral arrangements. This does not include referral for Medicare rebateable services for focussed

psychological strategy services, clinical psychology or other allied mental health services, unless the patient is being managed by the medical practitioner under a GP Mental Health Treatment Plan or under a referred psychiatrist assessment and management plan (item 291).

Consultations associated with this item must be at least 20 minutes duration.

REFERRAL

Once a GP Mental Health Treatment Plan has been completed and claimed on Medicare, or a medical practitioner is managing a patient under a referred psychiatrist assessment and management plan (item 291), a patient is eligible for up to 10 Medicare rebateable allied mental health services per calendar year for services by:

- clinical psychologists providing psychological therapies; or
- appropriately trained medical practitioners or allied mental health professionals providing focussed psychological strategy (FPS) services.

In addition to the above services, patients will also be eligible to claim up to 10 separate services for the provision of group therapy.

When referring patients, medical practitioners should provide similar information as per normal referral arrangements, and specifically consider including both a statement identifying that a GP Mental Health Treatment Plan has been completed for the patient (including, where appropriate and with the patient's agreement, attaching a copy of the patient's GP Mental Health Treatment Plan) and clearly identifying the specific number of sessions the patient is being referred for. Referrals for patients with either a GP Mental Health Treatment Plan or referred psychiatrist assessment and management plan (item 291) should be provided, as required, for an initial course of treatment (a maximum of six services in any one referral but may be less depending on the referral and the patient's clinical need). There may be two or more courses of treatment within a patient's entitlement of up to 10 services per calendar year. The medical practitioner should consider the patient's clinical need for further sessions after the initial referral. This can be done using a GP Mental Health Treatment Plan Review, a GP Mental Health Treatment Consultation or a standard consultation item.

In the instance where a patient has received the 10 psychological therapy services (items 80000 to 80021), focussed psychological services-allied mental health services (items 80100 to 80171) or GP focussed psychological strategies services (items 283 to 287 or GP items 2721 to 2727) available under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative per calendar year and is considered to clinically benefit from some additional services, the patient may be eligible for Primary Health Networks (PHNs) funded psychological therapies if they meet relevant eligibility criteria for the PHN commissioned services. It is recommended that providers refer to their PHN for further guidance.

ADDITIONAL CLAIMING INFORMATION

Before proceeding with any GP Mental Health Treatment Plan or Review service the medical practitioner must ensure that:

(a) the steps involved in providing the service are explained to the patient and (if appropriate and with the patient's permission) to the patient's carer; and

(b) the patient's agreement to proceed is recorded.

Before completing any GP Mental Health Treatment Plan or Review service and claiming a benefit for that service, the medical practitioner must offer the patient a copy of the treatment plan or reviewed treatment plan and add the document to the patient's records. This should include, subject to the patient's agreement, offering a copy to their carer, where appropriate. The medical practitioner may, with the permission of the patient, provide a copy of the GP Mental Health Treatment Plan, or relevant parts of the plan, to other providers involved in the patient's treatment.

The GP Mental Health Treatment Plan, Review and Consultation items cover the consultations at which the relevant items are undertaken, noting that:

- if a GP Mental Health Treatment item is undertaken or initiated during the course of a consultation for another purpose, the GP Mental Health Treatment Plan, Review or Consultation item and the relevant item for the other consultation may both be claimed;

- if a GP Mental Health Treatment Plan is developed over more than one consultation, and those consultations are for the purposes of developing the plan, only the GP Mental Health Treatment Plan item should be claimed; and

- if a consultation is for the purpose of a GP Mental Health Treatment Plan, Review or Consultation item, a separate and additional consultation should not be undertaken in conjunction with the mental health consultation, unless it is clinically indicated that a separate problem must be treated immediately.

Where separate consultations are undertaken in conjunction with mental health consultations, the patient's invoice or Medicare voucher (assignment of benefit form) for the separate consultation should be annotated (e.g. separate consultation clinically required/indicated).

A benefit is not claimable and an account should not be rendered until all components of the relevant item have been provided.

All consultations conducted as part of the GP Mental Health Treatment items must be rendered by the medical practitioner and include a personal attendance with the patient. A specialist mental health nurse, other allied health practitioner, Aboriginal and Torres Strait Islander health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to medical practitioners in provision of mental health care.

Links to other Medicare Services

It is preferable that wherever possible patients have only one plan for primary care management of their mental disorder. As a general principle the creation of multiple plans should be avoided, unless the patient clearly requires an additional plan for the management of a separate medical condition.

The Chronic Disease Management (CDM) care plan items (items 229, 230, 231, 232 and 233, and GP items 721, 723, 729, 731 and 732) continue to be available for patients with chronic medical conditions, including patients with complex needs.

- Where a patient has a mental health condition only, it is anticipated that they will be managed under the GP Mental Health Treatment items.

- Where a patient has a separate chronic medical condition, it may be appropriate to manage the patient's medical condition through a GP Management Plan, and to manage their mental health condition through a GP Mental Health Treatment Plan. In this case, both items can be used.

- Where a patient has a mental health condition as well as significant co-morbidities and complex needs requiring team-based care, the medical practitioner is able to use both the CDM items (for team-based care) and the GP Mental Health Treatment items.

AN.7.23 Medical Practitioner Provision of Focussed Psychological Strategies (Items 283 to 287, 371 and 372)

Focussed psychological strategies are specific mental health care management strategies, derived from evidence based psychological therapies that have been shown to integrate the best research evidence of clinical effectiveness with general practice clinical expertise. The decision to recommend Focussed Psychological Strategies to a patient must be made either in the context of a GP Mental Health Treatment Plan, shared care plan or a psychiatrist assessment and management plan.

Minimum Requirements

All consultations providing Focussed Psychological Strategies must be rendered by a medical practitioner (but not including a specialist or consultant physician).

To ensure appropriate standards for the provision of Focussed Psychological Strategies, payment of Medicare rebates for these items will be limited to medical practitioners who are registered with the Department of Human Services as having satisfied the requirements for higher level mental health skills for provision of the service, as determined by the General Practice Mental Health Standards Collaboration.

Continued access to item numbers 283 to 287, 371 and 372 will be dependent on the practitioner meeting the ongoing mental health education requirements as determined by the General Practice Mental Health Standards Collaboration.

Patients will be permitted to claim Medicare rebates for up to 10 allied mental health services under these item numbers per calendar year. The 10 services may consist of: GP focussed psychological strategies services (items 283 to 287, 371 and 372 or GP items 2721 to 2731); and/or psychological therapy services (items 80000 to 80015); and/or focussed psychological strategies – allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165).

Out-of-Surgery Consultation

It is expected that this service would be provided only for patients who are unable to attend the practice.

Telehealth Consultation

A **telehealth area** means an area that is a Modified Monash 4 area, Modified Monash 5 area, Modified Monash 6 area or Modified Monash 7 area.

Specific Modified Monash locations can be looked up at DoctorConnect

Specific Focussed Psychological Strategies

A range of acceptable strategies has been approved for use by medical practitioners in this context. These are:

1. Psycho-education
(including motivational interviewing)
2. Cognitive-behavioural therapy including:
· **Behavioural interventions**
- Behaviour modification
- Exposure techniques
- Activity scheduling
· **Cognitive interventions**
- Cognitive therapy
3. Relaxation strategies
- Progressive muscle relaxation
- Controlled breathing
4. Skills training
- Problem solving skills and training
- Anger management
- Social skills training
- Communication training
- Stress management
- Parent management training
5. Interpersonal therapy

Mental Disorder

A mental disorder may be defined as a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder – this definition is informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care:ICD - 10 Chapter V Primary Health Care Version.

Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of these items.

AN.7.24 Medical Practitioner After-Hours Attendances To Which No Other Item Applies (Items 733 to 789)

After-hours attendance items may be claimed as follows:

Items **733, 737, 741 and 745** apply only to a professional attendance on 1 patient on 1 occasion that is provided:

- on a public holiday;
- on a Sunday;
- before 8am, or after 1 pm on a Saturday;
- before 8am, or after 8pm on any day other than a Saturday, Sunday or public holiday.

Items **761, 763, 766, 769, 772, 776, 788 and 789** apply to a professional attendance on 1 or more patients on 1 occasion that is provided:

- on a public holiday;
- on a Sunday;
- before 8am, or after 12 noon on a Saturday;
- before 8am, or after 6pm on any day other than a Saturday, Sunday or public holiday.

AN.7.25 Medical Practitioner Non-Directive Pregnancy Support Counselling Service (Item 792)

The Pregnancy Support Counselling initiative provides for Medicare benefits to be paid for non-directive pregnancy support counselling services provided to a person who is pregnant or who has been pregnant in the 12 months preceding the first service to which this item or items 4001, 81000, 81005 or 81010 applies in relation to that pregnancy, by an eligible medical practitioner (not including a specialist or consultant physician) or allied health professional on referral from a medical practitioner.

There are five MBS items for the provision of non-directive pregnancy support counselling services:

- Item 792 – services provided by an eligible medical practitioner;
- Item 4001 - services provided by an eligible GP;
- Item 81000 - services provided by an eligible psychologist;
- Item 81005 - services provided by an eligible social worker; and
- Item 81010 - services provided by an eligible mental health nurse.

This note relates to the provision of a non-directive pregnancy support counselling service by an eligible medical practitioner.

Non-directive counselling is a form of counselling based on the understanding that, in many situations, people can resolve their own problems without being provided with a solution by the counsellor. The counsellor's role is to encourage the person to express their feelings but not suggest what decision the person should make. By listening

and reflecting back what the person reveals to them, the counsellor helps them to explore and understand their feelings. With this understanding, the person is able to make the decision which is best for them.

The service involves the medical practitioner undertaking a safe, confidential process that helps the patient explore concerns they have about a current pregnancy or a pregnancy that occurred in the preceding 12 months. This includes providing, on request, unbiased, evidence-based information about all options and services available to the patient.

The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

Patient eligibility

Medicare rebates for non-directive pregnancy support counselling services provided using item 792 are available to a person who is pregnant or who has been pregnant in the 12 months preceding the first service to which this item or item 4001, 81000, 81005 or 81010 applies in relation to that pregnancy.

Partners of eligible patients may attend each or any counselling session, however, only one fee applies to each service provided.

Medicare benefits

Medicare benefits are payable for up to three non-directive pregnancy support counselling services per patient, per pregnancy, from any of the following items – 792, 4001, 81000, 81005 and 81010.

Where the patient is unsure of the number of Medicare rebated non-directive pregnancy support counselling services they have already accessed, the patient may check with the Department of Human Services on 132 011. Alternatively, the medical practitioner may check with the Department of Human Services (although the patient must be present to give permission).

Item 10990 or item 10991 can also be claimed in conjunction with item 792 provided the conditions of the relevant item, 10990 or 10991, are satisfied.

Minimum Requirements

This service may only be provided by a medical practitioner who has completed appropriate non-directive pregnancy counselling training.

AN.7.26 Medical Practitioner Telehealth Patient-End Support Services (Items 812 to 892)

This note provides information on the telehealth MBS attendance items for medical practitioners to provide clinical support to their patients, when clinically relevant, during video consultations with specialists or consultant physicians under items 812, 827, 829, 867, 868, 869, 873, 876, 881, 885 and 892.

Telehealth patient-end support services can only be claimed where:

- a Medicare eligible specialist service is claimed;
- the service is rendered in Australia; and
- where this is necessary for the provision of the specialist service.

A video consultation will involve a single specialist or consultant physician attending to the patient, with the possible participation of another medical practitioner, a participating optometrist, a participating nurse practitioner, a participating midwife, practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker at the patient end. The above time-tiered items provide for patient-end support services by a medical practitioner in various settings including consulting rooms, other than consulting rooms, eligible residential aged care services and Aboriginal Medical Services.

Clinical indications

The specialist or consultant physician must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the specialist or physician.

Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

Collaborative Consultation

The medical practitioner, who provides assistance to the patient where this is necessary for the provision of the specialist service, may seek assistance from a health professional (e.g. a practice nurse, Aboriginal or Torres Strait Islander health practitioner or Aboriginal health worker) but only one item is billable for the patient-end support service. The medical practitioner must be present during part or all of the consultation in order to bill an appropriate time-tiered MBS item. Any time spent by another health professional called to assist with the consultation may not be counted against the overall time taken to complete the video consultation.

Restrictions

The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes Hospital in the Home patients). Benefits are not payable for telephone or email consultations. In order to fulfil the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Eligible Geographical Areas

Geographic eligibility for telehealth services funded under Medicare is determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are those areas that are outside a Major City (RA1) according to ASGC-RA (RA2-5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

This rule will not apply to specialist video consultation with patients who are a care recipient in an eligible residential care service; or at an eligible Aboriginal Medical Service or Aboriginal Community Controlled Health Service for which there is a direction, made under subsection 19(2) of the Health Insurance Act 1973, as these patients are able to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at www.mbsonline.gov.au/telehealtheligibleareas

Record Keeping

Participating telehealth medical practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Multiple attendances on the same day

In some situations a patient may receive a telehealth consultation and a face to face consultation by the same or different medical practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same medical practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Medical practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Extended Medicare Safety Net (EMSN)

Items which provide for telehealth patient-end support services are subject to EMSN caps equal to 300% of the schedule fee (to a maximum of $500). This is consistent with Government policy relating to capping EMSN for MBS consultation services.

Aftercare Rule

Video consultations are subject to the same aftercare rules as face to face consultations.

Referrals

The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Technical requirements

In order to fulfil the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a specialist video consultation is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

Bulk billing

Bulk bill incentive items 10990 or 10991 may be billed in conjunction with the telehealth items 812, 827, 829, 867, 868, 869, 873, 876, 881, 885 and 892.

Duration of attendance

The medical practitioner attending at the patient end of the video consultation does not need to be present for the entire consultation, only as long as is clinically relevant - this can be established in consultation with the specialist. The MBS fee payable for the supporting medical practitioner will be determined by the total time spent assisting the patient. This time does not need to be continuous.

AN.7.27 Non-Specialist Practitioner Multidisciplinary Case Conferences (Items 235 to 244)

Items 235 to 244 provide rebates for medical practitioners to organise and coordinate, or participate in, multidisciplinary case conferences for patients in the community or patients being discharged into the community from hospital or people living in residential aged care facilities. This group of items include two items for medical practitioners participating in cancer care case conferences.

REGULATORY REQUIREMENTS

To organise and coordinate case conference items 235, 236 and 237, the medical practitioner must:

(a) explain to the patient the nature of a multidisciplinary case conference, and ask the patient for their agreement to the conference taking place; and

(b) record the patient's agreement to the conference; and

(c) record the day on which the conference was held, and the times at which the conference started and ended; and

(d) record the names of the participants; and

(e) offer the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) a summary of the conference and provide this summary to other team members; and

(f) discuss the outcomes of the conference with the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees); and

(g) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

To participate in multidisciplinary case conference items 238, 239 and 240, the medical practitioner must:

(a) explain to the patient the nature of a multidisciplinary case conference, and ask the patient whether they agree to the medical practitioner's participation in the conference; and

(b) record the patient's agreement to the medical practitioner's participation; and

(c) record the day on which the conference was held, and the times at which the conference started and ended; and

(d) record the names of the participants; and

(e) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

Cancer care case conference items 243 and 244

For the purposes of these items:

- private patients in public or private hospitals or the community with a malignancy of a solid organ or tissue or a systemic cancer such as a leukaemia or lymphoma are covered, with the exception of patients whose only cancer is a non-melanoma skin cancer;
- the billing medical practitioner must be a treating doctor of the patient discussed at the case conference. A treating doctor should generally have treated or provided a formal diagnosis of the patient's cancer in the past 12 months or expect to do so within the next 12 months. Attending non-treating clinicians, allied health providers or support staff are not eligible to bill the item;
- only one medical practitioner is eligible to claim item 243 for each patient case conference. This should be the medical practitioner who assumes responsibility for leading and coordinating the case conference, ensures that records are kept and that the patient is informed of the outcome of the case conference. In most cases this will be the lead treating medical practitioner;
- each billing medical practitioner must ensure that his or her patient is informed that a charge will be incurred for the case conference for which a Medicare rebate will be payable;
- participants must be in communication with each other throughout the case conference, either face-to-face, or by telephone or video link;
- suitable allied health practitioners would generally be from one of the following disciplines: aboriginal health care worker; asthma educator; audiologist; dental therapist; dentist; diabetes educator; dietitian; mental health worker; occupational therapist; optometrist; orthoptist; orthotist or prosthetist; pharmacist; physiotherapist; podiatrist; psychologist; registered nurse; social worker; or speech pathologist;
- in general, it is expected that no more than two case conferences per patient per year will be billed by a medical practitioner; and
- cancer care case conferences are for the purpose of developing a cancer treatment plan in a multidisciplinary team meeting and should not be billed against case conference items for other purposes (eg. community or discharge case conferences).

ADDITIONAL INFORMATION

Usual medical practitioner

Items 235 to 244 should generally be undertaken by the patient's usual medical practitioner. This is a medical practitioner, or a medical practitioner working in the same medical practice that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

Multidisciplinary case conference team members

Examples of persons who, for the purposes of care planning and case conferencing may be included in a multidisciplinary care team are allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dietitians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers.

The patient's informal or family carer may be included as a formal member of the team in addition to the minimum of three health or care providers. The patient and the informal or family carer do not count towards the minimum of three.

Discharge case conference

Organisation and coordination of a multidisciplinary discharge case conference (items 235, 236 and 237) may be provided for private in-patients being discharged into the community from hospital.

Further sources of information

Advice on the items and further guidance are available at: www.health.gov.au/mbsprimarycareitems

Further information is also available for providers from the Department of Human Services provider inquiry line on 132 150.

AN.7.29 Explanatory note

Item 177 will support patients with cardiovascular disease, or patients at risk of developing cardiovascular disease, to access the heart health assessment through a doctor in general practice.

The item will fund a heart health assessment, lasting at least 20 minutes, by a medical practitioner working in general practice (177). The new item will provide patients with a comprehensive assessment of their cardiovascular health, identification of any physical or lifestyle-related risks to their cardiovascular health, and a comprehensive preventive health care plan to improve their cardiovascular health.

The heart health assessment item can be claimed once per patient in a 12 month period. The heart health assessment item cannot be claimed if a patient has had a health assessment service in the previous 12 months.

The intention of this item is to identify cardiovascular disease (CVD) in people not known to have CVD including:

(a) Aboriginal or Torres Strait Islander persons who are aged 30 years and above;

(b) Adults aged 45 years and above.

The absolute cardiovascular disease risk must be calculated as per the Australian Absolute Cardiovascular Disease Risk Calculator which can viewed at ‘http://www.cvdcheck.org.au/calculator/’.

A medical practitioner may use the National Vascular Disease Prevention Alliance 'Australian Guidelines for the Management of Absolute Cardiovascular Disease Risk' or the NACCHO/RACGP 'National Guide to a Preventative Assessment for Aboriginal and Torres Strait Islander People' to complete this assessment.

Health assessments are not available to people who are in-patients of a hospital or care recipients in a residential aged care facility (with the exception of a comprehensive medical assessment provided to a permanent resident of a residential aged care facility).

Before a health assessment is commenced, the patient (and/or his or her parent(s), carer or representative, as appropriate) must be given an explanation of the health assessment process and its likely benefits. The patient must be asked whether he or she consents to the health assessment being performed. In cases where the patient is not capable of giving consent, consent must be given by his or her parent(s), carer or representative. Consent to the health assessment must be noted in the patient's records.

A health assessment may only be billed by a medical practitioner (not including a specialist or consultant physician).

A health assessment should generally be undertaken by the patient's 'usual doctor'. For the purpose of the health assessment items, 'usual doctor' means the medical practitioner, or a medical practitioner working in the same medical practice, which has provided the majority of primary health care to the patient over the previous twelve months and/or will be providing the majority of care to the patient over the next twelve months.

A health assessment should not take the form of a health screening service.

MBS health assessment items 177, 224, 225, 226 and 227 must be provided by a medical practitioner personally attending upon a patient. Suitably qualified health professionals, such as practice nurses or Aboriginal and Torres Strait Islander health practitioners, employed and/or otherwise engaged by a medical practice or health service, may assist medical practitioners in performing health assessments. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the medical practitioner. This may include activities associated with:

· information collection; and

· providing patients with information about recommended interventions at the direction of the medical practitioner.

The medical practitioner should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the health assessment.

Medical practitioners should not conduct a separate consultation for another health-related issue in conjunction with a health assessment unless it is clinically necessary (ie. the patient has an acute problem that needs to be managed separately from the assessment). The only exception is the comprehensive medical assessment, where, if this health assessment is undertaken during the course of a consultation for another purpose, the health assessment item and the relevant item for the other consultation may both be claimed.

Items 177, 224, 225, 226 and 227 do not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, items 177, 224, 225, 226 and 227 can be claimed for services provided by medical practitioners salaried by or contracted to, the Service or health clinic. All other requirements of the items must be met.

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with any health assessment, provided the conditions of item 10990 and 10991 are satisfied.

AN.14.2 Explanatory note.

Item 699 will support patients with cardiovascular disease, or patients at risk of developing cardiovascular disease, to access the heart health assessment through a doctor in general practice.

The item will fund a heart health assessment, lasting at least 20 minutes, by a general practitioner (699). The new item will provide patients with a comprehensive assessment of their cardiovascular health, identification of any physical or lifestyle-related risks to their cardiovascular health, and a comprehensive preventive health care plan to improve their cardiovascular health.

The heart health assessment item can be claimed once per patient in a 12 month period. The heart health assessment items cannot be claimed if a patient has had a health assessment service in the previous 12 months.

The intention of this item is to identify cardiovascular disease (CVD) in people not known to have CVD including:

(a) Aboriginal or Torres Strait Islander persons who are aged 30 years and above;

(b) Adults aged 45 years and above.

The absolute cardiovascular disease risk must be calculated as per the Australian Absolute Cardiovascular Disease Risk Calculator which can viewed at 'http://www.cvdcheck.org.au/calculator/'.

A general practitioner may use the National Vascular Disease Prevention Alliance 'Australian Guidelines for the Management of Absolute Cardiovascular Disease Risk' or the NACCHO/RACGP 'National Guide to a Preventative Assessment for Aboriginal and Torres Strait Islander People' to complete this assessment.

Health assessments are not available to people who are in-patients of a hospital or care recipients in a residential aged care facility (with the exception of a comprehensive medical assessment provided to a permanent resident of a residential aged care facility).

Before a health assessment is commenced, the patient (and/or his or her parent(s), carer or representative, as appropriate) must be given an explanation of the health assessment process and its likely benefits. The patient must be asked whether he or she consents to the health assessment being performed. In cases where the patient is not capable of giving consent, consent must be given by his or her parent(s), carer or representative. Consent to the health assessment must be noted in the patient's records.

A health assessment may only be claimed by a general practitioner.

A health assessment should generally be undertaken by the patient's 'usual doctor'. For the purpose of the health assessment items, 'usual doctor' means the general practitioner, or a general practitioner working in the medical practice, which has provided the majority of primary health care to the patient over the previous twelve months and/or will be providing the majority of care to the patient over the next twelve months.

A health assessment should not take the form of a health screening service.

A copy of the Health Assessment must be retained for a period of 2 years after the date of service.

MBS health assessment items 699, 701, 703, 705, 707 must be provided by a general practitioner personally attending upon a patient. Suitably qualified health professionals, such as practice nurses or Aboriginal and Torres Strait Islander health practitioners, employed and/or otherwise engaged by a general practice or health service, may assist general practitioners in performing health assessments. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the general practitioner. This may include activities associated with:

· information collection; and

· providing patients with information about recommended interventions at the direction of the general practitioner.

The general practitioner should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the health assessment.

General practitioners should not conduct a separate consultation for another health-related issue in conjunction with a health assessment unless it is clinically necessary (ie. the patient has an acute problem that needs to be managed separately from the assessment). The only exception is the comprehensive medical assessment, where, if this health assessment is undertaken during the course of a consultation for another purpose, the health assessment item and the relevant item for the other consultation may both be claimed.

Items 699, 701, 703, 705 and 707 do not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, items 699, 701, 703, 705 and 707 can be claimed for services provided by general practitioners salaried by or contracted to, the Service or health clinic. All other requirements of the items must be met.

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with any health assessment, provided the conditions of item.

AN.30.1 MBS mental health and well-being telehealth support items for general practitioners

These notes provide information on the MBS mental health and well-being telehealth support items for general practitioners (GPs) under items 2121, 2150 and 2196 in Group A30, Subgroup 3.

Requirements

The mental health and well-being telehealth support items can only be claimed where:

- the patient lives in an area belonging to a declared council under the Drought Communities Programme (DCP);
- the GP works in an area belonging to the declared councils under the DCP in a Modified Monash area 3 to 7; and
- the patient and the GP have an existing relationship.

A list of declared councils and more information about the Drought Communities Programme is available at: http://regional.gov.au/regional/programs/drought-communities.aspx

Information about Modified Monash is available at
http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator

In addition:

- the attendance must be by video conference; and
- the patient must not be an admitted patient; and
- the patient must be, at the time of the attendance, at least 15 kilometres by road from the GP.

Minimum Distance

The minimum distance between the GP and the patient is measured by the most direct (ie least distance) route by road. The patient or the GP is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

Record Keeping

Participating GPs must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date and the time.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

In some situations a patient may receive a telehealth consultation and a face to face consultation by the same or different GP on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the GP, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. GPs will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Extended Medicare Safety Net (EMSN)

Items which provide for telehealth patient-end support services are subject to EMSN caps equal to 300% of the schedule fee (to a maximum of $500). This is consistent with Government policy relating to capping EMSN for MBS consultation services.

Aftercare Rule

Video consultations are subject to the same aftercare rules as face to face consultations.

Technical requirements

In order to fulfil the item descriptor there must be a visual and audio link between the patient and the GP. If the GP is unable to establish both a video and audio link with the patient, a MBS rebate for a video consultation is not payable.

Individual GPs must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a video conference meets the applicable laws for security and privacy.

AN.30.3 Teleheatlh (General and Medical Practitioner)

These eight services are available to patients who are unable to attend the practitioners' practice and reside in a Telehealth eligible areas MMM 6 or MMM 7.

Items 2461, 2463, 2464 and 2465, are for services provided by general practitioners and have the same clinical requirements, including time, as the equivalent face-to-face attendance services for general practitioners (items 3, 23, 36 and 44).

Items 2471, 2472, 2475 and 2478, are for services provided by medical practitioners who are not general practitioners and have the same clinical requirements, including time, as the equivalent face-to-face attendance services for medical practitioners who are not general practitioners (items 52, 53, 54 and 57).

The patient will also need to have received at least three face-to-face attendances from the same practitioner providing the video conferencing service in the preceding 12 months. This confirms that the video conferencing attendance services can only be rendered by a practitioner with an existing clinical relationship with the patient.

Eligible Geographical Areas

Geographic eligibility for these telehealth services funded under Medicare are determined according to the Modified Monash Model (MMM) classifications. Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and practitioner to be located a minimum of 15km apart at the time of the consultation. Minimum distance between practitioner and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the practitioner is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

Aftercare Rule

Video consultations are subject to the same aftercare rules as practitioners providing face-to-face consultations.

Multiple attendances on the same day

In some situations a patient may receive a telehealth consultation and a face-to-face consultation by the same or different practitioner on the same day. Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Restrictions

The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes hospital in the home patients). Benefits are not payable for telephone or email consultations.

Technical requirements

In order to fulfill the item descriptor there must be a visual and audio link between the patient and the practitioner. If the practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable. Individual practitioners must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

Record Keeping

Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

AN.30.4 Telehealth (Other Medical Practitioner)

These four services are available to patients who are unable to attend the practitioners' practice and reside in a Telehealth eligible areas MMM 6 or MMM 7.

Items 2480, 2481, 2482 and 2483, are for services provided by other medical practitioners and have the same clinical requirements, including time, as the equivalent face-to-face attendance services for items 179, 185, 189 and 203.

The patient will also need to have received at least three face-to-face attendances from the same practitioner providing the video conferencing service in the preceding 12 months. This confirms that the video conferencing attendance services can only be rendered by a practitioner with an existing clinical relationship with the patient.

Eligible Geographical Areas

Geographic eligibility for these telehealth services funded under Medicare are determined according to the Modified Monash Model (MMM) classifications. Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and practitioner to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the practitioner is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

Aftercare Rule

Video consultations are subject to the same aftercare rules as practitioners providing face-to-face consultations.

Multiple attendances on the same day

In some situations a patient may receive a telehealth consultation and a face-to-face consultation by the same or different practitioner on the same day. Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Restrictions

The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes hospital in the home patients). Benefits are not payable for telephone or email consultations.

Technical requirements

In order to fulfill the item descriptor there must be a visual and audio link between the patient and the practitioner. If the practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable. Individual practitioners must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

Record Keeping

Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

AN.33.1 TAVI CASE CONFERENCE - (ITEMS 6080 AND 6081)

Items 6080 and 6081 apply to a TAVI Case Conference organised to discuss a patient's suitability to receive the service described in Item 38495 for Transcatheter Aortic Valve Implantation (TAVI).

For items 6080 and 6081 a TAVI Case Conference is a process by which:

(a) there is a team of 3 or more participants, where:

(i) the first participant is a cardiothoracic surgeon; and

(ii) the second participant is an interventional cardiologist; and

(iii) the third participant is a specialist or consultant physician who does not perform a service described in Item 38495 for the patient being assessed; and

(iv) either the first or the second participant is also a TAVI Practitioner; and

(b) the team assesses a patient's risk and technical suitability to receive the service described in Item 38495, taking into account matters such as:

(i) the patient's risk and technical suitability for a surgical aortic valve replacement; and

(ii) the patient's cognitive function and frailty; and

(c) the result of the assessment is that the team makes a recommendation about whether or not the patient is suitable to receive the service described in Item 38495; and

(d) the particulars of the assessment and recommendation are recorded in writing.

TAVI Practitioner

For items 6080 and 6081 a TAVI Practitioner is either a cardiothoracic surgeon or interventional cardiologist who is accredited by Cardiac Accreditation Services Limited.

Accreditation by Cardiac Accreditation Services Limited must be valid prior to the service being undertaken in order for benefits to be payable under item 38495.

The process for accreditation and re-accreditation is outlined in the *Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners*, issued by Cardiac Accreditation Services Limited, and is available on the Cardiac Accreditation Services Limited website, www.tavi.org.au.

Cardiac Accreditation Services Limited is a national body comprising representatives from the Australian & New Zealand Society of Cardiac & Thoracic Surgeons (ANZSCTS) and the Cardiac Society of Australia and New Zealand (CSANZ).

Coordination of a TAVI Case Conference

For item 6080, coordination means undertaking all of the following activities in relation to a TAVI Case Conference:

a. ensuring that the patient is aware of the purpose and nature of the patient's TAVI Case Conference and has consented to their TAVI Case Conference;
b. recording the day the conference was held, and the times the conference started and ended;
c. recording the names of the participants of the conference;
d. provision of expertise to inform the recommendation resulting from the case conference;
e. recording minutes of the TAVI Case Conference including the recommendation resulting from the conference;
f. ensuring that the patient is aware of the recommendation.

Attendance at a TAVI Case Conference

For item 6081, attendance means undertaking all of the following activities in relation to a TAVI Case Conference:

a. retaining a record of the day the conference was held, and the times the conference started and ended;
b. retaining a record of the names of the participants;
c. provision of expertise to inform the recommendation resulting from the case conference;
d. retaining a record of the recommendation resulting from the conference.

General requirements

The TAVI Case Conference must be arranged in advance, within a time frame that allows for all the participants to attend. A TAVI Case Conference is to last at least 10 minutes and a minimum of three suitable participants (as defined under the item requirements), must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

A record of the TAVI Case Conference which contains: a list of the participants; the times the conference commenced and concluded; a description of the assessment of suitability; 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.

Prior informed consent must be obtained from the patient, or the patient's agent. In obtaining informed consent the TAVI Practitioner coordinating the TAVI Case Conference should ensure the patient has been:

- Informed that his or her medical history, diagnosis and care preferences will be discussed with other case conference participants;
- Informed that he or she may incur a charge for the service for which a Medicare rebate will be payable.

Medicare benefits are only payable in respect of the service provided by the coordinating TAVI Practitioner or the attending interventional cardiologist, cardiothoracic surgeon or independent specialist or consultant physician. Benefits are not payable for another medical practitioner organising a case conference or for attendance by other medical practitioners at a TAVI Case Conference.

It is expected that a patient would not normally require more than one TAVI Case Conference in determining suitability for the services described in Item 38495. As such, item 6080 is only payable once per patient in a five year period. Item 6081 is payable only twice per patient in a five year period.

Items 6080 and 6081 do not preclude the claiming of a consultation on the same day if other clinically relevant services are provided.

AN.34.1 HEALTH CARE HOMES

HEALTH CARE HOMES The Health Care Homes Program is administered by the Department of Health. A Health Care Homes trial site means a medical practice participating in the Health Care Homes Program. Commonwealth subsidy for the provision of services under the Health Care Homes Program is paid through bundled payments to the Health Care Home.

Item 6087 has been established so that, when claimed, it will record when a Health Care Home patient incurs an out-of-pocket expense. The out-of-pocket cost will then count toward their or their family's Extended Medicare Safety Net.

Item 6087 should only be claimed in the event that a Health Care Home charges a Health Care Home patient an out-of-pocket cost. Item 6087 must not be used for any other purpose.

Item 6087 cannot be claimed as a bulk-billed service.

AN.35.1 Flag fall amount for residential aged care facility attendance by a general practitioner

Medicare item 90001 provides a call-out fee for the initial attendance by a general practitioner at one RACF, on one occasion, applicable only to the first patient seen on the RACF visit.

The Medicare benefit for the single call-out fee and the associated general consultation (either Level A to D) applies only for patients within a RACF who have a general consultation with a doctor in person.

If doctors do not bill the single call-out fee, the benefit will not be paid.

If a doctor has to return to the RACF facility twice or more on the same day and the attendances are not a continuation of an earlier episode of treatment, another call-out fee would apply per subsequent RACF visit.

When claiming the new attendance items there is no longer a requirement to transmit the number of patients seen. A doctor would claim each attendance item like any other consultation service.

MBS items 90001 is not to be used with existing derived fee services such as for afterhours, urgent afterhours, or telehealth services. The bulk billing incentive only applies to the attendance item, not to the single call-out fee.

AN.35.2 Flag fall amount for residential aged care facility attendance by a medical practitioner

Medicare item 90002 provides a call-out fee for the initial attendance by a medical practitioner at one RACF, on one occasion, applicable only to the first patient seen on the RACF visit.

The Medicare benefit for the single call-out fee and the associated general consultation (either Level A to D) applies only for patients within a RACF who have a general consultation with a doctor in person.

If doctors do not bill the single call-out fee, the benefit will not be paid.

If a doctor has to return to the RACF facility twice or more on the same day and the attendances are not a continuation of an earlier episode of treatment, another call-out fee would apply per subsequent RACF visit.

When claiming the new attendance items there is no longer a requirement to transmit the number of patients seen. A doctor would claim each attendance item like any other consultation service.

MBS items 90002 is not to be used with existing derived fee services such as for afterhours, urgent afterhours, or telehealth services. The bulk billing incentive only applies to the attendance item, not to the single call-out fee.

AN.36.1 Eating Disorders General Explanatory Notes

Eating Disorders General Explanatory Notes (items 90250-90257, 90260-90269 and 90271-90282)

This note provides a general overview of the full range of 1 November 2019 eating disorders Items and supporting information more specifically on the Category 1 – Professional Attendances: Group A36 – Eating Disorders Services (90250-90257, 90260-90269 and 90271-90282).

It includes an overview of the items, model of care, patient eligibility, and inks to other guidance and resources.

Overview

All 1 November 2019 Eating Disorders new items:

The Eating Disorders items define services for which Medicare rebates are payable where service providers undertake assessment and management of patients with a diagnosis of anorexia nervosa and patients with other specified eating disorder diagnoses who meet the eligibility criteria (see – patient eligibility). It is expected that there will be a multidisciplinary approach to patient management through these items.

The items mean eligible patients are able to receive a Medicare rebate for development of an eating disorders treatment plan by a medical practitioner in general practice (Group A36, subgroup 1), psychiatry or paediatrics (Group A36, subgroup 2). Patients with an eating disorders treatment and management plan (EDP) will be eligible for comprehensive treatment and management services for a 12 month period, including:

a. Up to 20 dietetic services under items 10954, 82350 and 82351.
b. Up to 40 eating disorder psychological treatment services (EDPT service).
c. Review and ongoing management services to ensure that the patient accesses the appropriate level of intervention (Group A36, subgroup 3).

An EDPT service includes mental health treatment services which are provided by an allied health professional or a medical practitioner in general practice with appropriate mental health training. These treatment services include:

a. Medicare mental health treatment services currently provided to patients under the 'Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS ('Better Access') initiative.
    - This includes medical practitioner items 2721, 2723, 2725, 2727, 283, 285, 286, 287, 371, 372; and
    - This includes allied health items in Groups M6 and M7 of Category 8; and
b. new items for EDPT services provided by suitably trained medical practitioners in general practice (items 90271, 90272, 90273, 90274, 90275, 90276, 90277, 90278, 90279, 90280, 90281, 90282)
c. new items for EDPT services provided by eligible clinical psychologists (items 82352-82359), eligible psychologists (items 82360-82367), eligible occupational therapists (items 82368-82375) and eligible social workers (items 82376-82383)

For the purpose of the 40 EDPT count; eating disorder psychological treatment service includes a service under provided under the following items: 90271, 90272, 90273, 90274, 90275, 90276, 90277, 90278, 90279, 90280,

90281, 90282, 2721, 2723, 2725, 2727, 283, 285, 286, 287, 371, 372 and items in Groups M6, M7 and M16 (excluding items 82350 and 82351).

For any particular patient, an eating disorder treatment and management plan expires at the end of a 12 month period following provision of that service. After that period, a patient will require a new EDP to continue accessing EDPT services.

Patient Eligibility

The eating disorder items are available to eligible patients in the community. These items do not apply to services provided to admitted (in-hospital) patients.

The referring practitioner is responsible for determining that a patient is eligible for an EDP and therefore EDPT and dietetic services.

'Eligible patient' defines the group of patients who can access the new eating disorder services. There are two cohorts of eligible patients.

a. Patients with a clinical diagnosis of anorexia nervosa; or
b. Patients who meet the eligibility criteria (below), and have a clinical diagnosis of any of the following conditions:
    a. bulimia nervosa;
    b. binge-eating disorder;
    c. other specified feeding or eating disorder.

The eligibility criteria, for a patient, is:

a. a person who has been assessed as having an Eating Disorder Examination Questionnaire score of 3 or more; and
b. the condition is characterised by rapid weight loss, or frequent binge eating or inappropriate compensatory behaviour as manifested by 3 or more occurrences per week; and
c. a person who has at least two of the following indicators:
    a. clinically underweight with a body weight less than 85% of expected weight where weight loss is directly attributable to the eating disorder;
    b. current or high risk of medical complications due to eating disorder behaviours and symptoms;
    c. serious comorbid medical or psychological conditions significantly impacting on medical or psychological health status with impacts on function;
    d. the person has been admitted to a hospital for an eating disorder in the previous 12 months;
    e. inadequate treatment response to evidence based eating disorder treatment over the past six months despite active and consistent participation.

Practitioners should have regard to the relevant diagnostic criteria set out in the Diagnostic and Statistical Manual of the American Psychiatric Association – Fifth Edition (DSM-5)

Practitioners can access the Eating Disorder Examination Questionnaire at https://www.credo-oxford.com/pdfs/EDE_17.0D.pdf

The Eating Disorders Items Stepped Model of Care

The eating disorder items incorporate a 'stepped model' for best practice care for eligible patients with eating disorders that comprise:

- assessment and treatment planning
- provision of and/or referral for appropriate evidence based eating disorder specific treatment services by allied mental health professionals and provision of services by dietitians
- review and ongoing management items to ensure that the patient accesses the appropriate level of intervention.

The Stepped Model

‘STEP 1’ – PLANNING (trigger eating disorders pathway) 90250-90257 and 90260-90263

An eligible patient receives an eating disorder plan (EDP) developed by a medical practitioner in general practice (items 90250-90257), psychiatry (items 90260-90262) or paediatrics (items 90261-90263).

‘STEP 2’ – COMMENCE INITIAL COURSE OF TREATMENT (psychological & dietetic services)

Once an eligible patient has an EDP in place, the 12 month period commences, and the patient is eligible for an initial course of treatment up to 20 dietetic services and 10 eating disorder psychological treatment (EDPT) services. A patient will be eligible for an additional 30 EDPT services in the 12 month period, subject to reviews from medical practitioners to determine appropriate intensity of treatment.

‘STEP 3” – CONTINUE ON INITIAL COURSE OF TREATMENT 90264-90269 (managing practitioner review and progress up to 20 EDPT services)

It is expected that the managing practitioner will be reviewing the patient on a regular, ongoing and as required basis. However, a patient must have a review of the EDP (90264-90269), to assess the patient’s progress against the EDP or update the EDP, before they can access more than 10 EDPT services. This is known as the ‘first review’. The first review should be provided by the patient’s managing practitioner, where possible.

‘STEP 4’ FORMAL SPECIALIST AND PRACTITIONER REVIEW 90266-90269 (continue beyond 20 EDPT services)

A patient must have two additional reviews before they can access more than 20 EDPT services. One review (the ‘second review’) must be performed by a medical practitioner in general practice (who is expected to be the managing practitioner), and the other (the ‘third review’) must be performed by a paediatrician (90267 or 90269) or psychiatrist (90266 or 90268). Should both recommend the patient requires more intensive treatment, the patient would be able to access an additional 10 EDPT services in the 12 month period. These reviews are required to determine that the patient has not responded to treatment at the lower intensity levels.

The patient’s managing practitioner should be provided with a copy of the specialist review.

The specialist review by the psychiatrist or paediatrician can occur at any point before 20 EDPT services. The practitioner should refer the patient for specialist review as early in the treatment process as appropriate. If the practitioner is of the opinion that the patient should receive more than 20 EDPT services, the referral should occur at the first practitioner review (after the first course of treatment) if it has not been initiated earlier.

Practitioners should be aware that the specialist review can be provided via telehealth (90268 and 90269). Where appropriate, provision has been made for practitioner participation on the patient-end of the telehealth consultation.

It is expected that the managing practitioner will be reviewing the patient on a regular, ongoing and as required basis. However, a patient must have a review of the EDP (90264-90269), to assess the patient’s progress against the EDP or update the EDP, before they can access the next course of treatment.

‘STEP 5’ ACCESS TO MAXIMUM INTENSITY OF TREATMENT 90266-90269 (continue beyond 30 EDPT services)

To access more than 30 EDPT treatment services in the 12 month period, patients are required to have an additional review (the ‘fourth review’) to ensure the highest intensity of treatment is appropriate. Subject to this review, a patient could access the maximum of 40 EDPT treatment services in a 12 month period. The fourth review should be provided by the patient’s managing practitioner, where possible.

An Integrated Team Approach

A patient's family and/or carers should be involved in the treatment planning and discussions where appropriate. The family can be involved in care options throughout the diagnosis and assessment, and are usually the support unit that help to bridge the gap between initial diagnosis and eating disorder specific treatment.

The National Standards for the safe treatment of eating disorders specify a multi-disciplinary treatment approach that provides coordinated psychological, physical, behavioural, nutritional and functional care to address all aspects of eating disorders. People with eating disorders require integrated inter-professional treatment that is able to work within a framework of shared goals, care plans and client and family information. Frequent communication is required between treatment providers to prevent deterioration in physical and mental health (RANZCP Clinical Guidelines: Hay et al., 2014). Consider regular case conferencing to ensure that the contributing team members are able to work within a shared care plan and with client and carers to achieve best outcomes.

Clinical guidelines and other resources

It is expected that the consultants providing services under these items should have the appropriate skills, knowledge and experience to provide eating disorders treatment. However, there are a number of resources which may be of assistance to practitioners in supporting and developing eating disorders treatment plans, these include:

- TheRoyal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders
- The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Referred Patient Assessment and Management Plan Guidelines

Note: This information is provided as a guide only and each case should be addressed according to a patient's individual needs. An electronic version of the Guidelines is available on the RANZCP website at www.ranzcp.org

National Eating Disorders Collaboration Eating Disorders: a professional resources for general practitioners available at www.nedc.com.au

Eating Disorders Training

It is expected that practitioners who are providing services under these items have appropriate training, skills and experience in treatment of patients with eating disorders and meet the national workforce core competencies for the safe and effective identification of and response to eating disorders more information available at National Eating Disorders Collaboration

Training Services

Practitioners should contact their professional organisation to identify education and training which may assist to practitioners to gain the skills and knowledge to provide services under these items.

The following organisations provide training which may assist practitioners to meet the workforce competency standards:

- The Australia and New Zealand Academy of eating disorders (ANZAED) - National
- InsideOut Institute - National
- The Victorian Centre of Excellence in Eating Disorders (CEED) - VIC
- Queensland Eating Disorder Service (QuEDS) - QLD
- Statewide Eating Disorder Service (SEDS) - SA
- WA Eating Disorders Outreach & Consultation Service (WAEDOCS) – WA

This list is not exhaustive, but has been included to provide examples on the types of training available which may assist practitioners to upskill in this area.

AN.36.2 Eating Disorders Treatment and Management Plans Explanatory Notes

Eating Disorders Treatment and Management Plans Explanatory Notes (items 90250-90257 and 90260-90263)

This note provides information on Eating Disorders Treatment and Management Plan (EDP) items and should be read in conjunction with the Eating Disorders General Explanatory Notes

Eating Disorder Treatment Plan (EDP) items overview

The EDP items define services for which Medicare rebates are payable where practitioners undertake the development of a treatment and management plan for patients with a diagnosis of anorexia nervosa and patients with other specified eating disorder diagnoses who meet the eligibility criteria.

The EDP items trigger eligibility for items which provide delivery of eating disorders psychological treatment (EDPT) services (up to a total of 40 psychological services in a 12 month period) and dietetic services (up to a total of 20 in a 12 Month period).

For any particular patient, an eating disorder treatment and management plan expires at the end of a 12 month period following provision of that service. Eating Disorders treatment services are not available to the patient if the EDP has expired.

Preparation of the EDP must include:

- discussing the patient's medical and psychological health status with the patient and if appropriate their family/carer;
- identifying and discussing referral and treatment options with the patient and their family/carer where appropriate, including identification of appropriate support services;
- agreeing goals with the patient and their family/carer where appropriate - what should be achieved by the treatment - and any actions the patient will take;
- planning for the provision of appropriate patient and family/carer education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate at this stage;
- making arrangements for required referrals, treatment, appropriate support services, review and follow-up;
- documenting the results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date in the patient's plan;
- Discussing and organising the appropriate reviews throughout the patient's treatment; and
- discussing the need for the patient to be reviewed to access a higher intensity of EDPT services in a 12 month period.

Preparing a Medical practitioner in general practice Eating Disorder Treatment & Management Plan (items 90250-90257)

Who can provide the service

Items in subgroup 1 of Group A36 can be rendered by a medical practitioner in general practice. This includes:

- Medical practitioners who can render a general practitioner service in Group A1 of the MBS (see note AN.0.9 for the types of medical practitioners). These medical practitioners can render a 'general practitioner' service for items in subgroup 1 of Group A36.
- Medical practitioners who are not general practitioners, specialists or consultant physicians. These medical practitioners can render a 'medical practitioner' service for items in subgroup 1 of Group A36.

What is Involved - Assess and Plan

It is expected that the practitioner developing the EDP has either performed or reviewed the assessments and examinations required to make a judgement that the patient meets the eligibility criteria for accessing these items.

Items 90250-90257 provide services for development of the eating disorder treatment and management plan. Where a comprehensive physical examination is performed, either on the same occasion or different occasion, the appropriate item could be claimed provided the time taken performing the assessment is not included in the time for producing the plan, or time producing the EDP is not included in the time for assessment.

It is emphasised that it is best practice for the practitioner to perform a comprehensive physical assessment to facilitate ongoing patient management and monitoring of medical and nutritional status.

Patient Assessment

An assessment of a patient with an eating disorders includes:

- taking relevant history (biological, psychological, social, including family/carer support);
- eating disorder diagnostic assessment;
- medical review including physical examination and relevant tests;
- conducting an assessment of mental state, including identification of comorbid psychiatric conditions;
- an assessment of eating disorder behaviours;
- an assessment of associated risk and any medical co-morbidity, including as assessment on how this impacts on the patients functioning and activities of daily living;
- an assessment of family and/or carer support and
- administering an outcome measurement tool, except where it is considered clinically inappropriate.

Risk assessment for a patient with an eating disorder should include identification of:

- medical instability and risk of hospitalisation;
- level of psychological distress and suicide risk;
- level of malnourishment;
- identification of psychiatric comorbidity;
- level of disability;
- duration of illness;
- response to earlier evidence-based eating disorders treatment;
- level of family/carer support.

It should be noted that the patient's EDP should be treated as a living document for updating as required. In particular, the plan can be updated at any time to incorporate relevant information, such as feedback or advice from other health professionals on the diagnosis or treatment of the patient.

Preparing a Consultant Psychiatrist or Paediatrician Eating Disorder Treatment & Management Plan (90260-90263)

Who can provide the service

Items in subgroup 2 of Group 36 can be rendered by consultant psychiatrists (items 90260 and 90261) and consultant paediatricians (items 90262 and 90263).

What is Involved – Assess and Plan

Items 90260-90263 provide access to specialist assessment and treatment planning. It is expected that items will be a single attendance. However, there may be particular circumstances where a patient has been referred by a GP for an assessment and management plan, but it is not possible for the consultant to determine in the initial consultation whether the patient is suitable for management under such a plan. In these cases, where clinically appropriate, other appropriate consultation items may be used. In those circumstances where the consultant undertakes a consultation (in accordance with the item requirements) prior to the consultation for providing the referring practitioner with an

assessment and management plan. It is expected that such occurrences would be unusual for the purpose of diagnosis under items 90260 & 90262.

EDP Items 90262 and 90263 provide for provision of video conference attendance, consistent with other video conference services listed in the Table (see AN.36.6 Eating Disorders Telehealth – Consultant psychiatrists or paediatricians).

Patient Assessment

In order to facilitate ongoing patient focussed management, an assessment of the patient must include:

- administering an outcome measurement tool during the assessment and review stages of treatment, where clinically appropriate. The choice of outcome tool to be used is at the clinical discretion of the practitioner;
- conducting a mental state examination;
- taking relevant history (biological, psychological, behavioural, nutritional, social);
- assessing associated risk and any co-morbidity; and
- making a psychiatric diagnosis for conditions meeting the eligibility criteria.

Risk assessment for a patient with an eating disorder should include identification of:

- medical instability and risk of hospitalisation;
- level of psychological distress and suicide risk;
- level of malnourishment;
- identification of psychiatric comorbidity;
- level of disability;
- duration of illness;
- response to earlier evidence-based eating disorders treatment;
- level of family/carer support.

Where a consultant psychiatrist provides an EDP service, the service must also include:

i. administering an outcome measurement tool, where clinically appropriate. The choice of outcome tool to be used is at the clinical discretion of the practitioner. Practitioners using such tools should be familiar with their appropriate clinical use, and if not, should seek appropriate education and training; and
ii. conducting a mental state examination.

Consultation with the patient's managing practitioner

A written copy of the EDP should be provided to the patient's managing practitioner, within a maximum of two weeks of the assessment. It should be noted that two weeks is the outer limit and in more serious cases more prompt provision of the plan and verbal communication with the managing practitioner may be appropriate.

Additional Claiming Information (general conditions and limitations)

Patients seeking rebates for items 90250-90257 and 90260-90263 will not be eligible if the patient has had a claim within the last 12 months.

Items 90250-90257 cannot be claimed with Items 2713, 279, 735, 758, 235 and 244. Items 90261 and 90263 cannot be claimed with Items 110, 116, 119, 132, 133.

Consultant psychiatrist and paediatrician EDP items 90260-90263 do not apply if the patient does not have a referral within the period of validity.

Before proceeding with the EDP the medical practitioner must ensure that:

(a) the steps involved in providing the service are explained to the patient and (if appropriate and with the patient's permission) to the patient's carer; and

(b) the patient's agreement to proceed is recorded.

The medical practitioner must offer the patient a copy of the EDP and add the document to the patient's records. This should include, subject to the patient's agreement, offering a copy to their carer, where appropriate. The medical practitioner may, with the permission of the patient, provide a copy of the EDP, or relevant parts of the plan, to other providers involved in the patient's treatment.

The medical practitioner EDP cover the service of developing an EDP. A separate consultation item can be performed with the EDP if the patient is treated for an unrelated condition to their eating disorder. Where a separate consultation is performed, it should be annotated separately on the patient's account that a separate consultation was clinically required/indicated.

All consultations conducted as part of the EDP must be rendered by the medical practitioner and include a personal attendance with the patient. A specialist mental health nurse, other allied health practitioner, Aboriginal and Torres Strait Islander health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to the medical practitioner in provision of this care.

Additional Claiming Information (interaction with Chronic Disease Management and Better Access)

It is preferable that wherever possible patients have only one plan for primary care management of their disorder. As a general principle the creation of multiple plans should be avoided, unless the patient clearly requires an additional plan for the management of a separate medical condition.

The Chronic Disease Management (CDM) care plan items (items 721, 723, 729, 731 and 732) continue to be available for patients with chronic medical conditions, including patients with complex needs.

Where a patient has a separate chronic medical condition, it may be appropriate to manage the patient's medical condition through a CDM Plan, and to manage their eating disorder through an EDP. In this case, both items can be used. Where the patient receives dietetic services under the CDM arrangements (item 10954), these services will count towards the patients maximum of 20 dietetic services in a 12 month period.

Where a patient has other psychiatric comorbidities, these conditions should be managed under the EDP. Once a patient has a claim for an EDP, the patient should not be able to have a claim for the development or review of a Mental Health Treatment plan by a GP (items 2700, 2701, 2715 and 2717) or medical practitioner in general practice (items 272, 276, 281 and 282) within 12 months of their EDP unless there are exceptional circumstances.

For the purpose of the 40 EDPT count; eating disorder psychological treatment service includes a service under provided under the following items: 90271, 90272, 90273, 90274, 90275, 90276, 90277, 90278, 90279, 90280, 90281, 90282, 2721, 2723, 2725, 2727, 283, 285, 286, 287, 371, 372 and items in Groups M6, M7 and M16 (excluding items 82350 and 82351).

AN.36.3 Eating Disorders Treatment and Management Plan Reviews

Eating Disorders Treatment and Management Plan Reviews (items 90264-90269)

This note provides information on Eating Disorders Treatment and Management Plan (EDP) review items and should be read in conjunction with the AN.36.1 Eating Disorders General Explanatory Notes and the AN.36.2 Eating Disorders Treatment and Management Plans Explanatory Notes

Eating Disorder Treatment Plan review (EDR) items overview

The EDR items define services for which Medicare rebates are payable where practitioners undertake to review the efficacy of the patient's eating disorder treatment and management plan (EDP). This includes modifying the patient's plan, where appropriate, to improve patient outcomes. The review services can be provided by medical practitioners working in general practice, psychiatry and paediatrics.

An EDR may be provided by the managing practitioner who prepared the patient's initial plan (or another practitioner in the same practice or in another practice where the patient has changed practices) and should include a systematic review of the patient's progress against the initial EDP (whether it was prepared by a GP, psychiatrist or paediatrician) and by completing the activities that must be included in a review (see below).

When to render an EDR review item

It is expected that the managing practitioner will be reviewing the patient on a regular, ongoing and as required basis. However, a patient must have a review of the EDP to assess the patient's progress against the EDP or update the EDP, as the patient is approaching the end of each course of treatment before they can access the next course of treatment.

The eating disorder items incorporate a 'stepped model' for best practice care for eligible patients with eating disorders. Under the Eating Disorders Items Stepped Model of Care a course of treatment is defined as 10 eating disorder psychological treatment (EDPT) services. It is required that a patient must have a review after each course of treatment (see AN.36.1 Eating Disorders General Explanatory Notes).

Reviewing an Eating Disorders Treatment Plan

The EDR must include:

- recording the patient's agreement for this service;
- referral to a psychiatrist or paediatrician for review under items 90266-90269, if this has not been initiated at an earlier stage;
- a review of the patient's progress against the goals outlined in the EDP, including discussion with the patient/and or their family/carer as to whether the EDPT services are meeting their needs;
- modification of the documented EDP if required;
- checking, reinforcing and expanding education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided; and
- reviewing reports back from the allied mental health professional on the patient's response to treatment and documenting a recommendation on whether patient should continue with another course of EDPT services with that health professional or another health professional.

Where a consultant psychiatrist or paediatrician provides an EDR, the consultant physician must give the referring practitioner a copy of the diagnosis and the revised EDP within 2 weeks after the attendance. Where a consultant psychiatrist provides an EDR service, the review must also include:

- administering an outcome measurement tool, where clinically appropriate. The choice of outcome tool to be used is at the clinical discretion of the practitioner. Practitioners using such tools should be familiar with their appropriate clinical use, and if not, should seek appropriate education and training; and
- conducting a mental state examination.

Note: It is expected there will be other consultations between the patient and the managing practitioner as part of ongoing patient and medical management, including the ordering and reviewing of the required testing for monitoring the patients' medical and nutritional status. All other ongoing patient reviews should be claimed under the appropriate item.

Checking patient eligibility for services

Note: The 12 month period commences from the date of the EDP.

To provide an EDR service in items 90264-90269, the patient must have had an EDP 90250-90257 or 90260-90263 in the previous 12 months.

If the EDP service has not yet been claimed, the Department of Human Services will not be aware of the patient's eligibility. In this case the practitioner should, with the patient's permission, contact the referring practitioner to ensure the relevant service has been provided to the patient.

Support:

If there is any doubt about whether a patient has had a claim for an eating disorder service, health professionals can access the Health Professionals Online System (HPOS). HPOS is a fast and secure way for health professionals and administrators to check if a patient is eligible for a Medicare benefit for a specific item on the date of the proposed service. However, this system will only return advice that the service/item is payable or not payable.

Patients can also access their own claiming history with a My Health Record or by establishing a Medicare online account through myGov or the Express Plus Medicare mobile app.

Alternatively, health professionals can call the Department of Human Services on 132 150 to check this information, while patients can seek clarification by calling 132 011.

Additional Claiming Information (general conditions and limitations)

Items 90264- 90265 cannot be claimed with item 2713 and 279.

Consultant psychiatrist and paediatrician EDP items 90266- 90269 do not apply if the patient does not have a referral within the period of validity.

Before proceeding with the EDR service the medical practitioner must ensure that:

(a) the steps involved in providing the service are explained to the patient and (if appropriate and with the patient's permission) to the patient's carer; and

(b) the patient's agreement to proceed is recorded.

The medical practitioner must offer the patient a copy of the reviewed EDP and add the document to the patient's records. This should include, subject to the patient's agreement, offering a copy to their carer, where appropriate. The medical practitioner may, with the permission of the patient, provide a copy of the revised EDP, or relevant parts of the plan, to other providers involved in the patient's treatment.

The medical practitioner EDR items cover the service of reviewing an EDP. A separate consultation item can be performed with the EDP if the patient is treated for an unrelated condition to their eating disorder. Where a separate consultation is performed, it should be annotated separately on the patient’s account that a separate consultation was clinically required/indicated.

All consultations conducted as part of the EDP or review must be rendered by the medical practitioner and include a personal attendance with the patient. A specialist mental health nurse, other allied health practitioner, Aboriginal and Torres Strait Islander health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to the medical practitioner in provision of this care.

Additional Claiming Information (interaction with Better Access)

Items 90264-90265 for an EDR, performed by a medical practitioner working in general practice, should not be performed in association with a GP mental health consultation review service (item 2712 and 277).

AN.36.4 Eating Disorders Psychological Treatment (EDPT) Services

Eating Disorders Psychological Treatment (EDPT) services (90271-90282)

This note provides information on the Category 1 – Professional Attendances: Group A36 – Subgroup 4 (90271-90282) and should be read in conjunction the AN.36.1 Eating Disorders General Explanatory Notes

Eating Disorder Psychological Treatment (EDPT) Services Overview

Provision of EDPT by a suitably trained medical practitioner in general practice (90271 – 90282) is for patients with anorexia nervosa and other patients with complex presentations of diagnosed eating disorders who meet the eligibility requirements and would benefit from a structured approach to the management of their treatment needs in the community setting.

Patients seeking rebates for EDPT services must have had an EDP 90250-90257 or 90260-90263 in the previous 12 Months.

An 'eating disorder psychological treatment service' (EDPT) is defined in the AN.36.1 Eating Disorders General Explanatory Note. For any particular patient, an eating disorder treatment and management plan expires at the end of a 12 month period following provision of that service. After that period, a patient will require a new EDP to continue accessing EDPT services.

Rendering an EDPT item

Who can provide the service

Items in subgroup 4 of Group A36 can be rendered by a medical practitioner in general practice with the required mental training. This includes:

- Medical practitioners who can render a general practitioner service in Group A1 of the MBS (see note AN.0.9 for the types of medical practitioners). These medical practitioners can render a 'general practitioner' service for items in subgroup 1 of Group A36. These doctors must have the mental health training requirements as specified below.
- Medical practitioners who are not general practitioners, specialists or consultant physicians. These medical practitioners can render a 'medical practitioner' service for items in subgroup 1 of Group A36. These doctors must have the mental health training requirements as specified below.

Mental health training

Medical practitioner in general practice who meets the training and skills requirements as determined by the General Practice Mental Health Standards Collaboration, and are entered on the Register as being eligible to render a focussed psychological strategy service, can render an eating disorders psychological treatment service.

Note: The General Practice Mental Health Standards Collaboration operates under the auspices of the Royal Australian College of General Practitioners.

What is Involved in an EDPT service

The eating disorder items incorporate a 'stepped model' for best practice care for eligible patients with eating disorders. Under the Eating Disorders Items Stepped Model of Care a course of treatment is defined as 10 eating disorder psychological treatment (EDPT) services. It is required that a patient must have a review (an EDR item in subgroup 3 of A36) after each course of treatment (see AN.36.1 Eating Disorders General Explanatory Notes).

After each course of treatment, the relevant practitioners should provide the medical practitioner who is the managing the patient's EDP (where appropriate) with a written report.

A range of acceptable treatments has been approved for use by practitioners in this context. It is expected that professionals will have the relevant education and training to deliver these services. The approved treatments are:

- Family Based Treatment for Eating Disorders (EDs) (including whole family, Parent Based Therapy, parent only or separated therapy)
- Adolescent Focused Therapy for EDs
- Cognitive Behavioural Therapy (CBT) for EDs (CBT-ED)

- CBT-Anorexia Nervosa (AN) (CBT-AN)
- CBT for Bulimia Nervosa (BN) and Binge-eating Disorder (BED) (CBT-BN and CBT-BED)
- Specialist Supportive Clinical Management (SSCM) for EDs
- Maudsley Model of Anorexia Treatment in Adults (MANTRA)
- Interpersonal Therapy (IPT) for BN, BED
- Dialectical Behavioural Therapy (DBT) for BN, BED
- Focal psychodynamic therapy for EDs

Checking patient eligibility for services

Note: The 12 month period commences from the date of the EDP.

Patients seeking rebates for EDPT 90271-90282 must have had an EDP 90250-90257 or 90260-90263 in the previous 12 months.

If the EDP service has not yet been claimed, the Department of Human Services will not be aware of the patient's eligibility. In this case the practitioner should, with the patient's permission, contact the practitioner who developed the plan to ensure the relevant service has been provided to the patient.

Support:

If there is any doubt about whether a patient has had a claim for an eating disorder service, health professionals can access the Health Professionals Online System (HPOS). HPOS is a fast and secure way for health professionals and administrators to check if a patient is eligible for a Medicare benefit for a specific item on the date of the proposed service. However, this system will only return advice that the service/item is payable or not payable.

Patients can also access their own claiming history with a My Health Record or by establishing a Medicare online account through myGov or the Express Plus Medicare mobile app.

Alternatively, health professionals can call the Department of Human Services on 132 150 to check this information, while patients can seek clarification by calling 132 011.

Additional Claiming Information (general conditions and limitations)

Other than Consultation Room (items 90272, 90274, 90276, 90278)

It is expected that this service would be provided only for patients who are unable to attend the practice.

AN.36.5 Eating Disorders Telehealth – Medical Practitioner in general practice

Eating Disorders Telehealth – Medical Practitioner in general practice (90279-90282)

This note provides telehealth supporting information for eating disorders Items provided via telehealth by a medical practitioner in general practice and should be read in conjunction with Eating Disorders General Explanatory Notes.

Eligible Geographical Areas

Geographic eligibility for eating disorders telehealth services funded under Medicare (90279-90282) is determined according to the Modified Monash Model (MMM) classifications. Telehealth Eligible Areas are those areas that are within MMM classifications 4 to 7. Patients and providers are able to check their eligibility using the Modified Monash Model locator on the Department of Health's website at Health Workforce Locator.

There is a requirement for the patient and practitioner to be located a minimum of 15 kilometres apart at the time of the consultation. Minimum distance between practitioner and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the practitioner is not permitted to travel to an area outside the minimum 15 kilometres distance in order to claim a video consultation.

Record Keeping

Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Aftercare Rule

Video consultations are subject to the same aftercare rules as practitioners providing face-to-face consultations.

Multiple Attendances on the Same Day

In some situations a patient may receive a telehealth consultation and a face to face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

AN.36.6 Eating Disorders Telehealth – Consultant psychiatrists or paediatricians

Eating Disorders Telehealth – Consultant psychiatrists or paediatricians (90262-90263 and 90268-90269)

This note provides telehealth supporting information for eating disorders Items provided via telehealth / videoconference by consultant psychiatrists or paediatricians and should be read in conjunction with Eating Disorders General Explanatory Notes.

Eligible Geographical Areas

Geographic eligibility for telehealth services funded under Medicare are determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are those areas that are outside a Major City (RA1) according to ASGC-RA (RA2-5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

This rule will not apply to specialist video consultation with patients who are a care recipient in a residential care service; or at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the Health Insurance Act 1973 as these patients are able to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at www.mbsonline.gov.au telehealth eligible areas.

Record Keeping

Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Aftercare Rule

Video consultations are subject to the same aftercare rules as practitioners providing face-to-face consultations.

Multiple Attendances on the Same Day

In some situations a patient may receive a telehealth consultation and a face to face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Referrals

The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

1. FEES AND BENEFITS FOR GP ATTENDANCES AT A RESIDENTIAL AGED CARE FACILITY

LEVEL A - ITEM 5010		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	76.90	76.90
TWO	53.15	53.15
THREE	45.25	45.25
FOUR	41.30	41.30
FIVE	38.95	38.95
SIX	37.35	37.35
SEVEN+	32.80	32.80

LEVEL B - ITEM 5028		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	97.25	97.25
TWO	73.50	73.50
THREE	65.60	65.60
FOUR	61.65	61.65
FIVE	59.30	59.30
SIX	57.70	57.70
SEVEN+	53.15	53.15

LEVEL C - ITEM 5049		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	132.75	132.75
TWO	109.00	109.00
THREE	101.10	101.10
FOUR	97.15	97.15
FIVE	94.80	94.80
SIX	93.20	93.20
SEVEN+	88.65	88.65

LEVEL D - ITEM 5067		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	167.10	167.10
TWO	143.35	143.35
THREE	135.45	135.45
FOUR	131.50	131.50
FIVE	129.15	129.15
SIX	127.55	127.55
SEVEN+	123.00	123.00

2. FEES AND BENEFITS FOR OTHER NON REFERRED ATTENDANCES AT A RESIDENTIAL AGED CARE FACILITY

BRIEF - ITEM 5260		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	46.45	46.45
TWO	32.45	32.45
THREE	27.80	27.80
FOUR	25.50	25.50
FIVE	24.10	24.10
SIX	23.15	23.15
SEVEN+	19.75	19.75

STANDARD - ITEM 5263		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	57.55	57.55
TWO	41.75	41.75
THREE	36.50	36.50
FOUR	33.90	33.90
FIVE	32.30	32.30
SIX	31.25	31.25
SEVEN+	27.25	27.25

LONG - ITEM 5265		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	73.45	73.45
TWO	59.45	59.45
THREE	54.80	54.80
FOUR	52.50	52.50
FIVE	51.10	51.10
SIX	50.15	50.15
SEVEN+	46.75	46.75

PROLONGED - ITEM 5267		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	95.45	95.45
TWO	81.45	81.45
THREE	76.80	76.80
FOUR	74.50	74.50
FIVE	73.10	73.10
SIX	72.15	72.15
SEVEN+	68.75	68.75

3. FEES AND BENEFITS FOR GP ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT A HOSPITAL, INSTITUTION OR HOME

LEVEL A - ITEM 4		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	44.25	33.20
TWO	30.85	23.15
THREE	26.40	19.80
FOUR	24.20	18.15
FIVE	22.85	17.15
SIX	21.95	16.50
SEVEN+	19.60	14.70

LEVEL B - ITEM 24		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	64.95	48.75
TWO	51.55	38.70
THREE	47.10	35.35
FOUR	44.90	33.70
FIVE	43.55	32.70
SIX	42.65	32.00
SEVEN+	40.30	30.25

LEVEL B - ITEM 2503, 2518, 2547		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	64.00	48.00
TWO	50.80	38.10
THREE	46.45	34.85
FOUR	44.25	33.20
FIVE	42.90	32.20
SIX	42.05	31.55
SEVEN+	39.70	29.80

LEVEL C – ITEM 37		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	100.70	75.55
TWO	87.30	65.50
THREE	82.85	62.15
FOUR	80.65	60.50
FIVE	79.30	59.50
SIX	78.40	58.80
SEVEN+	76.05	57.05

LEVEL C – ITEM 2506, 2522, 2553		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	99.20	74.40
TWO	86.00	64.50
THREE	81.65	61.25
FOUR	79.45	59.60
FIVE	78.10	58.60
SIX	77.25	57.95
SEVEN+	74.90	56.20

LEVEL D – ITEM 47		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	135.60	101.70
TWO	122.20	91.65
THREE	117.75	88.35
FOUR	115.55	86.70
FIVE	114.20	85.65
SIX	113.30	85.00
SEVEN+	110.95	83.25

LEVEL D – ITEM 2509, 2526, 2559		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	133.60	100.20
TWO	120.40	90.30
THREE	116.05	87.05
FOUR	113.85	85.40
FIVE	112.50	84.40
SIX	111.65	83.75
SEVEN+	109.30	82.00

4. FEES AND BENEFITS FOR OTHER NON-REFERRED ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT A HOSPITAL, INSTITUTION OR HOME

BRIEF – ITEM 58		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	24.00	18.00
TWO	16.25	12.20
THREE	13.65	10.25
FOUR	12.35	9.30
FIVE	11.60	8.70
SIX	11.10	8.35
SEVEN+	9.20	6.90

STANDARD - ITEM 59, 2610, 2631, 2673		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	33.50	25.15
TWO	24.75	18.60
THREE	21.85	16.40
FOUR	20.35	15.30
FIVE	19.50	14.65
SIX	18.90	14.20
SEVEN+	16.70	12.55

LONG – ITEM 60, 2613, 2633, 2675		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	51.00	38.25
TWO	43.25	32.45
THREE	40.65	30.50
FOUR	39.35	29.55
FIVE	38.60	28.95
SIX	38.10	28.60
SEVEN+	36.20	27.15

PROLONGED – ITEM 65, 2616, 2635, 2677		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	73.00	54.75
TWO	65.25	48.95
THREE	62.65	47.00
FOUR	61.35	46.05
FIVE	60.60	45.45
SIX	60.10	45.10
SEVEN+	58.20	43.65

AFTER HOURS ATTENDANCES

5. FEES AND BENEFITS FOR GP ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT AN INSTITUTION OR HOME

LEVEL A – ITEM 5003		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	55.80	55.80
TWO	42.60	42.60
THREE	38.25	38.25
FOUR	36.05	36.05
FIVE	34.70	34.70
SIX	33.85	33.85
SEVEN+	31.50	31.50

LEVEL B – ITEM 5023		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	76.15	76.15
TWO	62.95	62.95
THREE	58.60	58.60
FOUR	56.40	56.40
FIVE	55.05	55.05
SIX	54.20	54.20
SEVEN+	51.85	51.85

LEVEL C – ITEM 5043		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	111.65	111.65
TWO	98.45	98.45
THREE	94.10	94.10
FOUR	91.90	91.90
FIVE	90.55	90.55
SIX	89.70	89.70
SEVEN+	87.35	87.35

LEVEL D – ITEM 5063		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	146.00	146.00
TWO	132.80	132.80
THREE	128.45	128.45
FOUR	126.25	126.25
FIVE	124.90	124.90
SIX	124.05	124.05
SEVEN+	121.70	121.70

6. FEES AND BENEFITS FOR OTHER NON REFERRED ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT AN INSTITUTION OR HOME

BRIEF – ITEM 5220		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	34.00	34.00
TWO	26.25	26.25
THREE	23.65	23.65
FOUR	22.35	22.35
FIVE	21.60	21.60
SIX	21.10	21.10
SEVEN+	19.20	19.20

STANDARD – ITEM 5223		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	43.50	43.50
TWO	34.75	34.75
THREE	31.85	31.85
FOUR	30.35	30.35
FIVE	29.50	29.50
SIX	28.90	28.90
SEVEN+	26.70	26.70

LONG – ITEM 5227		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	61.00	61.00
TWO	53.25	53.25
THREE	50.65	50.65
FOUR	49.35	49.35
FIVE	48.60	48.60
SIX	48.10	48.10
SEVEN+	46.20	46.20

PROLONGED – ITEM 5228		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	83.00	83.00
TWO	75.25	75.25
THREE	72.65	72.65
FOUR	71.35	71.35
FIVE	70.60	70.60
SIX	70.10	70.10
SEVEN+	68.20	68.20

7. PUBLIC HEALTH PHYSICIAN ATTENDANCES

ITEM 414		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	46.40	34.80
TWO	33.25	24.95
THREE	28.90	21.70
FOUR	26.70	20.05
FIVE	25.40	19.05
SIX	24.50	18.40
SEVEN+	22.20	16.65

ITEM 415		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	70.35	52.80
TWO	57.20	42.90
THREE	52.85	39.65
FOUR	50.65	38.00
FIVE	49.35	37.05
SIX	48.45	36.35
SEVEN+	46.15	34.65

ITEM 416		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	111.50	83.65
TWO	98.35	73.80
THREE	94.00	70.50
FOUR	91.80	68.85
FIVE	90.50	67.90
SIX	89.60	67.20
SEVEN+	87.30	65.50

ITEM 417		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	151.80	113.85
TWO	138.65	104.00
THREE	134.30	100.75
FOUR	132.10	99.10
FIVE	130.80	98.10
SIX	129.90	97.45
SEVEN+	127.60	95.70

8. FOCUSSED PSYCHOLOGICAL STRATEGIES

ITEM 2723		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	120.60	120.60
TWO	107.40	107.40
THREE	103.05	103.05
FOUR	100.85	100.85
FIVE	99.50	99.50
SIX	98.65	98.65
SEVEN+	96.30	96.30

ITEM 2727		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	161.20	161.20
TWO	148.00	148.00
THREE	143.65	143.65
FOUR	141.45	141.45
FIVE	140.10	140.10
SIX	139.25	139.25
SEVEN+	136.90	136.90

9. FEES AND BENEFITS FOR MEDICAL PRACTITIONER TELEHEALTH ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT A HOME OR OTHER INSTITUTION

LEVEL A – ITEM 2122		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	49.60	49.60
TWO	36.40	36.40
THREE	32.05	32.05
FOUR	29.85	29.85
FIVE	28.50	28.50
SIX	27.65	27.65
SEVEN+	25.30	25.30

LEVEL B – ITEM 2137		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	77.10	77.10
TWO	63.90	63.90
THREE	59.55	59.55
FOUR	57.35	57.35
FIVE	56.00	56.00
SIX	55.15	55.15
SEVEN+	52.80	52.80

LEVEL C – ITEM 2147		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	124.75	124.75
TWO	111.55	111.55
THREE	107.20	107.20
FOUR	105.00	105.00
FIVE	103.65	103.65
SIX	102.80	102.80
SEVEN+	100.45	100.45

LEVEL D – ITEM 2199		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	171.15	171.15
TWO	157.95	157.95
THREE	153.60	153.60
FOUR	151.40	151.40
FIVE	150.05	150.05
SIX	149.20	149.20
SEVEN+	146.85	146.85

10. FEES AND BENEFITS FOR MEDICAL PRACTITIONER TELEHEALTH ATTENDANCES AT A RESIDENTIAL AGED CARE FACILITY

LEVEL A – ITEM 2125		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	70.70	70.70
TWO	46.95	46.95
THREE	39.05	39.05
FOUR	35.10	35.10
FIVE	32.75	32.75
SIX	31.15	31.15
SEVEN+	26.60	26.60

LEVEL B – ITEM 2138		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	98.20	98.20
TWO	74.45	74.45
THREE	66.55	66.55
FOUR	62.60	62.60
FIVE	60.25	60.25
SIX	58.65	58.65
SEVEN+	54.10	54.10

LEVEL C – ITEM 2179		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	145.85	145.85
TWO	122.10	122.10
THREE	114.20	114.20
FOUR	110.25	110.25
FIVE	107.90	107.90
SIX	106.30	106.30
SEVEN+	101.75	101.75

LEVEL D – ITEM 2220		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	192.25	192.25
TWO	168.50	168.50
THREE	160.60	160.60
FOUR	156.65	156.65
FIVE	154.30	154.30
SIX	152.70	152.70
SEVEN+	148.15	148.15

11. ACUPUNCTURE

LEVEL A – ITEM 195		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	64.00	64.00
TWO	50.80	50.80
THREE	46.45	46.45
FOUR	44.25	44.25
FIVE	42.90	42.90
SIX	42.05	42.05
SEVEN+	39.70	39.70

12. FEES AND BENEFITS FOR NON-SPECIALIST PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

ITEM 181		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	35.40	35.40
TWO	24.70	24.70
THREE	21.15	21.15
FOUR	19.35	19.35
FIVE	18.30	18.30
SIX	17.55	17.55
SEVEN+	15.70	15.70

ITEM 187		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	51.95	51.95
TWO	41.25	41.25
THREE	37.70	37.70
FOUR	35.90	35.90
FIVE	34.85	34.85
SIX	34.10	34.10
SEVEN+	32.25	32.25

ITEM 191		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	80.55	80.55
TWO	69.85	69.85
THREE	66.30	66.30
FOUR	64.50	64.50
FIVE	63.45	63.45
SIX	62.70	62.70
SEVEN+	60.85	60.85

ITEM 206		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	108.50	108.50
TWO	97.80	97.80
THREE	94.25	94.25
FOUR	92.45	92.45
FIVE	91.40	91.40
SIX	90.65	90.65
SEVEN+	88.80	88.80

13. FEES AND BENEFITS FOR NON-SPECIALIST PRACTITIONER ATTENDANCES ASSOCIATED WITH PRACTICE INCENTIVE PROGRAM PAYMENTS

ITEM 253, 260, 266		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	51.20	51.20
TWO	40.65	40.65
THREE	37.15	37.15
FOUR	35.35	35.35
FIVE	34.30	34.30
SIX	33.60	33.60
SEVEN+	31.75	31.75

ITEM 255, 262, 269		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	79.40	79.40
TWO	68.85	68.85
THREE	65.35	65.35
FOUR	63.55	63.55
FIVE	62.50	62.50
SIX	61.80	61.80
SEVEN+	59.95	59.95

ITEM 257, 264, 271		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	106.90	106.90
TWO	96.35	96.35
THREE	92.85	92.85
FOUR	91.05	91.05
FIVE	90.00	90.00
SIX	89.30	89.30
SEVEN+	87.45	87.45

14. FEES AND BENEFITS FOR NON-SPECIALIST PRACTITIONER MENTAL HEALTH CARE

ITEM 285		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	96.50	96.50
TWO	85.95	85.95
THREE	82.45	82.45
FOUR	80.65	80.65
FIVE	79.60	79.60
SIX	78.90	78.90
SEVEN+	77.05	77.05

ITEM 287		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	129.00	129.00
TWO	118.45	118.45
THREE	114.95	114.95
FOUR	113.15	113.15
FIVE	112.10	112.10
SIX	111.40	111.40
SEVEN+	109.55	109.55

15. FEES AND BENEFITS FOR NON-SPECIALIST PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

ITEM 761		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	44.65	44.65
TWO	34.10	34.10
THREE	30.60	30.60
FOUR	28.80	28.80
FIVE	27.75	27.75
SIX	27.05	27.05
SEVEN+	25.20	25.20

ITEM 763		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	60.95	60.95
TWO	50.40	50.40
THREE	46.90	46.90
FOUR	45.10	45.10
FIVE	44.05	44.05
SIX	43.35	43.35
SEVEN+	41.50	41.50

ITEM 766		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	89.35	89.35
TWO	78.80	78.80
THREE	75.30	75.30
FOUR	73.50	73.50
FIVE	72.45	72.45
SIX	71.75	71.75
SEVEN+	69.90	69.90

ITEM 769		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	116.80	116.80
TWO	106.25	106.25
THREE	102.75	102.75
FOUR	100.95	100.95
FIVE	99.90	99.90
SIX	99.20	99.20
SEVEN+	97.35	97.35

ITEM 772		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	61.50	61.50
TWO	42.50	42.50
THREE	36.20	36.20
FOUR	33.05	33.05
FIVE	31.15	31.15
SIX	29.85	29.85
SEVEN+	26.25	26.25

ITEM 776		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	77.80	77.80
TWO	58.80	58.80
THREE	52.50	52.50
FOUR	49.35	49.35
FIVE	47.45	47.45
SIX	46.15	46.15
SEVEN+	42.55	42.55

ITEM 788		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	106.20	106.20
TWO	87.20	87.20
THREE	80.90	80.90
FOUR	77.75	77.75
FIVE	75.85	75.85
SIX	74.55	74.55
SEVEN+	70.95	70.95

ITEM 789		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	133.65	133.65
TWO	114.65	114.65
THREE	108.35	108.35
FOUR	105.20	105.20
FIVE	103.30	103.30
SIX	102.00	102.00
SEVEN+	98.40	98.40

16. FEES AND BENEFITS FOR NON-SPECIALIST PRACTITIONER VIDEO CONFERENCING CONSULTATION

ITEM 827		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	39.70	39.70
TWO	29.15	29.15
THREE	25.65	25.65
FOUR	23.85	23.85
FIVE	22.80	22.80
SIX	22.10	22.10
SEVEN+	20.25	20.25

ITEM 829		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	56.55	56.55
TWO	37.55	37.55
THREE	31.25	31.25
FOUR	28.10	28.10
FIVE	26.20	26.20
SIX	24.90	24.90
SEVEN+	21.30	21.30

ITEM 868		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	61.70	61.70
TWO	51.15	51.15
THREE	47.65	47.65
FOUR	45.85	45.85
FIVE	44.80	44.80
SIX	44.10	44.10
SEVEN+	42.25	42.25

ITEM 869		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	78.55	78.55
TWO	59.55	59.55
THREE	53.25	53.25
FOUR	50.10	50.10
FIVE	48.20	48.20
SIX	46.90	46.90
SEVEN+	43.30	43.30

ITEM 876		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	99.80	99.80
TWO	89.25	89.25
THREE	85.75	85.75
FOUR	83.95	83.95
FIVE	82.90	82.90
SIX	82.20	82.20
SEVEN+	80.35	80.35

ITEM 881		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	116.65	116.65
TWO	97.65	97.65
THREE	91.35	91.35
FOUR	88.20	88.20
FIVE	86.30	86.30
SIX	85.00	85.00
SEVEN+	81.40	81.40

ITEM 891		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	136.95	136.95
TWO	126.40	126.40
THREE	122.90	122.90
FOUR	121.10	121.10
FIVE	120.05	120.05
SIX	119.35	119.35
SEVEN+	117.50	117.50

ITEM 892		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	153.80	153.80
TWO	134.80	134.80
THREE	128.50	128.50
FOUR	125.35	125.35
FIVE	123.45	123.45
SIX	122.15	122.15
SEVEN+	118.55	118.55

Services that attract the 100% Medicare rebate – as at 1 March 2019

Medicare Benefits Schedule (MBS) Group	Name of Subgroup	Item numbers
Group A1	General practitioner attendances to which no other item applies	3, 4, 23, 24, 36, 37, 44, 47
Group A2	Other non-referred attendances to which no other item applies	52, 53, 54, 57, 58, 59, 60, 65
Group A5	Prolonged attendances to which no other item applies	160, 161, 162, 163, 164
Group A6	Group therapy	170, 171, 172
Group A7	Acupuncture	173, 193, 195, 197, 199
Group A7	Non-Specialist Practitioner attendances to which no other item applies	179, 181, 185, 187, 189, 191, 203, 206
Group A7	Non-Specialist Practitioner prolonged attendances to which no other item applies	214, 215, 218, 219, 220
Group A7	Non-Specialist Practitioner group therapy	221, 222, 223
Group A7	Non-Specialist Practitioner health assessments	224, 225, 226, 227, 228
Group A7	Non-Specialist Practitioner management plans, team care arrangements and multidisciplinary care plans and case conferences	229, 230, 231, 232, 233, 235, 236, 237, 238, 239, 240, 243, 244
Group A7	Non-Specialist Practitioner domiciliary and residential medication management review	245, 249
Group A7	Non-Specialist Practitioner attendances associated with Practice Incentive Program payments	251, 252, 253, 254, 255, 256, 257, 259, 260, 261, 262, 263, 264, 265, 266, 268, 269, 270, 271
Group A7	Non-Specialist Practitioner mental health care	272, 276, 277, 279, 281, 282, 283, 285, 286, 287
Group A7	Non-Specialist Practitioner after-hours attendances to which no other item applies	733, 737, 741, 745, 761, 763, 766, 769, 772, 776, 788, 789
Group A7	Non-Specialist Practitioner pregnancy support counselling	792
Group A7	Non-Specialist Practitioner video conferencing consultation	812, 827, 829, 867, 868, 869, 873, 876, 881, 885, 891, 892
Group A11	Urgent Attendances After hours	585, 588, 591, 594, 599, 600
Group A14	Health assessments	701, 703, 705, 707, 715
Group A15	GP care plans and multidisciplinary case conferences	721, 723, 729, 731, 732, 735, 739, 743, 747, 750, 758
Group A17	Medication management review	900, 903

Group A18	General practitioner attendances associated with Practice Incentives Program (PIP) payments	2497, 2501, 2503, 2504, 2506, 2507, 2509, 2517, 2518, 2521, 2522, 2525, 2526, 2546, 2547, 2552, 2553, 2558, 2559,
Group A19	Other non-referred attendances associated with Practice Incentives Program (PIP) payments to which no other item applies	2598, 2600, 2603, 2606, 2610, 2613, 2616, 2620, 2622, 2624, 2631, 2633, 2635, 2664, 2666, 2668, 2673, 2675, 2677
Group A20	GP mental health care	2700, 2701, 2712, 2713, 2715, 2717, 2721, 2723, 2725, 2727
Group A22	General practitioner after-hours attendances to which no other item applies	5000, 5003, 5010, 5020, 5023, 5028, 5040, 5043, 5049, 5060, 5063, 5067
Group A23	Other non-referred after-hours attendances to which no other item applies	5200, 5203, 5207, 5208, 5220, 5223, 5227, 5228, 5260, 5263, 5265, 5267
Group A27	Pregnancy support couselling	4001
Group A29	Early intervention services for children with autism, pervasive developmental disorder or disability	139
Group A30	Medical Practitioners – Telehealth Atendances	2100, 2122, 2125, 2126, 2137, 2138, 2143, 2147, 2179, 2195, 2199, 2220
Group A35	Services For Patients in Residential Aged Care Facilities	90001, 90002, 90020, 90035, 90043, 90051, 90092, 90093, 90095, 90096, 90183, 90188, 90202, 90212
Group M12	Services provided by a practice nurse or registered Aboriginal Health Worker on behalf of a medical practitioner	10983, 10984, 10987, 10988, 10989, 10997

A1. GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

	Group A1. General Practitioner Attendances To Which No Other Item Applies
	LEVEL A Professional attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.
3	Professional attendance at consulting rooms (other than a service to which another 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 (See para AN.0.9 of explanatory notes to this Category) **Fee:** $17.50 **Benefit:** 100% = $17.50 **Extended Medicare Safety Net Cap:** $52.50
4	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies) that requires a short patient history and, if necessary, limited examination and management-an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.13, AN.0.9, AN.0.11 of explanatory notes to this Category) **Derived Fee:** The fee for item 3, plus $26.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $2.10 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL B Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
23	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance (See para AN.0.9 of explanatory notes to this Category) **Fee:** $38.20 **Benefit:** 100% = $38.20 **Extended Medicare Safety Net Cap:** $114.60
24	Professional attendance by a general practitioner (other than attendance at consulting rooms or a

A1. GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	residential aged care facility or a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.13, AN.0.9, AN.0.11 of explanatory notes to this Category) **Derived Fee:** The fee for item 23, plus $26.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $2.10 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL C Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
36	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance (See para AN.0.9 of explanatory notes to this Category) **Fee:** $73.95 **Benefit:** 100% = $73.95 **Extended Medicare Safety Net Cap:** $221.85
37	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history;

A1. GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.13, AN.0.9, AN.0.11 of explanatory notes to this Category) **Derived Fee:** The fee for item 36, plus $26.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $2.10 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
44	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance (See para AN.0.9 of explanatory notes to this Category) **Fee:** $108.85 **Benefit:** 100% = $108.85 **Extended Medicare Safety Net Cap:** $326.55
47	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan;

A1. GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.13, AN.0.9, AN.0.11 of explanatory notes to this Category) **Derived Fee:** The fee for item 44, plus $26.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $2.10 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A2. OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	1. OTHER MEDICAL PRACTITIONER ATTENDANCES
	Group A2. Other Non-Referred Attendances To Which No Other Item Applies
	Subgroup 1. Other Medical Practitioner Attendances
	CONSULTATION AT CONSULTING ROOMS Professional attendance at consulting rooms
Amend 52	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which any other item applies)-each attendance, by: (a) a medical practitioner (who is not a general practitioner); or (b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). **Fee:** $11.00 **Benefit:** 100% = $11.00 **Extended Medicare Safety Net Cap:** $33.00
Amend 53	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes (other than a service to which any other item applies)-each attendance, by: (a) a medical practitioner (who is not a general practitioner); or (b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
Amend 54	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes (other than a service to which any other item applies)-each attendance, by: (a) a medical practitioner (who is not a general practitioner); or (b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00
Amend 57	Professional attendance at consulting rooms of more than 45 minutes in duration (other than a service to which any other item applies)-each attendance, by: (a) a medical practitioner (who is not a general practitioner); or

	(b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00
	CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS OR A RESIDENTIAL AGED CARE FACILITY Professional attendance by a medical practitioner (other than a general practitioner) on 1 or more patients on 1 occasion at a place other than consulting rooms or a residential aged care facility.
Amend 58	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies), not more than 5 minutes in duration-an attendance on one or more patients at one place on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). **Derived Fee:** An amount equal to $8.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $8.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Amend 59	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 5 minutes in duration but not more than 25 minutes-an attendance on one or more patients at one place on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Amend 60	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 25 minutes in duration but not more than 45 minutes-an attendance on one or more patients at one place on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Amend 65	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 45 minutes in duration-an attendance on one or more patients at one place on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or

	(b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A3. SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

	Group A3. Specialist Attendances To Which No Other Item Applies
Amend 99	Professional attendance on a patient by a specialist practising in the specialist's specialty if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 104 lasting more than 10 minutes; or (ii) provided with item 105; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.0.68 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 104 or 105. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Amend 104	Professional attendance at consulting rooms or hospital by a specialist in the practice of the specialist's specialty after referral of the patient to the specialist-each attendance, other than a second or subsequent attendance, in a single course of treatment, other than a service to which item 106, 109 or 16401 applies (See para TN.1.4 of explanatory notes to this Category) **Fee:** $88.25 **Benefit:** 75% = $66.20 85% = $75.05 **Extended Medicare Safety Net Cap:** $264.75
Amend 105	Professional attendance by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist-an attendance after the first in a single course of treatment, if that attendance is at consulting rooms or hospital, other than a service to which item 16404 applies

A3. SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(See para TN.1.4, AN.0.70 of explanatory notes to this Category) **Fee:** $44.35 **Benefit:** 75% = $33.30 85% = $37.70 **Extended Medicare Safety Net Cap:** $133.05
Amend 106	Professional attendance by a specialist in the practice of the specialist's specialty of ophthalmology and following referral of the patient to the specialist-an attendance (other than a second or subsequent attendance in a single course of treatment) at which the only service provided is refraction testing for the issue of a prescription for spectacles or contact lenses, if that attendance is at consulting rooms or hospital (other than a service to which any of items 104, 109 and 10801 to 10816 applies) **Fee:** $73.20 **Benefit:** 75% = $54.90 85% = $62.25 **Extended Medicare Safety Net Cap:** $219.60
Amend 107	Professional attendance by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist-an attendance (other than a second or subsequent attendance in a single course of treatment), if that attendance is at a place other than consulting rooms or hospital **Fee:** $129.45 **Benefit:** 75% = $97.10 85% = $110.05 **Extended Medicare Safety Net Cap:** $388.35
Amend 108	Professional attendance by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist-each attendance after the first in a single course of treatment, if that attendance is at a place other than consulting rooms or hospital **Fee:** $81.95 **Benefit:** 75% = $61.50 85% = $69.70 **Extended Medicare Safety Net Cap:** $245.85
Amend 109	Professional attendance by a specialist in the practice of the specialist's specialty of ophthalmology following referral of the patient to the specialist-an attendance (other than a second or subsequent attendance in a single course of treatment) at which a comprehensive eye examination, including pupil dilation, is performed on: (a) a patient aged 9 years or younger; or (b) a patient aged 14 years or younger with developmental delay; (other than a service to which any of items 104, 106 and 10801 to 10816 applies) **Fee:** $198.85 **Benefit:** 75% = $149.15 85% = $169.05 **Extended Medicare Safety Net Cap:** $500.00
Amend 111	Professional attendance at consulting rooms or in hospital by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist by a referring practitioner-an attendance after the first attendance in a single course of treatment, if: (a) during the attendance, the specialist determines the need to perform an operation on the patient that had not otherwise been scheduled; and (b) the specialist subsequently performs the operation on the patient, on the same day; and (c) the operation is a service to which an item in Group T8 applies; and (d) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $304.80 or more For any particular patient, once only on the same day **Fee:** $44.35 **Benefit:** 75% = $33.30 85% = $37.70 **Extended Medicare Safety Net Cap:** $133.05

Amend 113	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist in the practice of the specialist's speciality if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment (See para AN.0.68 of explanatory notes to this Category) **Fee:** $66.20 **Benefit:** 85% = $56.30 **Extended Medicare Safety Net Cap:** $198.60
115	Professional attendance at consulting rooms or in hospital by a specialist or consultant physician in the practice of the medical practitioner's specialty after referral of the patient to the specialist or consultant physician by a referring practitioner—an attendance after the first attendance in a single course of treatment, if: (a) the specialist or consultant physician performs a scheduled operation on that patient on the same day; and (b) the operation is one to which an item in Group T8 applies; and (c) the amount specified in the item in Group T8 as the fee for a service to which the item applies is $304.80 or more; and (d) the attendance is unrelated to the scheduled operation; and (e) it is considered a clinical risk to defer the attendance to a later date. For any particular patient, once only on the same day. (See para AN.3.1 of explanatory notes to this Category) **Fee:** $44.35 **Benefit:** 75% = $33.30 85% = $37.70 **Extended Medicare Safety Net Cap:** $133.05

A4. CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A4. Consultant Physician Attendances To Which No Other Item Applies
Amend 110	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-initial attendance in a single course of treatment **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30 **Extended Medicare Safety Net Cap:** $466.80
Amend 112	Professional attendance on a patient by a consultant physician practising in the consultant physician's specialty if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 110 lasting more than 10 minutes; or (ii) provided with item 116, 119, 132 or 133; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.0.68 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for the associated item. Benefit: 85% of derived fee. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Amend 114	Initial professional attendance of 10 minutes or less in duration on a patient by a consultant physician practising in the consultant physician's specialty if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and

A4. CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(B) at the time of the attendance-at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment (See para AN.0.68 of explanatory notes to this Category) **Fee:** $116.75 **Benefit:** 85% = $99.25 **Extended Medicare Safety Net Cap:** $350.25
Amend 116	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-each attendance (other than a service to which item 119 applies) after the first in a single course of treatment (See para AN.0.70 of explanatory notes to this Category) **Fee:** $77.90 **Benefit:** 75% = $58.45 85% = $66.25 **Extended Medicare Safety Net Cap:** $233.70
Amend 117	Professional attendance at consulting rooms or in hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-an attendance after the first attendance in a single course of treatment, if: (a) the attendance is not a minor attendance; and (b) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (c) the consultant physician subsequently performs the operation on the patient, on the same day; and (d) the operation is a service to which an item in Group T8 applies; and (e) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $304.80 or more For any particular patient, once only on the same day **Fee:** $77.90 **Benefit:** 75% = $58.45 85% = $66.25 **Extended Medicare Safety Net Cap:** $233.70
Amend 119	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-each minor attendance after the first in a single course of treatment (See para AN.0.21, AN.0.70 of explanatory notes to this Category) **Fee:** $44.35 **Benefit:** 75% = $33.30 85% = $37.70 **Extended Medicare Safety Net Cap:** $133.05

Amend 120	Professional attendance at consulting rooms or in hospital by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-an attendance after the first attendance in a single course of treatment, if: (a) the attendance is a minor attendance; and (b) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (c) the consultant physician subsequently performs the operation on the patient, on the same day; and (d) the operation is a service to which an item in Group T8 applies; and (e) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $304.80 or more For any particular patient, once only on the same day (See para AN.0.21 of explanatory notes to this Category) **Fee:** $44.35 **Benefit:** 75% = $33.30 85% = $37.70 **Extended Medicare Safety Net Cap:** $133.05
Amend 122	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-initial attendance in a single course of treatment **Fee:** $188.80 **Benefit:** 75% = $141.60 85% = $160.50 **Extended Medicare Safety Net Cap:** $500.00
Amend 128	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-each attendance (other than a service to which item 131 applies) after the first in a single course of treatment **Fee:** $114.20 **Benefit:** 75% = $85.65 85% = $97.10 **Extended Medicare Safety Net Cap:** $342.60
Amend 131	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-each minor attendance after the first in a single course of treatment (See para AN.0.21 of explanatory notes to this Category) **Fee:** $82.25 **Benefit:** 75% = $61.70 85% = $69.95 **Extended Medicare Safety Net Cap:** $246.75
Amend 132	Professional attendance by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) of at least 45 minutes in duration for an initial assessment of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) following referral of the patient to the consultant physician by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and

	(b) a consultant physician treatment and management plan of significant complexity is prepared and provided to the referring practitioner, which involves: (i) an opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) medication recommendations; and (c) an attendance on the patient to which item 110, 116 or 119 applies did not take place on the same day by the same consultant physician; and (d) this item has not applied to an attendance on the patient in the preceding 12 months by the same consultant physician (See para AN.0.23 of explanatory notes to this Category) **Fee:** $272.15 **Benefit:** 75% = $204.15 85% = $231.35 **Extended Medicare Safety Net Cap:** $500.00
Amend 133	Professional attendance by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) of at least 20 minutes in duration after the first attendance in a single course of treatment for a review of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified consultant physician treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on the diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient to which item 110, 116 or 119 applies did not take place on the same day by the same consultant physician; and (d) item 132 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same consultant physician who claimed item 132 or a locum tenens; and (f) this item has not applied more than twice in any 12 month period (See para AN.0.23 of explanatory notes to this Category) **Fee:** $136.25 **Benefit:** 75% = $102.20 85% = $115.85 **Extended Medicare Safety Net Cap:** $408.75

A5. PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A5. Prolonged Attendances To Which No Other Item Applies
	PROLONGED PROFESSIONAL ATTENDANCE Professional attendance (not being a service to which another item in this Category applies) on a patient in imminent danger of death. The time period relates to the total time spent with a single patient, even if the time spent by the practitioner is not continuous. Attendance on one patient at risk of imminent death may be provided by one or more general practitioners, specialists or consultant physicians on the one occasion.
160	Professional attendance by a general practitioner, specialist or consultant physician for a period of not less than 1 hour but less than 2 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.0.27 of explanatory notes to this Category) **Fee:** $225.05 **Benefit:** 75% = $168.80 100% = $225.05 **Extended Medicare Safety Net Cap:** $500.00
161	Professional attendance by a general practitioner, specialist or consultant physician for a period of not less than 2 hours but less than 3 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.0.27 of explanatory notes to this Category) **Fee:** $375.05 **Benefit:** 75% = $281.30 100% = $375.05 **Extended Medicare Safety Net Cap:** $500.00
162	Professional attendance by a general practitioner, specialist or consultant physician for a period of not less than 3 hours but less than 4 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.0.27 of explanatory notes to this Category) **Fee:** $524.90 **Benefit:** 75% = $393.70 100% = $524.90 **Extended Medicare Safety Net Cap:** $500.00
163	Professional attendance by a general practitioner, specialist or consultant physician for a period of not less than 4 hours but less than 5 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.0.27 of explanatory notes to this Category) **Fee:** $675.20 **Benefit:** 75% = $506.40 100% = $675.20 **Extended Medicare Safety Net Cap:** $500.00
164	Professional attendance by a general practitioner, specialist or consultant physician for a period of 5 hours or more (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.0.27 of explanatory notes to this Category) **Fee:** $750.20 **Benefit:** 75% = $562.65 100% = $750.20 **Extended Medicare Safety Net Cap:** $500.00
A6. GROUP THERAPY	
	Group A6. Group Therapy
Amend 170	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of the consultant physician's specialty of psychiatry) involving members of a family and persons with close personal relationships with that family-each group of 2 patients (See para AN.0.28, AN.0.5 of explanatory notes to this Category)

A6. GROUP THERAPY	
	Fee: $119.45 **Benefit:** 75% = $89.60 100% = $119.45 **Extended Medicare Safety Net Cap:** $358.35
Amend 171	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of the consultant physician's specialty of psychiatry) involving members of a family and persons with close personal relationships with that family-each group of 3 patients (See para AN.0.28, AN.0.5 of explanatory notes to this Category) **Fee:** $125.85 **Benefit:** 75% = $94.40 100% = $125.85 **Extended Medicare Safety Net Cap:** $377.55
Amend 172	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of the consultant physician's specialty of psychiatry) involving members of a family and persons with close personal relationships with that family-each group of 4 or more patients (See para AN.0.28, AN.0.5 of explanatory notes to this Category) **Fee:** $153.10 **Benefit:** 75% = $114.85 100% = $153.10 **Extended Medicare Safety Net Cap:** $459.30

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	1. ACUPUNCTURE
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 1. Acupuncture
173	Professional 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 another attendance on the same day related to the condition for which the acupuncture was performed (See para AN.0.29 of explanatory notes to this Category) **Fee:** $21.65 **Benefit:** 75% = $16.25 100% = $21.65 **Extended Medicare Safety Net Cap:** $64.95
193	Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed (See para AN.0.29, AN.0.9 of explanatory notes to this Category)

	Fee: $37.65 **Benefit:** 100% = $37.65 **Extended Medicare Safety Net Cap:** $112.95
195	Professional attendance by a general practitioner who is a qualified medical acupuncturist, on one or more patients at a hospital, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed (See para AN.0.29, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 193, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 193 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
197	Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed (See para AN.0.29, AN.0.9 of explanatory notes to this Category) **Fee:** $72.85 **Benefit:** 100% = $72.85 **Extended Medicare Safety Net Cap:** $218.55
199	Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history;

	(b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed (See para AN.0.29, AN.0.9 of explanatory notes to this Category) **Fee:** $107.25 **Benefit:** 100% = $107.25 **Extended Medicare Safety Net Cap:** $321.75

	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 2. Non-Specialist Practitioner attendances to which no other item applies
179	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which any other item applies)—each attendance, by a medical practitioner in an eligible area. (See para AN.7.1, AN.7.2, GN.7.17 of explanatory notes to this Category) **Fee:** $14.00 **Benefit:** 100% = $14.00 **Extended Medicare Safety Net Cap:** $42.00
181	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies), not more than 5 minutes in duration—an attendance on one or more patients at one place on one occasion—each patient, by a medical practitioner in an eligible area (See para AN.7.1, AN.7.2, GN.7.17 of explanatory notes to this Category) **Derived Fee:** The fee for item 179, plus $21.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 179 plus $1.70 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
185	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes (other than a service to which any other item applies)—each attendance, by a medical practitioner in an eligible area (See para AN.7.1, AN.7.2, GN.7.17 of explanatory notes to this Category) **Fee:** $30.55 **Benefit:** 100% = $30.55 **Extended Medicare Safety Net Cap:** $91.65
187	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 5 minutes in duration but not more than 25 minutes—an attendance on one or more patients at one place on one occasion—each patient, by a medical practitioner in an eligible area (See para AN.7.1, AN.7.2, GN.7.17 of explanatory notes to this Category) **Derived Fee:** The fee for item 185, plus $21.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 185 plus $1.70 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	2. NON-SPECIALIST PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	lesser amount
189	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes (other than a service to which any other item applies)—each attendance, by a medical practitioner in an eligible area (See para AN.7.1, AN.7.2, GN.7.17 of explanatory notes to this Category) **Fee:** $59.15 **Benefit:** 100% = $59.15 **Extended Medicare Safety Net Cap:** $177.45
191	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 25 minutes in duration but not more than 45 minutes—an attendance on one or more patients at one place on one occasion—each patient, by a medical practitioner in an eligible area (See para AN.7.1, AN.7.2, GN.7.17 of explanatory notes to this Category) **Derived Fee:** The fee for item 189, plus $21.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 189 plus $1.70 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
203	Professional attendance at consulting rooms of more than 45 minutes in duration (other than a service to which any other item applies)—each attendance, by a medical practitioner in an eligible area (See para AN.7.1, AN.7.2, GN.7.17 of explanatory notes to this Category) **Fee:** $87.10 **Benefit:** 100% = $87.10 **Extended Medicare Safety Net Cap:** $261.30
206	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 45 minutes in duration—an attendance on one or more patients at one place on one occasion—each patient, by a medical practitioner in an eligible area (See para AN.7.1, AN.7.2, GN.7.17 of explanatory notes to this Category) **Derived Fee:** The fee for item 203, plus $21.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 203 plus $1.70 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	3. NON-SPECIALIST PRACTITIONER PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 3. Non-Specialist Practitioner prolonged attendances to which no other item applies
214	Professional attendance by a medical practitioner for a period of not less than 1 hour but less than 2 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $180.05 **Benefit:** 75% = $135.05 100% = $180.05 **Extended Medicare Safety Net Cap:** $500.00
215	Professional attendance by a medical practitioner for a period of not less than 2 hours but less than 3 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $300.05 **Benefit:** 75% = $225.05 100% = $300.05 **Extended Medicare Safety Net Cap:** $500.00
218	Professional attendance by a medical practitioner for a period of not less than 3 hours but less than 4

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	3. NON-SPECIALIST PRACTITIONER PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $419.90 **Benefit:** 75% = $314.95 100% = $419.90 **Extended Medicare Safety Net Cap:** $500.00
219	Professional attendance by a medical practitioner for a period of not less than 4 hours but less than 5 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $540.15 **Benefit:** 75% = $405.15 100% = $540.15 **Extended Medicare Safety Net Cap:** $500.00
220	Professional attendance by a medical practitioner for a period of 5 hours or more (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $600.15 **Benefit:** 75% = $450.15 100% = $600.15 **Extended Medicare Safety Net Cap:** $500.00

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	4. NON-SPECIALIST PRACTITIONER GROUP THERAPY
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 4. Non-Specialist Practitioner group therapy
221	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a medical practitioner involving members of a family and persons with close personal relationships with that family—each Group of 2 patients (See para AN.7.1, AN.7.4 of explanatory notes to this Category) **Fee:** $95.55 **Benefit:** 75% = $71.70 100% = $95.55 **Extended Medicare Safety Net Cap:** $286.65
222	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a medical practitioner involving members of a family and persons with close personal relationships with that family—each Group of 3 patients (See para AN.7.1, AN.7.4 of explanatory notes to this Category) **Fee:** $100.70 **Benefit:** 75% = $75.55 100% = $100.70 **Extended Medicare Safety Net Cap:** $302.10
223	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a medical practitioner involving members of a family and persons with close personal relationships with that family—each Group of 4 or more patients (See para AN.7.1, AN.7.4 of explanatory notes to this Category) **Fee:** $122.50 **Benefit:** 75% = $91.90 100% = $122.50 **Extended Medicare Safety Net Cap:** $367.50

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	5. NON-SPECIALIST PRACTITIONER HEALTH ASSESSMENTS
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 5. Non-Specialist Practitioner health assessments
Amend Fee 177	Professional attendance for a heart health assessment by a medical practitioner (other than a specialist or consultant physician) at consulting rooms lasting at least 20 minutes and must include: (a) collection of relevant information, including taking a patient history that is aimed at identifying cardiovascular disease risk factors, including diabetes status, alcohol intake, smoking status and blood

	glucose; (b) a physical examination, which must include recording of blood pressure and cholesterol status; (c) initiating interventions and referrals to address the identified risk factors; (d) implementing a management plan for appropriate treatment of identified risk factors; (e) providing the patient with preventative health care advice and information, including modifiable lifestyle factors; with appropriate documentation. Claimable once only in a 12 month period. The heart health assessment item cannot be claimed if a patient has had a health assessment service (items 224, 225, 226, 227, 228) in the previous 12 months. **Fee:** $59.15 **Benefit:** 100% = $59.15 **Extended Medicare Safety Net Cap:** $177.45
224	Professional attendance by a medical practitioner to perform a brief health assessment, lasting not more than 30 minutes and including: (a) collection of relevant information, including taking a patient history; and (b) a basic physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing the patient with preventive health care advice and information (See para AN.7.1, AN.7.5, AN.7.6, AN.7.7, AN.7.8, AN.7.9, AN.7.10, AN.7.11, AN.7.12 of explanatory notes to this Category) **Fee:** $48.25 **Benefit:** 100% = $48.25 **Extended Medicare Safety Net Cap:** $144.75
225	Professional attendance by a medical practitioner to perform a standard health assessment, lasting more than 30 minutes but less than 45 minutes, including: (a) detailed information collection, including taking a patient history; and (b) an extensive physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing a preventive health care strategy for the patient (See para AN.7.1, AN.7.5, AN.7.6, AN.7.7, AN.7.8, AN.7.9, AN.7.10, AN.7.11, AN.7.12 of explanatory notes to this Category) **Fee:** $112.10 **Benefit:** 100% = $112.10 **Extended Medicare Safety Net Cap:** $336.30
226	Professional attendance by a medical practitioner to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes, including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition and physical function; and (c) initiating interventions and referrals as indicated; and

	(d) providing a basic preventive health care management plan for the patient (See para AN.7.1, AN.7.5, AN.7.6, AN.7.7, AN.7.8, AN.7.9, AN.7.10, AN.7.11, AN.7.12 of explanatory notes to this Category) **Fee:** $154.70 **Benefit:** 100% = $154.70 **Extended Medicare Safety Net Cap:** $464.10
227	Professional attendance by a medical practitioner to perform a prolonged health assessment (lasting at least 60 minutes) including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition, and physical, psychological and social function; and (c) initiating interventions or referrals as indicated; and (d) providing a comprehensive preventive health care management plan for the patient (See para AN.7.1, AN.7.5, AN.7.6, AN.7.7, AN.7.8, AN.7.9, AN.7.10, AN.7.11, AN.7.12 of explanatory notes to this Category) **Fee:** $218.50 **Benefit:** 100% = $218.50 **Extended Medicare Safety Net Cap:** $500.00
228	Professional attendance by a medical practitioner at consulting rooms or in another place other than a hospital or residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent—this item or item 715 not more than once in a 9 month period (See para AN.7.1, AN.7.13, AN.7.14, AN.7.15, AN.7.16 of explanatory notes to this Category) **Fee:** $172.50 **Benefit:** 100% = $172.50 **Extended Medicare Safety Net Cap:** $500.00

	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 6. Non-Specialist Practitioner management plans, team care arrangements and multidisciplinary care plans and case conferences
229	Attendance by a medical practitioner, for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 735 to 758 and items 235 to 240 apply) (See para AN.7.1, AN.7.17 of explanatory notes to this Category) **Fee:** $117.25 **Benefit:** 75% = $87.95 100% = $117.25 **Extended Medicare Safety Net Cap:** $351.75
230	Attendance by a medical practitioner, to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 735 to 758 and items 235 to 240 apply) (See para AN.7.1, AN.7.17 of explanatory notes to this Category) **Fee:** $92.90 **Benefit:** 75% = $69.70 100% = $92.90 **Extended Medicare Safety Net Cap:** $278.70
231	Contribution by a medical practitioner, to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated

	with a service to which any of items 735 to 758 and items 235 to 240 apply) (See para AN.7.1, AN.7.17 of explanatory notes to this Category) **Fee:** $57.25 **Benefit:** 75% = $42.95 100% = $57.25 **Extended Medicare Safety Net Cap:** $171.75
232	Contribution by a medical practitioner, to: (a) a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or (b) a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider (other than a service associated with a service to which items 735 to 758 and items 235 to 240 apply) (See para AN.7.1, AN.7.17 of explanatory notes to this Category) **Fee:** $57.25 **Benefit:** 75% = $42.95 100% = $57.25 **Extended Medicare Safety Net Cap:** $171.75
233	Attendance by a medical practitioner to review or coordinate a review of: (a) a GP management plan prepared by a medical practitioner (or an associated medical practitioner) to which item 721 or item 229 applies; or (b) team care arrangements which have been coordinated by the medical practitioner (or an associated medical practitioner) to which item 723 or item 230 applies (See para AN.7.1, AN.7.17 of explanatory notes to this Category) **Fee:** $58.55 **Benefit:** 75% = $43.95 100% = $58.55 **Extended Medicare Safety Net Cap:** $175.65
235	Attendance by a medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which items 721 to 732 or items 229 to 233 apply) (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $57.45 **Benefit:** 75% = $43.10 100% = $57.45 **Extended Medicare Safety Net Cap:** $172.35
236	Attendance by a medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service

	associated with a service to which items 721 to 732 or items 229 to 233 apply) (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $98.30 **Benefit:** 75% = $73.75 100% = $98.30 **Extended Medicare Safety Net Cap:** $294.90
237	Attendance by a medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes (other than a service associated with a service to which items 721 to 732 or items 229 to 233 apply) (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $163.90 **Benefit:** 75% = $122.95 100% = $163.90 **Extended Medicare Safety Net Cap:** $491.70
238	Attendance by a medical practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which items 721 to 732 or items 229 to 233 apply) (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $42.20 **Benefit:** 75% = $31.65 100% = $42.20 **Extended Medicare Safety Net Cap:** $126.60
239	Attendance by a medical practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which items 721 to 732 or items 229 to 233 apply) (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $72.30 **Benefit:** 75% = $54.25 100% = $72.30 **Extended Medicare Safety Net Cap:** $216.90
240	Attendance by a medical practitioner, as a member of a multidisciplinary case conference team, to participate in:

	(a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes (other than a service associated with a service to which items 721 to 732 or items 229 to 233 apply) (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $120.45 **Benefit:** 75% = $90.35 100% = $120.45 **Extended Medicare Safety Net Cap:** $361.35
243	Attendance by a medical practitioner, as a member of a case conference team, to lead and coordinate a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 3 other medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $66.25 **Benefit:** 75% = $49.70 100% = $66.25 **Extended Medicare Safety Net Cap:** $198.75
244	Attendance by a medical practitioner, as a member of a case conference team, to participate in a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 4 medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $30.85 **Benefit:** 75% = $23.15 100% = $30.85 **Extended Medicare Safety Net Cap:** $92.55

	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 7. Non-Specialist Practitioner domiciliary and residential medication management review
245	Participation by a medical practitioner in a Domiciliary Medication Management Review (DMMR) for a patient living in a community setting, in which the medical practitioner, with the patient's consent: (a) assesses the patient as: (i) having a chronic medical condition or a complex medication regimen; and (ii) not having their therapeutic goals met; and (b) following that assessment: (i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and (ii) provides relevant clinical information required for the DMMR; and (c) discusses with the reviewing pharmacist the results of the DMMR including suggested medication

	management strategies; and (d) develops a written medication management plan following discussion with the patient; and (e) provides the written medication management plan to a community pharmacy chosen by the patient For any particular patient—this item or item 900 is applicable not more than once in each 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (See para AN.7.1, AN.7.18 of explanatory notes to this Category) **Fee:** $125.85 **Benefit:** 100% = $125.85 **Extended Medicare Safety Net Cap:** $377.55
249	Participation by a medical practitioner in a residential medication management review (RMMR) for a patient who is a permanent resident of a residential aged care facility—other than an RMMR for a resident in relation to whom, in the preceding 12 months, this item or item 903 has applied, unless there has been a significant change in the resident's medical condition or medication management plan requiring a new RMMR (See para AN.7.1, AN.7.18 of explanatory notes to this Category) **Fee:** $86.15 **Benefit:** 100% = $86.15 **Extended Medicare Safety Net Cap:** $258.45

	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 8. Non-Specialist Practitioner attendances associated with Practice Incentive Program payments
251	Professional attendance at consulting rooms of less than 5 minutes in duration by a medical practitioner in an eligible area at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.7.1, AN.7.19 of explanatory notes to this Category) **Fee:** $13.75 **Benefit:** 100% = $13.75 **Extended Medicare Safety Net Cap:** $41.25
252	Professional attendance at consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner in an eligible area, at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.7.1, AN.7.19 of explanatory notes to this Category) **Fee:** $30.10 **Benefit:** 100% = $30.10 **Extended Medicare Safety Net Cap:** $90.30
253	Professional attendance at a place other than consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner in an eligible area, at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.7.1, AN.7.19 of explanatory notes to this Category)

	Derived Fee: The fee for item 252, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 252 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
254	Professional attendance at consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner in an eligible area, at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.7.1, AN.7.19 of explanatory notes to this Category) **Fee:** $58.30 **Benefit:** 100% = $58.30 **Extended Medicare Safety Net Cap:** $174.90
255	Professional attendance at a place other than consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner in an eligible area, at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.7.1, AN.7.19 of explanatory notes to this Category) **Derived Fee:** The fee for item 254, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 254 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
256	Professional attendance at consulting rooms of more than 45 minutes in duration by a medical practitioner in an eligible area, at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.7.1, AN.7.19 of explanatory notes to this Category) **Fee:** $85.80 **Benefit:** 100% = $85.80 **Extended Medicare Safety Net Cap:** $257.40
257	Professional attendance at a place other than consulting rooms of more than 45 minutes in duration by a medical practitioner in an eligible area, at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.7.1, AN.7.19 of explanatory notes to this Category) **Derived Fee:** The fee for item 256, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 256 plus $1.65 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
259	Professional attendance at consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.7.1, AN.7.20 of explanatory notes to this Category) **Fee:** $30.10 **Benefit:** 100% = $30.10 **Extended Medicare Safety Net Cap:** $90.30
260	Professional attendance at a place other than consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.7.1, AN.7.20 of explanatory notes to this Category)

	Derived Fee: The fee for item 259, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 259 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
261	Professional attendance at consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.7.1, AN.7.20 of explanatory notes to this Category) **Fee:** $58.30 **Benefit:** 100% = $58.30 **Extended Medicare Safety Net Cap:** $174.90
262	Professional attendance at a place other than consulting rooms of more than 25 minutes but not more than 45 minutes, in duration by a medical practitioner in an eligible area, that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.7.1, AN.7.20 of explanatory notes to this Category) **Derived Fee:** The fee for item 261, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 261 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
263	Professional attendance at consulting rooms of more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.7.1, AN.7.20 of explanatory notes to this Category) **Fee:** $85.80 **Benefit:** 100% = $85.80 **Extended Medicare Safety Net Cap:** $257.40
264	Professional attendance at a place other than consulting rooms of more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.7.1, AN.7.20 of explanatory notes to this Category) **Derived Fee:** The fee for item 263, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 263 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
265	Professional attendance at consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements of the Asthma Cycle of Care (See para AN.7.1, AN.7.21 of explanatory notes to this Category) **Fee:** $30.10 **Benefit:** 100% = $30.10 **Extended Medicare Safety Net Cap:** $90.30
266	Professional attendance at a place other than consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements of the Asthma Cycle of Care (See para AN.7.1, AN.7.21 of explanatory notes to this Category) **Derived Fee:** The fee for item 265, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 265 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
268	Professional attendance at consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements of the

	Asthma Cycle of Care (See para AN.7.1, AN.7.21 of explanatory notes to this Category) **Fee:** $58.30 **Benefit:** 100% = $58.30 **Extended Medicare Safety Net Cap:** $174.90
269	Professional attendance at a place other than consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements of the Asthma Cycle of Care (See para AN.7.1, AN.7.21 of explanatory notes to this Category) **Derived Fee:** The fee for item 268, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 268 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
270	Professional attendance at consulting rooms of more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements of the Asthma Cycle of Care (See para AN.7.1, AN.7.21 of explanatory notes to this Category) **Fee:** $85.80 **Benefit:** 100% = $85.80 **Extended Medicare Safety Net Cap:** $257.40
271	Professional attendance at a place other than consulting rooms of more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements of the Asthma Cycle of Care (See para AN.7.1, AN.7.21 of explanatory notes to this Category) **Derived Fee:** The fee for item 270, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 270 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 9. Non-Specialist Practitioner mental health care
272	Professional attendance by a medical practitioner (who has not undertaken mental health skills training) of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.7.1, AN.7.22 of explanatory notes to this Category) **Fee:** $58.30 **Benefit:** 75% = $43.75 100% = $58.30 **Extended Medicare Safety Net Cap:** $174.90
276	Professional attendance by a medical practitioner (who has not undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.7.1, AN.7.22 of explanatory notes to this Category) **Fee:** $85.80 **Benefit:** 75% = $64.35 100% = $85.80 **Extended Medicare Safety Net Cap:** $257.40
277	Professional attendance by a medical practitioner to review a GP mental health treatment plan which he or she, or an associated medical practitioner has prepared, or to review a Psychiatrist Assessment and Management Plan (See para AN.7.1, AN.7.22 of explanatory notes to this Category) **Fee:** $58.30 **Benefit:** 75% = $43.75 100% = $58.30

	Extended Medicare Safety Net Cap: $174.90
279	Professional attendance by a medical practitioner in relation to a mental disorder and of at least 20 minutes in duration, involving taking relevant history and identifying the presenting problem (to the extent not previously recorded), providing treatment and advice and, if appropriate, referral for other services or treatments, and documenting the outcomes of the consultation (See para AN.7.1, AN.7.22 of explanatory notes to this Category) **Fee:** $58.30 **Benefit:** 75% = $43.75 100% = $58.30 **Extended Medicare Safety Net Cap:** $174.90
281	Professional attendance by a medical practitioner (who has undertaken mental health skills training) of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.7.1, AN.7.22 of explanatory notes to this Category) **Fee:** $74.00 **Benefit:** 75% = $55.50 100% = $74.00 **Extended Medicare Safety Net Cap:** $222.00
282	Professional attendance by a medical practitioner (who has undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.7.1, AN.7.22 of explanatory notes to this Category) **Fee:** $109.00 **Benefit:** 75% = $81.75 100% = $109.00 **Extended Medicare Safety Net Cap:** $327.00
283	Professional attendance at consulting rooms by a medical practitioner, for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes (See para AN.7.1, AN.7.23 of explanatory notes to this Category) **Fee:** $75.40 **Benefit:** 100% = $75.40 **Extended Medicare Safety Net Cap:** $226.20
285	Professional attendance at a place other than consulting rooms by a medical practitioner, for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes (See para AN.7.1, AN.7.23 of explanatory notes to this Category) **Derived Fee:** The fee for item 283, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 283 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
286	Professional attendance at consulting rooms by a medical practitioner, for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 40 minutes (See para AN.7.1, AN.7.23 of explanatory notes to this Category) **Fee:** $107.90 **Benefit:** 100% = $107.90 **Extended Medicare Safety Net Cap:** $323.70
287	Professional attendance at a place other than consulting rooms by a medical practitioner, for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 40 minutes (See para AN.7.1, AN.7.23 of explanatory notes to this Category) **Derived Fee:** The fee for item 286, plus $21.10 divided by the number of patients seen, up to a maximum of six

	patients. For seven or more patients - the fee for item 286 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
371	Professional attendance at consulting rooms by a medical practitioner, for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient is located within a telehealth area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the medical practitioner. (See para AN.7.1, AN.7.23 of explanatory notes to this Category) **Fee:** $75.40 **Benefit:** 100% = $75.40 **Extended Medicare Safety Net Cap:** $226.20
372	Professional attendance at consulting rooms by a medical practitioner, for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 40 minutes if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient is located within a telehealth area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the medical practitioner. (See para AN.7.1, AN.7.23 of explanatory notes to this Category) **Fee:** $107.90 **Benefit:** 100% = $107.90 **Extended Medicare Safety Net Cap:** $323.70

	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 10. Non-Specialist Practitioner after-hours attendances to which no other item applies
733	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which another item applies) by a medical practitioner—each attendance (See para AN.7.1, AN.7.24, GN.7.17 of explanatory notes to this Category) **Fee:** $23.55 **Benefit:** 100% = $23.55 **Extended Medicare Safety Net Cap:** $70.65
737	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes in duration (other than a service to which another item applies) by a medical practitioner—each attendance (See para AN.7.1, AN.7.24, GN.7.17 of explanatory notes to this Category) **Fee:** $39.85 **Benefit:** 100% = $39.85

	Extended Medicare Safety Net Cap: $119.55
741	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes in duration (other than a service to which another item applies) by a medical practitioner—each attendance (See para AN.7.1, AN.7.24, GN.7.17 of explanatory notes to this Category) **Fee:** $68.25 **Benefit:** 100% = $68.25 **Extended Medicare Safety Net Cap:** $204.75
745	Professional attendance at consulting rooms of more than 45 minutes in duration (other than a service to which another item applies) by a medical practitioner—each attendance (See para AN.7.1, AN.7.24, GN.7.17 of explanatory notes to this Category) **Fee:** $95.70 **Benefit:** 100% = $95.70 **Extended Medicare Safety Net Cap:** $287.10
761	Professional attendance by a medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting not more than 5 minutes—an attendance on one or more patients on one occasion—each patient (See para AN.7.1, AN.7.24, GN.7.17 of explanatory notes to this Category) **Derived Fee:** The fee for item 733, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 733 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
763	Professional attendance by a medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 5 minutes, but not more than 25 minutes—an attendance on one or more patients on one occasion—each patient (See para AN.7.1, AN.7.24, GN.7.17 of explanatory notes to this Category) **Derived Fee:** The fee for item 737, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 737 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
766	Professional attendance by a medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 25 minutes, but not more than 45 minutes—an attendance on one or more patients on one occasion—each patient (See para AN.7.1, AN.7.24, GN.7.17 of explanatory notes to this Category) **Derived Fee:** The fee for item 741, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 741 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
769	Professional attendance by a medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 45 minutes—an attendance on one or more patients on one occasion—each patient (See para AN.7.1, AN.7.24, GN.7.17 of explanatory notes to this Category) **Derived Fee:** The fee for item 745, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 745 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
772	Professional attendance (other than a service to which another 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 if the patient is accommodated in the residential aged care facility (other than accommodation in a self contained unit) of not more than 5 minutes in duration by a medical practitioner—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.7.1, AN.7.24, GN.7.17 of explanatory notes to this Category) **Derived Fee:** The fee for item 733, plus $37.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 733 plus $2.70 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
776	Professional attendance (other than a service to which another 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 if the patient is accommodated in the residential aged care facility (other than accommodation in a self contained unit) of more than 5 minutes in duration but not more than 25 minutes in duration by a medical practitioner—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.7.1, AN.7.24, GN.7.17 of explanatory notes to this Category) **Derived Fee:** The fee for item 737, plus $37.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 737 plus $2.70 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
788	Professional attendance (other than a service to which another 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 if the patient is accommodated in the residential aged care facility (other than accommodation in a self contained unit) of more than 25 minutes in duration but not more than 45 minutes by a medical practitioner—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.7.1, AN.7.24, GN.7.17 of explanatory notes to this Category) **Derived Fee:** The fee for item 741, plus $37.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 741 plus $2.70 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
789	Professional attendance (other than a service to which another 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 if the patient is accommodated in the residential aged care facility (other than accommodation in a self contained unit) of more than 45 minutes in duration by a medical practitioner—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.7.1, AN.7.24, GN.7.17 of explanatory notes to this Category) **Derived Fee:** The fee for item 745, plus $37.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 745 plus $2.70 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 11. Non-Specialist Practitioner pregnancy support counselling
792	Professional attendance of at least 20 minutes in duration at consulting rooms by a medical practitioner who is registered with the Chief Executive Medicare as meeting the credentialing requirements for

	provision of this service for the purpose of providing non-directive pregnancy support counselling to a person who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item or items 4001, 81000, 81005 or 81010 applies in relation to that pregnancy (See para AN.7.1, AN.7.25 of explanatory notes to this Category) **Fee:** $62.30 **Benefit:** 100% = $62.30 **Extended Medicare Safety Net Cap:** $186.90

	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 12. Non-Specialist Practitioner video conferencing consultation
812	Professional attendance at consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service: for which a direction made under subsection 19(2) of the Act applies (See para AN.7.1, AN.7.26 of explanatory notes to this Category) **Fee:** $18.60 **Benefit:** 100% = $18.60 **Extended Medicare Safety Net Cap:** $55.80
827	Professional attendance not in consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both:

	(i) within a telehealth eligible area; and (ii) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion—each patient (See para AN.7.1, AN.7.26 of explanatory notes to this Category) **Derived Fee:** The fee for item 812, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 812 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
829	Professional attendance of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion—each patient (See para AN.7.1, AN.7.26 of explanatory notes to this Category) **Derived Fee:** The fee for item 812, plus $37.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 812 plus $2.70 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
867	Professional attendance at consulting rooms of less than 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.7.1, AN.7.26 of explanatory notes to this Category) **Fee:** $40.60 **Benefit:** 100% = $40.60 **Extended Medicare Safety Net Cap:** $121.80
868	Professional attendance not in consulting rooms of less than 20 minutes in duration (whether or not

	continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion—each patient (See para AN.7.1, AN.7.26 of explanatory notes to this Category) **Derived Fee:** The fee for item 867, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 867 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
869	Professional attendance of less than 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion—each patient (See para AN.7.1, AN.7.26 of explanatory notes to this Category) **Derived Fee:** The fee for item 867, plus $37.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 867 plus $2.70 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
873	Professional attendance at consulting rooms of at least 20 minutes in duration (whether or not continuous) by a medical practitioner who provides clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of:

	(A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service: for which a direction made under subsection 19(2) of the Act applies (See para AN.7.1, AN.7.26 of explanatory notes to this Category) **Fee:** $78.70 **Benefit:** 100% = $78.70 **Extended Medicare Safety Net Cap:** $236.10
876	Professional attendance not in consulting rooms of at least 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion—each patient (See para AN.7.1, AN.7.26 of explanatory notes to this Category) **Derived Fee:** The fee for item 873, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 873 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
881	Professional attendance of at least 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion—each patient (See para AN.7.1, AN.7.26 of explanatory notes to this Category) **Derived Fee:** The fee for item 873, plus $37.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 873 plus $2.70 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
885	Professional attendance at consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either:

	(i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.7.1, AN.7.26 of explanatory notes to this Category) **Fee:** $115.85 **Benefit:** 100% = $115.85 **Extended Medicare Safety Net Cap:** $347.55
891	Professional attendance not in consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion—each patient (See para AN.7.1, AN.7.26 of explanatory notes to this Category) **Derived Fee:** The fee for item 885, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 885 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
892	Professional attendance of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion—each patient (See para AN.7.1, AN.7.26 of explanatory notes to this Category) **Derived Fee:** The fee for item 885, plus $37.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 885 plus $2.70 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

894	Professional attendance at consulting rooms by a medical practitioner, lasting more than 5 minutes but not more than 25 minutes, for providing mental health services to a patient with mental health issues, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient and the medical practitioner are located within a drought affected eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the medical practitioner; and (e) the patient has an existing relationship with the medical practitioner. **Fee:** $35.90 **Benefit:** 85% = $30.55 **Extended Medicare Safety Net Cap:** $107.70
896	Professional attendance at consulting rooms by a medical practitioner, lasting more than 25 minutes but not more than 45 minutes, for providing mental health services to a patient with mental health issues, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient and the medical practitioner are located within a drought affected eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the medical practitioner; and (e) the patient has an existing relationship with the medical practitioner. **Fee:** $69.55 **Benefit:** 85% = $59.15 **Extended Medicare Safety Net Cap:** $208.65
898	Professional attendance at consulting rooms by a medical practitioner, lasting more than 45 minutes, for providing mental health services to a patient with mental health issues, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient and the medical practitioner are located within a drought affected eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the medical practitioner; and (e) the patient has an existing relationship with the medical practitioner. **Fee:** $102.45 **Benefit:** 85% = $87.10 **Extended Medicare Safety Net Cap:** $307.35

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

	Group A8. Consultant Psychiatrist Attendances To Which No Other Item Applies
Amend 288	Professional attendance on a patient by a consultant physician practising in the consultant physician's specialty of psychiatry if:

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(a) the attendance is by video conference; and (b) item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 348, 350 or 352 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.0.68 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 291, 293,296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 348, 350 or 352.Benefit: 85% of derived fee. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Amend 289	Professional attendance of at least 45 minutes in duration at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant by a referring practitioner, for assessment, diagnosis and preparation of a treatment and management plan for a patient under 13 years with autism or another pervasive developmental disorder, if the consultant psychiatrist does all of the following: (a) undertakes a comprehensive assessment and makes a diagnosis (if appropriate, using information provided by an eligible allied health provider); (b) develops a treatment and management plan which must include the following: (i) an assessment and diagnosis of the patient's condition; (ii) a risk assessment; (iii) treatment options and decisions; (iv) if necessary-medication recommendations; (c) provides a copy of the treatment and management plan to the referring practitioner; (d) provides a copy of the treatment and management plan to one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	135, 137 or 139) (See para AN.0.24 of explanatory notes to this Category) **Fee:** $272.15 **Benefit:** 75% = $204.15 85% = $231.35 **Extended Medicare Safety Net Cap:** $500.00
Amend 291	Professional attendance of more than 45 minutes in duration at consulting rooms by a consultant physician in the practice of the consultant physician's specialty of psychiatry, if: (a) the attendance follows referral of the patient to the consultant for an assessment or management by a medical practitioner in general practice (including a general practitioner, but not a specialist or consultant physician) or a participating nurse practitioner; and (b) during the attendance, the consultant: (i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (c) the consultant decides that it is clinically appropriate for the patient to be managed by the referring practitioner without ongoing treatment by the consultant; and (d) within 2 weeks after the attendance, the consultant: (i) prepares a written diagnosis of the patient; and (ii) prepares a written management plan for the patient that: (A) covers the next 12 months; and (B) is appropriate to the patient's diagnosis; and (C) comprehensively evaluates the patient's biological, psychological and social issues; and (D) addresses the patient's diagnostic psychiatric issues; and (E) makes management recommendations addressing the patient's biological, psychological and social issues; and (iii) gives the referring practitioner a copy of the diagnosis and the management plan; and (iv) if clinically appropriate, explains the diagnosis and management plan, and a gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees (See para AN.0.30 of explanatory notes to this Category) **Fee:** $466.80 **Benefit:** 85% = $396.80 **Extended Medicare Safety Net Cap:** $500.00
Amend 293	Professional attendance of more than 30 minutes but not more than 45 minutes in duration at consulting rooms by a consultant physician in the practice of the consultant physician's specialty of psychiatry, if: (a) the patient is being managed by a medical practitioner or a participating nurse practitioner in

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	accordance with a management plan prepared by the consultant in accordance with item 291; and (b) the attendance follows referral of the patient to the consultant for review of the management plan by the medical practitioner or a participating nurse practitioner managing the patient; and (c) during the attendance, the consultant: (i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (iv) reviews the management plan; and (d) within 2 weeks after the attendance, the consultant: (i) prepares a written diagnosis of the patient; and (ii) revises the management plan; and (iii) gives the referring practitioner a copy of the diagnosis and the revised management plan; and (iv) if clinically appropriate, explains the diagnosis and the revised management plan, and gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees; and (e) in the preceding 12 months, a service to which item 291 applies has been provided; and (f) in the preceding 12 months, a service to which this item or item 293 applies has not been provided (See para AN.0.30 of explanatory notes to this Category) **Fee:** $291.80 **Benefit:** 85% = $248.05 **Extended Medicare Safety Net Cap:** $500.00
Amend 296	Professional attendance of more than 45 minutes in duration by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance at consulting rooms if the patient: (a) is a new patient for this consultant psychiatrist; or (b) has not received a professional attendance from this consultant psychiatrist in the preceding 24 months; other than attendance on a patient in relation to whom this item, item 297 or 299, or any of items 300 to 346, 353 to 358 and 361 to 370, has applied in the preceding 24 months (See para AN.0.30 of explanatory notes to this Category) **Fee:** $268.45 **Benefit:** 75% = $201.35 85% = $228.20 **Extended Medicare Safety Net Cap:** $500.00
Amend 297	Professional attendance of more than 45 minutes by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to him or her by a

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	referring practitioner-an attendance at hospital if the patient: (a) is a new patient for this consultant psychiatrist; or (b) has not received a professional attendance from this consultant psychiatrist in the preceding 24 months; other than attendance on a patient in relation to whom this item, item 296 or 299, or any of items 300 to 346, 353 to 358 and 361 to 370, has applied in the preceding 24 months (H) (See para AN.0.30 of explanatory notes to this Category) **Fee:** $268.45 **Benefit:** 75% = $201.35 85% = $228.20 **Extended Medicare Safety Net Cap:** $500.00
Amend 299	Professional attendance of more than 45 minutes by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance at a place other than consulting rooms or a hospital if the patient: (a) is a new patient for this consultant psychiatrist; or (b) has not received a professional attendance from this consultant psychiatrist in the preceding 24 months; other than attendance on a patient in relation to whom this item, item 296 or 297, or any of items 300 to 346, 353 to 358 and 361 to 370, has applied in the preceding 24 months (See para AN.0.30 of explanatory notes to this Category) **Fee:** $321.00 **Benefit:** 75% = $240.75 85% = $272.85 **Extended Medicare Safety Net Cap:** $500.00
Amend 300	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of not more than 15 minutes in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient **Fee:** $44.70 **Benefit:** 75% = $33.55 85% = $38.00 **Extended Medicare Safety Net Cap:** $134.10
Amend 302	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 15 minutes, but not more than 30 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient **Fee:** $89.15 **Benefit:** 75% = $66.90 85% = $75.80 **Extended Medicare Safety Net Cap:** $267.45
Amend 304	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration at consulting rooms), if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient **Fee:** $137.25 **Benefit:** 75% = $102.95 85% = $116.70 **Extended Medicare Safety Net Cap:** $411.75
Amend 306	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	more than 45 minutes, but not more than 75 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient **Fee:** $189.40 **Benefit:** 75% = $142.05 85% = $161.00 **Extended Medicare Safety Net Cap:** $500.00
Amend 308	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 75 minutes in duration at consulting rooms), if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient **Fee:** $219.80 **Benefit:** 75% = $164.85 85% = $186.85 **Extended Medicare Safety Net Cap:** $500.00
Amend 310	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of not more than 15 minutes in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient **Fee:** $22.25 **Benefit:** 75% = $16.70 85% = $18.95 **Extended Medicare Safety Net Cap:** $66.75
Amend 312	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 15 minutes, but not more than 30 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient **Fee:** $44.70 **Benefit:** 75% = $33.55 85% = $38.00 **Extended Medicare Safety Net Cap:** $134.10
Amend 314	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient **Fee:** $68.75 **Benefit:** 75% = $51.60 85% = $58.45 **Extended Medicare Safety Net Cap:** $206.25
Amend 316	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 45 minutes, but not more than 75 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient **Fee:** $94.85 **Benefit:** 75% = $71.15 85% = $80.65 **Extended Medicare Safety Net Cap:** $284.55
Amend 318	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 75 minutes in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient **Fee:** $109.95 **Benefit:** 75% = $82.50 85% = $93.50

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Extended Medicare Safety Net Cap: $329.85
Amend 319	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 45 minutes in duration at consulting rooms, if 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; if that attendance and another attendance to which any of items 296, 300 to 319, 353 to 358 and 361 to 370 applies have not exceeded 160 attendances in a calendar year for the patient (See para AN.0.31 of explanatory notes to this Category) **Fee:** $189.40 **Benefit:** 75% = $142.05 85% = $161.00 **Extended Medicare Safety Net Cap:** $500.00
Amend 320	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of not more than 15 minutes in duration at hospital **Fee:** $44.70 **Benefit:** 75% = $33.55 85% = $38.00 **Extended Medicare Safety Net Cap:** $134.10
Amend 322	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 15 minutes, but not more than 30 minutes, in duration at hospital **Fee:** $89.15 **Benefit:** 75% = $66.90 85% = $75.80 **Extended Medicare Safety Net Cap:** $267.45
Amend 324	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration at hospital **Fee:** $137.25 **Benefit:** 75% = $102.95 85% = $116.70 **Extended Medicare Safety Net Cap:** $411.75
Amend 326	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 45 minutes, but not more than 75 minutes, in duration at hospital **Fee:** $189.40 **Benefit:** 75% = $142.05 85% = $161.00 **Extended Medicare Safety Net Cap:** $500.00
Amend 328	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 75 minutes in duration at hospital **Fee:** $219.80 **Benefit:** 75% = $164.85 85% = $186.85 **Extended Medicare Safety Net Cap:** $500.00
Amend 330	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of not more than 15 minutes in duration if that attendance is at a place other than consulting rooms or hospital

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Fee: $82.05 **Benefit:** 75% = $61.55 85% = $69.75 **Extended Medicare Safety Net Cap:** $246.15
Amend 332	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 15 minutes, but not more than 30 minutes, in duration if that attendance is at a place other than consulting rooms or hospital **Fee:** $128.50 **Benefit:** 75% = $96.40 85% = $109.25 **Extended Medicare Safety Net Cap:** $385.50
Amend 334	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration if that attendance is at a place other than consulting rooms or hospital **Fee:** $187.30 **Benefit:** 75% = $140.50 85% = $159.25 **Extended Medicare Safety Net Cap:** $500.00
Amend 336	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 45 minutes, but not more than 75 minutes, in duration if that attendance is at a place other than consulting rooms or hospital **Fee:** $226.60 **Benefit:** 75% = $169.95 85% = $192.65 **Extended Medicare Safety Net Cap:** $500.00
Amend 338	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 75 minutes in duration if that attendance is at a place other than consulting rooms or hospital **Fee:** $257.35 **Benefit:** 75% = $193.05 85% = $218.75 **Extended Medicare Safety Net Cap:** $500.00
Amend 342	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 hour in duration given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's 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 referring practitioner-each patient (See para AN.0.5 of explanatory notes to this Category) **Fee:** $50.85 **Benefit:** 75% = $38.15 85% = $43.25 **Extended Medicare Safety Net Cap:** $152.55
Amend 344	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 hour in duration given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry, involving a family group of 3 patients, each of whom is referred to the consultant physician by a referring practitioner-each patient (See para AN.0.5 of explanatory notes to this Category) **Fee:** $67.50 **Benefit:** 75% = $50.65 85% = $57.40 **Extended Medicare Safety Net Cap:** $202.50
Amend 346	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 hour in duration given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry, involving a family group of 2 patients, each of whom is

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	referred to the consultant physician by a referring practitioner-each patient (See para AN.0.5 of explanatory notes to this Category) **Fee:** $99.80 **Benefit:** 75% = $74.85 85% = $84.85 **Extended Medicare Safety Net Cap:** $299.40
Amend 348	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant physician by a referring practitioner, involving an interview of a person other than the patient of not less than 20 minutes, but less than 45 minutes, in duration, in the course of initial diagnostic evaluation of a patient (See para AN.0.32, AN.0.5 of explanatory notes to this Category) **Fee:** $130.70 **Benefit:** 75% = $98.05 85% = $111.10 **Extended Medicare Safety Net Cap:** $392.10
Amend 350	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant physician by a referring practitioner, involving an interview of a person other than the patient of not less than 45 minutes in duration, in the course of initial diagnostic evaluation of a patient (See para AN.0.32, AN.0.5 of explanatory notes to this Category) **Fee:** $180.45 **Benefit:** 75% = $135.35 85% = $153.40 **Extended Medicare Safety Net Cap:** $500.00
Amend 352	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant physician by a referring practitioner, involving an interview of a person other than the patient of not less than 20 minutes in duration, in the course of continuing management of a patient-if that attendance and another attendance to which this item applies have not exceeded 4 in a calendar year for the patient (See para AN.0.32, AN.0.5 of explanatory notes to this Category) **Fee:** $130.70 **Benefit:** 75% = $98.05 85% = $111.10 **Extended Medicare Safety Net Cap:** $392.10
Amend 353	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a telepsychiatry consultation of not more than 15 minutes in duration, if: (a) that attendance and another attendance to which any of items 353 to 358 and 361 applies have not exceeded 12 attendances in a calendar year for the patient; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient (See para AN.0.59 of explanatory notes to this Category) **Fee:** $59.00 **Benefit:** 75% = $44.25 85% = $50.15 **Extended Medicare Safety Net Cap:** $177.00
Amend 355	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a telepsychiatry consultation of more than 15 minutes, but not more than 30 minutes, in duration, if: (a) that attendance and another attendance to which any of items 353 to 358 and 361 applies have not exceeded 12 attendances in a calendar year for the patient; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient (See para AN.0.59 of explanatory notes to this Category)

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Fee: $118.00 **Benefit:** 75% = $88.50 85% = $100.30 **Extended Medicare Safety Net Cap:** $354.00
Amend 356	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a telepsychiatry consultation of more than 30 minutes, but not more than 45 minutes, in duration, if: (a) that attendance and another attendance to which any of items 353 to 358 and 361 applies have not exceeded 12 attendances in a calendar year for the patient; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient (See para AN.0.59 of explanatory notes to this Category) **Fee:** $173.00 **Benefit:** 75% = $129.75 85% = $147.05 **Extended Medicare Safety Net Cap:** $500.00
Amend 357	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a telepsychiatry consultation of more than 45 minutes, but not more than 75 minutes, in duration, if: (a) that attendance and another attendance to which any of items 353 to 358 and 361 applies have not exceeded 12 attendances in a calendar year for the patient; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient (See para AN.0.59 of explanatory notes to this Category) **Fee:** $238.65 **Benefit:** 75% = $179.00 85% = $202.90 **Extended Medicare Safety Net Cap:** $500.00
Amend 358	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a telepsychiatry consultation of more than 75 minutes in duration, if: (a) that attendance and another attendance to which any of items 353 to 358 and 361 applies have not exceeded 12 attendances in a calendar year for the patient; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient (See para AN.0.59 of explanatory notes to this Category) **Fee:** $290.85 **Benefit:** 75% = $218.15 85% = $247.25 **Extended Medicare Safety Net Cap:** $500.00
Amend 359	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry-a telepsychiatry consultation of more than 30 minutes but not more than 45 minutes in duration, if: (a) the patient is being managed by a medical practitioner or a participating nurse practitioner in accordance with a management plan prepared by the consultant physician in accordance with item 291; and (b) the attendance follows referral of the patient to the consultant physician for review of the management plan by the referring practitioner managing the patient; and (c) during the attendance, the consultant physician:

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (iv) reviews the management plan; and (d) within 2 weeks after the attendance, the consultant physician: (i) prepares a written diagnosis of the patient; and (ii) revises the management plan; and (iii) gives the referring practitioner a copy of the diagnosis and the revised management plan; and (iv) if clinically appropriate, explains the diagnosis and the revised management plan, and gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees; and (e) the patient is located in a regional, rural or remote area; and (f) in the preceding 12 months, a service to which item 291 applies has been performed; and (g) in the preceding 12 months, a service to which this item or item 293 applies has not been performed (See para AN.0.59, AN.0.30 of explanatory notes to this Category) **Fee:** $335.55 **Benefit:** 75% = $251.70 85% = $285.25 **Extended Medicare Safety Net Cap:** $500.00
Amend 361	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a telepsychiatry consultation of more than 45 minutes in duration, if the patient: (a) either: (i) is a new patient for this consultant physician; or (ii) has not received a professional attendance from this consultant physician in the preceding 24 months; and (b) is located in a regional, rural or remote area; other than attendance on a patient in relation to whom this item, item 296, 297 or 299, or any of items 300 to 346 and 353 to 370, has applied in the preceding 24 month period (See para AN.0.59, AN.0.30 of explanatory notes to this Category) **Fee:** $308.65 **Benefit:** 75% = $231.50 85% = $262.40 **Extended Medicare Safety Net Cap:** $500.00
Amend 364	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a face-to-face consultation of not more than 15 minutes in duration, if:

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(a) the patient has had a telepsychiatry consultation to which any of items 353 to 358 and 361 applies before that attendance; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient (See para AN.0.59 of explanatory notes to this Category) **Fee:** $44.70 **Benefit:** 75% = $33.55 85% = $38.00 **Extended Medicare Safety Net Cap:** $134.10
Amend 366	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a face-to-face consultation of more than 15 minutes, but not more than 30 minutes, in duration, if: (a) the patient has had a telepsychiatry consultation to which any of items 353 to 358 and 361 applies before that attendance; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient (See para AN.0.59 of explanatory notes to this Category) **Fee:** $89.15 **Benefit:** 75% = $66.90 85% = $75.80 **Extended Medicare Safety Net Cap:** $267.45
Amend 367	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a face-to-face consultation of more than 30 minutes, but not more than 45 minutes, in duration, if: (a) the patient has had a telepsychiatry consultation to which any of items 353 to 358 and 361 applies before that attendance; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient (See para AN.0.59 of explanatory notes to this Category) **Fee:** $137.25 **Benefit:** 75% = $102.95 85% = $116.70 **Extended Medicare Safety Net Cap:** $411.75
Amend 369	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a face-to-face consultation of more than 45 minutes, but not more than 75 minutes, in duration, if: (a) the patient has had a telepsychiatry consultation to which any of items 353 to 358 and 361 applies before that attendance; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient (See para AN.0.59 of explanatory notes to this Category) **Fee:** $189.55 **Benefit:** 75% = $142.20 85% = $161.15 **Extended Medicare Safety Net Cap:** $500.00
Amend 370	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a face-to-face consultation of more than 75 minutes in duration, if: (a) the patient has had a telepsychiatry consultation to which any of items 353 to 358 and 361 applies

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	before that attendance; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient (See para AN.0.59 of explanatory notes to this Category) **Fee:** $219.80 **Benefit:** 75% = $164.85 85% = $186.85 **Extended Medicare Safety Net Cap:** $500.00
A9. CONTACT LENSES - ATTENDANCES	
	Group A9. Contact Lenses - Attendances
10801	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-one service in any period of 36 months-patient with myopia of 5.0 dioptres or greater (spherical equivalent) in one eye (See para AN.0.34 of explanatory notes to this Category) **Fee:** $125.45 **Benefit:** 75% = $94.10 85% = $106.65 **Extended Medicare Safety Net Cap:** $376.35
10802	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-one service in any period of 36 months-patient with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in one eye (See para AN.0.34 of explanatory notes to this Category) **Fee:** $125.45 **Benefit:** 75% = $94.10 85% = $106.65 **Extended Medicare Safety Net Cap:** $376.35
10803	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-one service in any period of 36 months-patient with astigmatism of 3.0 dioptres or greater in one eye (See para AN.0.34 of explanatory notes to this Category) **Fee:** $125.45 **Benefit:** 75% = $94.10 85% = $106.65 **Extended Medicare Safety Net Cap:** $376.35
10804	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-one service in any period of 36 months-patient 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 (See para AN.0.34 of explanatory notes to this Category) **Fee:** $125.45 **Benefit:** 75% = $94.10 85% = $106.65 **Extended Medicare Safety Net Cap:** $376.35
10805	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-one service in any period of 36 months-patient with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents) (See para AN.0.34 of explanatory notes to this Category) **Fee:** $125.45 **Benefit:** 75% = $94.10 85% = $106.65 **Extended Medicare Safety Net Cap:** $376.35
10806	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-one service in any period of 36 months-patient with corrected visual acuity of 0.7 logMAR (6/30) or worse in both eyes and for whom a contact lens is prescribed as part of a telescopic system

A9. CONTACT LENSES - ATTENDANCES	
	(See para AN.0.34 of explanatory notes to this Category) **Fee:** $125.45 **Benefit:** 75% = $94.10 85% = $106.65 **Extended Medicare Safety Net Cap:** $376.35
10807	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-one service in any period of 36 months-patient 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 (See para AN.0.34 of explanatory notes to this Category) **Fee:** $125.45 **Benefit:** 75% = $94.10 85% = $106.65 **Extended Medicare Safety Net Cap:** $376.35
10808	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-one service in any period of 36 months-patient who, because of physical deformity, are unable to wear spectacles (See para AN.0.34 of explanatory notes to this Category) **Fee:** $125.45 **Benefit:** 75% = $94.10 85% = $106.65 **Extended Medicare Safety Net Cap:** $376.35
10809	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-one service in any period of 36 months-patient with 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, if the condition is specified on the patient's account (See para AN.0.34 of explanatory notes to this Category) **Fee:** $125.45 **Benefit:** 75% = $94.10 85% = $106.65 **Extended Medicare Safety Net Cap:** $376.35
10816	Attendance for the refitting of contact lenses with keratometry and testing with trial lenses and the issue of a prescription, if 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 after the fitting of a contact lens to which items 10801 to 10809 apply (See para AN.0.35 of explanatory notes to this Category) **Fee:** $125.45 **Benefit:** 75% = $94.10 85% = $106.65 **Extended Medicare Safety Net Cap:** $376.35

A10. OPTOMETRICAL SERVICES	1. GENERAL
	Group A10. Optometrical Services
	Subgroup 1. General
10905	REFERRED COMPREHENSIVE INITIAL CONSULTATION Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has been referred by another optometrist who is not associated with the optometrist to whom the patient is referred (See para AN.0.10 of explanatory notes to this Category) **Fee:** $67.85 **Benefit:** 85% = $57.70
10907	COMPREHENSIVE INITIAL CONSULTATION BY ANOTHER PRACTITIONER

	Professional attendance of more than 15 minutes in duration, being the first in a course of attention if the patient has attended another optometrist for an attendance to which this item or item 10905, 10910, 10911, 10912, 10913, 10914 or 10915 applies, or to which old item 10900 applied: (a) for a patient who is less than 65 years of age-within the previous 36 months; or (b) for a patient who is at least 65 years or age-within the previous 12 months (See para AN.0.10 of explanatory notes to this Category) **Fee:** $34.00 **Benefit:** 85% = $28.90
10910	COMPREHENSIVE INITIAL CONSULTATION - PATIENT IS LESS THAN 65 YEARS OF AGE Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if: (a) the patient is less than 65 years of age; and (b) the patient has not, within the previous 36 months, received a service to which: (i) this item or item 10905, 10907, 10912, 10913, 10914 or 10915 applies; or (ii) old item 10900 applied (See para AN.0.10 of explanatory notes to this Category) **Fee:** $67.85 **Benefit:** 85% = $57.70
10911	COMPREHENSIVE INITIAL CONSULTATION - PATIENT IS AT LEAST 65 YEARS OF AGE Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if: (a) the patient is at least 65 years of age; and (b) the patient has not, within the previous 12 months, received a service to which: (i) this item, or item 10905, 10907, 10910, 10912, 10913, 10914 or 10915 applies; or (ii) old item 10900 applied (See para AN.0.10 of explanatory notes to this Category) **Fee:** $67.85 **Benefit:** 85% = $57.70
10912	OTHER COMPREHENSIVE CONSULTATIONS Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has suffered a significant change of visual function requiring comprehensive reassessment: (a) for a patient who is less than 65 years of age-within 36 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10913, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied; or (b) for a patient who is at least 65 years of age-within 12 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10911, 10913, 10914 or 10915 at the same practice

	applies; or (ii) old item 10900 at the same practice applied (See para AN.0.10 of explanatory notes to this Category) **Fee:** $67.85 **Benefit:** 85% = $57.70
10913	Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has new signs or symptoms, unrelated to the earlier course of attention, requiring comprehensive reassessment: (a) for a patient who is less than 65 years of age-within 36 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10912, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied; or (b) for a patient who is at least 65 years of age-within 12 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10911, 10912, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied (See para AN.0.10 of explanatory notes to this Category) **Fee:** $67.85 **Benefit:** 85% = $57.70
10914	Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has a progressive disorder (excluding presbyopia) requiring comprehensive reassessment: (a) for a patient who is less than 65 years of age-within 36 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10912, 10913 or 10915 applies; or (ii) old item 10900 applied; or (b) for a patient who is at least 65 years of age-within 12 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10911, 10912, 10913 or 10915 applies; or (ii) old item 10900 applied (See para AN.0.10 of explanatory notes to this Category) **Fee:** $67.85 **Benefit:** 85% = $57.70
10915	Professional attendance of more than 15 minutes duration, being the first in a course of attention involving the examination of the eyes, with the instillation of a mydriatic, of a patient with diabetes mellitus requiring comprehensive reassessment. (See para AN.0.10 of explanatory notes to this Category) **Fee:** $67.85 **Benefit:** 85% = $57.70
10916	BRIEF INITIAL CONSULTATION Professional attendance, being the first in a course of attention, of not more than 15 minutes duration, not being a service associated with a service to which item 10931, 10932, 10933, 10940, 10941, 10942 or 10943 applies (See para AN.0.10 of explanatory notes to this Category)

	Fee: $34.00 **Benefit:** 85% = $28.90
10918	SUBSEQUENT CONSULTATION Professional attendance being the second or subsequent in a course of attention not related to the prescription and fitting of contact lenses, not being a service associated with a service to which item 10940 or 10941 applies (See para AN.0.10 of explanatory notes to this Category) **Fee:** $34.00 **Benefit:** 85% = $28.90
10921	CONTACT LENSES FOR SPECIFIED CLASSES OF PATIENTS - BULK ITEMS FOR ALL SUBSEQUENT CONSULTATIONS All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with myopia of 5.0 dioptres or greater (spherical equivalent) in one eye (See para AN.0.2 of explanatory notes to this Category) **Fee:** $168.45 **Benefit:** 85% = $143.20
10922	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in one eye (See para AN.0.2 of explanatory notes to this Category) **Fee:** $168.45 **Benefit:** 85% = $143.20
10923	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with astigmatism of 3.0 dioptres or greater in one eye (See para AN.0.2 of explanatory notes to this Category)

	Fee: $168.45 **Benefit:** 85% = $143.20
10924	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens (See para AN.0.2 of explanatory notes to this Category) **Fee:** $212.55 **Benefit:** 85% = $180.70
10925	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents) (See para AN.0.2 of explanatory notes to this Category) **Fee:** $168.45 **Benefit:** 85% = $143.20
10926	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with corrected visual acuity of 0.7 logMAR (6/30) or worse in both eyes, being patients for whom a contact lens is prescribed as part of a telescopic system (See para AN.0.2 of explanatory notes to this Category) **Fee:** $168.45 **Benefit:** 85% = $143.20
10927	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for

	- patients for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by: i. pathological mydriasis; or ii. aniridia; or iii. coloboma of the iris; or iv. pupillary malformation or distortion; or v. significant ocular deformity or corneal opacity -whether congenital, traumatic or surgical in origin (See para AN.0.2 of explanatory notes to this Category) **Fee:** $212.55 **Benefit:** 85% = $180.70
10928	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients who, because of physical deformity, are unable to wear spectacles (See para AN.0.2 of explanatory notes to this Category) **Fee:** $168.45 **Benefit:** 85% = $143.20
10929	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients who have a medical or optical condition (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10926, 10927 or 10928 applies) requiring the use of a contact lens for correction, if the condition is specified on the patient's account *Note: Benefits may not be claimed under Item 10929 where the patient wants the contact lenses for appearance, sporting, work or psychological reasons - see paragraph O6 of explanatory notes to this category.* (See para AN.0.2 of explanatory notes to this Category) **Fee:** $212.55 **Benefit:** 85% = $180.70
10930	All professional attendances regarded as a single service in a single course of attention involving the prescription and fitting of contact lenses where the patient meets the requirements of an item in the range 10921-10929 and requires a <u>change in contact lens material or basic lens parameters</u>, other than a simple power change, because of a <u>structural or functional change in the eye or an allergic response</u> within 36 months of the fitting of a contact lens covered by item 10921 to 10929

	Fee: $168.45 **Benefit:** 85% = $143.20
	DOMICILIARY VISITS An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10932, 10933, 10940 or 10941) applies (the applicable item) if the service is: a) rendered at a place other than consulting rooms, being at: (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on one patient at a single location on one occasion, and c) either: (i) bulk-billed in respect of the fees for both: - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both: - this item; and - the applicable item (See para AN.0.10 of explanatory notes to this Category)
10931	**Fee:** $23.65 **Benefit:** 85% = $20.15
	An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10931, 10933, 10940 or 10941) applies (the applicable item) if the service is: a) rendered at a place other than consulting rooms, being at: (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on two patients at the same location on one occasion, and c) either: (i) bulk-billed in respect of the fees for both: - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both:
10932	

	- this item; and - the applicable item (See para AN.0.10 of explanatory notes to this Category) **Fee:** $11.80 **Benefit:** 85% = $10.05
10933	An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10931, 10932, 10940 or 10941) applies (the applicable item) if the service is: a) rendered at a place other than consulting rooms, being at: (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on three patients at the same location on one occasion, and c) either: (i) bulk-billed in respect of the fees for both: - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both: - this item; and - the applicable item (See para AN.0.10 of explanatory notes to this Category) **Fee:** $7.80 **Benefit:** 85% = $6.65
10940	COMPUTERISED PERIMETRY Full quantitative computerised perimetry (automated absolute static threshold), with bilateral assessment and report, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain that: (a) is not a service involving multifocal multi channel objective perimetry; and (b) is performed by an optometrist; not being a service associated with a service to which item 10916, 10918, 10931, 10932 or 10933 applies To a maximum of 2 examinations per patient (including examinations to which item 10941 applies) in any 12 month period. (See para DN.1.6, AN.0.10 of explanatory notes to this Category) **Fee:** $64.75 **Benefit:** 85% = $55.05
10941	COMPUTERISED PERIMETRY Full quantitative computerised perimetry (automated absolute static threshold) with unilateral assessment and report, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain that: (a) is not a service involving multifocal multichannel objective perimetry; and (b) is performed by an optometrist; not being a service associated with a service to which item 10916, 10918 10931, 10932 or 10933 applies To a maximum of 2 examinations per patient (including examinations to which item 10940 applies) in any 12 month period. (See para DN.1.6, AN.0.10 of explanatory notes to this Category)

A10. OPTOMETRICAL SERVICES	1. GENERAL
	Fee: $39.05 **Benefit:** 85% = $33.20
10942	LOW VISION ASSESSMENT Testing of residual vision to provide optimum visual performance for a patient who has best corrected visual acuity of 6/15 or N.12 or worse in the better eye or a horizontal visual field of less than 120 degrees and within 10 degrees above and below the horizontal midline, involving 1 or more of the following: (a) spectacle correction; (b) determination of contrast sensitivity; (c) determination of glare sensitivity; (d) prescription of magnification aids; not being a service associated with a service to which item 10916, 10921, 10922, 10923, 10924, 10925, 10926, 10927, 10928, 10929 or 10930 applies Not payable more than twice per patient in a 12 month period. (See para AN.0.10 of explanatory notes to this Category) **Fee:** $34.00 **Benefit:** 85% = $28.90
10943	CHILDREN'S VISION ASSESSMENT Additional testing to confirm diagnosis of, or establish a treatment regime for, a significant binocular or accommodative dysfunction, in a patient aged 3 to 14 years, including assessment of 1 or more of the following: (a) accommodation; (b) ocular motility; (c) vergences; (d) fusional reserves; (e) cycloplegic refraction; not being a service to which item 10916, 10921, 10922, 10923, 10924, 10925, 10926, 10927, 10928, 10929 or 10930 applies Not to be used for the assessment of learning difficulties or learning disabilities. Not payable more than once per patient in a 12 month period. (See para AN.0.10 of explanatory notes to this Category) **Fee:** $34.00 **Benefit:** 85% = $28.90
10944	CORNEA, complete removal of embedded foreign body from - not more than once on the same day by the same practitioner (excluding aftercare) The item is not to be billed on the same occasion as MBS items 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915, 10916 or 10918. If the embedded foreign body is not completely removed, this item does not apply but item 10916 may apply. **Fee:** $73.30 **Benefit:** 85% = $62.35

A10. OPTOMETRICAL SERVICES	2. TELEHEALTH ATTENDANCE
	Group A10. Optometrical Services
	Subgroup 2. Telehealth Attendance
	TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS
10945	A professional attendance of less than 15 minutes (whether or not continuous) by an attending optometrist that requires the provision of clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and (b) is not an admitted patient; and (c) either: (i) is located within a telehealth eligible area and, at the time of the attendance, is at least 15 kilometres by road from the specialist mentioned in paragraph (a); or

	(ii) is a patient of an Aboriginal Medical Service, or an Aboriginal Community Controlled Health Service, for which a direction under subsection 19(2) of the Act applies (See para AN.0.22 of explanatory notes to this Category) **Fee:** $34.00 **Benefit:** 85% = $28.90
10946	A professional attendance of at least 15 minutes (whether or not continuous) by an attending optometrist that requires the provision of clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and (b) is not an admitted patient; and (c) either: (i) is located within a telehealth eligible area and, at the time of the attendance, is at least 15 kilometres by road from the specialist mentioned in paragraph (a); or (ii) is a patient of an Aboriginal Medical Service, or an Aboriginal Community Controlled Health Service, for which a direction under subsection 19(2) of the Act applies (See para AN.0.22 of explanatory notes to this Category) **Fee:** $67.85 **Benefit:** 85% = $57.70
10947	A professional attendance (not being a service to which any other item applies) of less than 15 minutes (whether or not continuous) by an attending optometrist that requires the provision of clinical support to a patient who: a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and b) at the time of the attendance, is located at a residential aged care facility (whether or not at consulting rooms situated within the facility); and c) is a care recipient in the facility; and d) is not a resident of a self-contained unit; for an attendance on one occasion-each patient (See para AN.0.22 of explanatory notes to this Category) **Fee:** $34.00 **Benefit:** 85% = $28.90
10948	A professional attendance (not being a service to which any other item applies) of at least 15 minutes (whether or not continuous) by an attending optometrist that requires the provision of clinical support to a patient who: a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and b) at the time of the attendance, is located at a residential aged care facility (whether or not at consulting rooms situated within the facility); and c) is a care recipient in the facility; and d) is not a resident of a self-contained unit; for an attendance on one occasion-each patient

A10. OPTOMETRICAL SERVICES	2. TELEHEALTH ATTENDANCE
	(See para AN.0.22 of explanatory notes to this Category) **Fee:** $67.85 **Benefit:** 85% = $57.70
A11. URGENT ATTENDANCE AFTER HOURS	**1. URGENT ATTENDANCE - AFTER HOURS**
	Group A11. Urgent Attendance After Hours
	Subgroup 1. Urgent Attendance - After Hours
585	Professional attendance by a general practitioner on one patient on one occasion—each attendance (other than an attendance in unsociable hours) in an after-hours period if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance (See para AN.0.19, AN.0.9 of explanatory notes to this Category) **Fee:** $131.90 **Benefit:** 75% = $98.95 100% = $131.90 **Extended Medicare Safety Net Cap:** $395.70
588	Professional attendance by a medical practitioner (other than a general practitioner) on one patient on one occasion—each attendance (other than an attendance in unsociable hours) in an after-hours period if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) the attendance is in an after-hours rural area; and (d) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance (See para AN.0.19 of explanatory notes to this Category) **Fee:** $131.90 **Benefit:** 75% = $98.95 100% = $131.90 **Extended Medicare Safety Net Cap:** $395.70
591	Professional attendance by a medical practitioner (other than a general practitioner) on one patient on one occasion—each attendance (other than an attendance in unsociable hours) in an after-hours period if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) the attendance is not in an after-hours rural area; and (d) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance (See para AN.0.19 of explanatory notes to this Category) **Fee:** $101.60 **Benefit:** 75% = $76.20 100% = $101.60 **Extended Medicare Safety Net Cap:** $304.80
594	Professional attendance by a medical practitioner—each additional patient at an attendance that qualifies

A11. URGENT ATTENDANCE AFTER HOURS	1. URGENT ATTENDANCE - AFTER HOURS
	for item 585, 588 or 591 in relation to the first patient (See para AN.0.19, AN.0.9 of explanatory notes to this Category) **Fee:** $42.60 **Benefit:** 75% = $31.95 100% = $42.60 **Extended Medicare Safety Net Cap:** $127.80
A11. URGENT ATTENDANCE AFTER HOURS	**2. URGENT ATTENDANCE UNSOCIABLE AFTER HOURS**
	Group A11. Urgent Attendance After Hours
	Subgroup 2. Urgent Attendance Unsociable After Hours
599	Professional attendance by a general practitioner on not more than one patient on one occasion—each attendance in unsociable hours if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance (See para AN.0.19, AN.0.9 of explanatory notes to this Category) **Fee:** $155.45 **Benefit:** 75% = $116.60 100% = $155.45 **Extended Medicare Safety Net Cap:** $466.35
600	Professional attendance by a medical practitioner (other than a general practitioner) on not more than one patient on one occasion—each attendance in unsociable hours if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance (See para AN.0.19 of explanatory notes to this Category) **Fee:** $124.25 **Benefit:** 75% = $93.20 100% = $124.25 **Extended Medicare Safety Net Cap:** $372.75
A12. CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A12. Consultant Occupational Physician Attendances To Which No Other Item Applies
Amend 384	Initial professional attendance of 10 minutes or less in duration on a patient by a consultant occupational physician practising in the consultant occupational physician's specialty of occupational medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and

A12. CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(B) at the time of the attendance-at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment (See para AN.0.68 of explanatory notes to this Category) **Fee:** $66.20 **Benefit:** 85% = $56.30 **Extended Medicare Safety Net Cap:** $198.60
Amend 385	Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner-initial attendance in a single course of treatment (See para AN.0.33 of explanatory notes to this Category) **Fee:** $88.25 **Benefit:** 75% = $66.20 85% = $75.05 **Extended Medicare Safety Net Cap:** $264.75
Amend 386	Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner-each attendance after the first in a single course of treatment (See para AN.0.33, AN.0.70 of explanatory notes to this Category) **Fee:** $44.35 **Benefit:** 75% = $33.30 85% = $37.70 **Extended Medicare Safety Net Cap:** $133.05
Amend 387	Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner-initial attendance in a single course of treatment (See para AN.0.33 of explanatory notes to this Category) **Fee:** $129.45 **Benefit:** 75% = $97.10 85% = $110.05 **Extended Medicare Safety Net Cap:** $388.35
Amend 388	Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner-each attendance after the first in a single course of treatment (See para AN.0.33 of explanatory notes to this Category) **Fee:** $81.95 **Benefit:** 75% = $61.50 85% = $69.70 **Extended Medicare Safety Net Cap:** $245.85
Amend 389	Professional attendance on a patient by a consultant occupational physician practising in the consultant occupational physician's specialty of occupational medicine if: (a) the attendance is by video conference; and

A12. CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(b) the attendance is for a service: (i) provided with item 385 lasting more than 10 minutes; or (ii) provided with item 386; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.0.68 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 385 or 386. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A13. PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A13. Public Health Physician Attendances To Which No Other Item Applies
	PUBLIC HEALTH PHYSICIAN ATTENDANCES - AT CONSULTING ROOMS Professional attendance at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine
410	LEVEL A Professional attendance at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management. (See para AN.0.50 of explanatory notes to this Category) **Fee:** $20.15 **Benefit:** 75% = $15.15 85% = $17.15 **Extended Medicare Safety Net Cap:** $60.45
411	LEVEL B Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination;

A13. PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation. (See para AN.0.50 of explanatory notes to this Category) **Fee:** $44.10 **Benefit:** 75% = $33.10 85% = $37.50 **Extended Medicare Safety Net Cap:** $132.30
412	LEVEL C Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation. (See para AN.0.50 of explanatory notes to this Category) **Fee:** $85.25 **Benefit:** 75% = $63.95 85% = $72.50 **Extended Medicare Safety Net Cap:** $255.75
413	LEVEL D Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation. (See para AN.0.50 of explanatory notes to this Category) **Fee:** $125.55 **Benefit:** 75% = $94.20 85% = $106.75 **Extended Medicare Safety Net Cap:** $376.65
	PUBLIC HEALTH PHYSICIAN ATTENDANCES - OTHER THAN AT CONSULTING ROOMS Professional attendance other than at consulting rooms by a public health physician in the practice of his

A13. PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	or her specialty of public health medicine.
414	LEVEL A Professional attendance by a public health physician in the practice of his or her specialty of public health medicine other than at consulting rooms for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management (See para AN.0.50 of explanatory notes to this Category) **Derived Fee:** The fee for item 410, plus $26.25 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 $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
415	LEVEL B Professional attendance by a public health physician in the practice of his or her specialty of public health medicine other than at consulting rooms, lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation. (See para AN.0.50 of explanatory notes to this Category) **Derived Fee:** The fee for item 411, plus $26.25 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 $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
416	LEVEL C Professional attendance by a public health physician in the practice of his or her specialty of public health medicine other than at consulting rooms lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.

A13. PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(See para AN.0.50 of explanatory notes to this Category) **Derived Fee:** The fee for item 412, plus $26.25 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 $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
417	LEVEL D Professional attendance by a public health physician in the practice of his or her specialty of public health medicine other than at consulting rooms lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation. (See para AN.0.50 of explanatory notes to this Category) **Derived Fee:** The fee for item 413, plus $26.25 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 $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A14. HEALTH ASSESSMENTS	
	Group A14. Health Assessments
	HEALTH ASSESSMENTS The category of people eligible for health assessments are : a) People aged 40 to 49 years (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool b) People between the age of 45 and 49 (inclusive) who are at risk of developing a chronic disease c) People aged 75 years and older d) Permanent residents of a Residential Aged Care Facility e) People who have an intellectual disability f) Humanitarian entrants who are resident in Australia with access to Medicare services, including Refugees and Special Humanitarian Program and Protection Program entrants g) Former serving members of the Australian Defence Force including former members of permanent and reserve forces
Amend Fee 699	Professional attendance for a heart health assessment by a general practitioner at consulting rooms lasting at least 20 minutes and must include: (a) collection of relevant information, including taking a patient history that is aimed at identifying cardiovascular disease risk factors, including diabetes status, alcohol intake, smoking status and blood glucose; (b) a physical examination, which must include recording of blood pressure and cholesterol status; (c) initiating interventions and referrals to address the identified risk factors; (d) implementing a management plan for appropriate treatment of identified risk factors; (e) providing the patient with preventative health care advice and information, including modifiable

	lifestyle factors; with appropriate documentation. Claimable once only in a 12 month period. The heart health assessment item cannot be claimed if a patient has had a health assessment service (items 701, 703, 705, 707, 715) in the previous 12 months. (See para AN.14.2 of explanatory notes to this Category) **Fee:** $73.95 **Benefit:** 100% = $73.95 **Extended Medicare Safety Net Cap:** $221.85
701	Professional attendance by a general practitioner to perform a brief health assessment, lasting not more than 30 minutes and including: (a) collection of relevant information, including taking a patient history; and (b) a basic physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing the patient with preventive health care advice and information (See para AN.0.69, AN.0.40, AN.0.37, AN.0.38, AN.0.39, AN.0.41, AN.0.36, AN.0.42 of explanatory notes to this Category) **Fee:** $60.30 **Benefit:** 100% = $60.30 **Extended Medicare Safety Net Cap:** $180.90
703	Professional attendance by a general practitioner to perform a standard health assessment, lasting more than 30 minutes but less than 45 minutes, including: (a) detailed information collection, including taking a patient history; and (b) an extensive physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing a preventive health care strategy for the patient (See para AN.0.69, AN.0.40, AN.0.37, AN.0.38, AN.0.39, AN.0.41, AN.0.36, AN.0.42 of explanatory notes to this Category) **Fee:** $140.10 **Benefit:** 100% = $140.10 **Extended Medicare Safety Net Cap:** $420.30
705	Professional attendance by a general practitioner to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes, including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition and physical function; and (c) initiating interventions and referrals as indicated; and (d) providing a basic preventive health care management plan for the patient (See para AN.0.69, AN.0.40, AN.0.37, AN.0.38, AN.0.39, AN.0.41, AN.0.36, AN.0.42 of explanatory notes to this Category) **Fee:** $193.35 **Benefit:** 100% = $193.35

A14. HEALTH ASSESSMENTS	
	Extended Medicare Safety Net Cap: $500.00
707	Professional attendance by a general practitioner to perform a prolonged health assessment (lasting at least 60 minutes) including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition, and physical, psychological and social function; and (c) initiating interventions or referrals as indicated; and (d) providing a comprehensive preventive health care management plan for the patient (See para AN.0.69, AN.0.40, AN.0.37, AN.0.38, AN.0.39, AN.0.41, AN.0.36, AN.0.42 of explanatory notes to this Category) **Fee:** $273.10 **Benefit:** 100% = $273.10 **Extended Medicare Safety Net Cap:** $500.00
	ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES HEALTH ASSESSMENT Details of the requirements for the Aboriginal and Torres Strait Islander Peoples Health Assessment, The Aboriginal and Torres Strait Islander Peoples Health Assessment is available to: a) Children between ages of 0 and 14 years, b) Adults between the ages of 15 and 54 years, c) Older people over the age of 55 years.
715	Professional attendance by a general practitioner at consulting rooms or in another place other than a hospital or residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent-not more than once in a 9 month period (See para AN.0.44, AN.0.45, AN.0.46, AN.0.43 of explanatory notes to this Category) **Fee:** $215.65 **Benefit:** 100% = $215.65 **Extended Medicare Safety Net Cap:** $500.00

A15. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS, MULTIDISCIPLINARY CARE PLANS	1. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS AND MULTIDISCIPLINARY CARE PLANS
	Group A15. GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans
	Subgroup 1. GP Management Plans, Team Care Arrangements And Multidisciplinary Care Plans
721	Attendance by a general practitioner for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 735 to 758 apply) (See para AN.0.47 of explanatory notes to this Category) **Fee:** $146.55 **Benefit:** 75% = $109.95 100% = $146.55 **Extended Medicare Safety Net Cap:** $439.65
723	Attendance by a general practitioner to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 735 to 758 apply) (See para AN.0.47 of explanatory notes to this Category) **Fee:** $116.15 **Benefit:** 75% = $87.15 100% = $116.15 **Extended Medicare Safety Net Cap:** $348.45
729	Contribution by a general practitioner to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758 apply) (See para AN.0.47 of explanatory notes to this Category) **Fee:** $71.55 **Benefit:** 100% = $71.55 **Extended Medicare Safety Net Cap:** $214.65

731	Contribution by a general practitioner to: (a) a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or (b) a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider (other than a service associated with a service to which items 735 to 758 apply) (See para AN.0.47 of explanatory notes to this Category) **Fee:** $71.55 **Benefit:** 100% = $71.55 **Extended Medicare Safety Net Cap:** $214.65
732	Attendance by a general practitioner to review or coordinate a review of: (a) a GP management plan prepared by a general practitioner (or an associated general practitioner) to which item 721 applies; or (b) team care arrangements which have been coordinated by the general practitioner (or an associated general practitioner) to which item 723 applies (See para AN.0.47 of explanatory notes to this Category) **Fee:** $73.20 **Benefit:** 75% = $54.90 100% = $73.20 **Extended Medicare Safety Net Cap:** $219.60

A15. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS, MULTIDISCIPLINARY CARE PLANS — 2. CASE CONFERENCES

	Group A15. GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans
	Subgroup 2. Case Conferences
735	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which items 721 to 732 apply) (See para AN.0.49 of explanatory notes to this Category) **Fee:** $71.80 **Benefit:** 75% = $53.85 100% = $71.80 **Extended Medicare Safety Net Cap:** $215.40
739	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference;

	if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which items 721 to 732 apply) (See para AN.0.49 of explanatory notes to this Category) **Fee:** $122.90 **Benefit:** 75% = $92.20 100% = $122.90 **Extended Medicare Safety Net Cap:** $368.70
743	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes (other than a service associated with a service to which items 721 to 732 apply) (See para AN.0.49 of explanatory notes to this Category) **Fee:** $204.90 **Benefit:** 75% = $153.70 100% = $204.90 **Extended Medicare Safety Net Cap:** $500.00
747	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which items 721 to 732 apply) (See para AN.0.49 of explanatory notes to this Category) **Fee:** $52.75 **Benefit:** 75% = $39.60 100% = $52.75 **Extended Medicare Safety Net Cap:** $158.25
750	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which items 721 to 732 apply) (See para AN.0.49 of explanatory notes to this Category) **Fee:** $90.40 **Benefit:** 75% = $67.80 100% = $90.40 **Extended Medicare Safety Net Cap:** $271.20
758	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in:

	(a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes (other than a service associated with a service to which items 721 to 732 apply) **Fee:** $150.55 **Benefit:** 75% = $112.95 100% = $150.55 **Extended Medicare Safety Net Cap:** $451.65
Amend 820	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $143.45 **Benefit:** 75% = $107.60 85% = $121.95 **Extended Medicare Safety Net Cap:** $430.35
Amend 822	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $215.25 **Benefit:** 75% = $161.45 85% = $183.00 **Extended Medicare Safety Net Cap:** $500.00
Amend 823	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $286.80 **Benefit:** 75% = $215.10 85% = $243.80 **Extended Medicare Safety Net Cap:** $500.00
Amend 825	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $103.00 **Benefit:** 75% = $77.25 85% = $87.55 **Extended Medicare Safety Net Cap:** $309.00
Amend 826	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $164.30 **Benefit:** 75% = $123.25 85% = $139.70 **Extended Medicare Safety Net Cap:** $492.90
Amend 828	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different

	disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $225.60 **Benefit:** 75% = $169.20 85% = $191.80 **Extended Medicare Safety Net Cap:** $500.00
Amend 830	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $143.45 **Benefit:** 75% = $107.60 85% = $121.95 **Extended Medicare Safety Net Cap:** $430.35
Amend 832	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $215.25 **Benefit:** 75% = $161.45 85% = $183.00 **Extended Medicare Safety Net Cap:** $500.00
Amend 834	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $286.80 **Benefit:** 75% = $215.10 85% = $243.80 **Extended Medicare Safety Net Cap:** $500.00
Amend 835	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $103.00 **Benefit:** 75% = $77.25 85% = $87.55 **Extended Medicare Safety Net Cap:** $309.00
Amend 837	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $164.30 **Benefit:** 75% = $123.25 85% = $139.70 **Extended Medicare Safety Net Cap:** $492.90
Amend 838	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $225.60 **Benefit:** 75% = $169.20 85% = $191.80 **Extended Medicare Safety Net Cap:** $500.00
Amend	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry,

855	as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.62 of explanatory notes to this Category) **Fee:** $143.45 **Benefit:** 75% = $107.60 85% = $121.95 **Extended Medicare Safety Net Cap:** $430.35
Amend 857	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.62 of explanatory notes to this Category) **Fee:** $215.25 **Benefit:** 75% = $161.45 85% = $183.00 **Extended Medicare Safety Net Cap:** $500.00
Amend 858	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.62 of explanatory notes to this Category) **Fee:** $286.80 **Benefit:** 75% = $215.10 85% = $243.80 **Extended Medicare Safety Net Cap:** $500.00
Amend 861	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.62 of explanatory notes to this Category) **Fee:** $143.45 **Benefit:** 75% = $107.60 85% = $121.95 **Extended Medicare Safety Net Cap:** $430.35
Amend 864	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.62 of explanatory notes to this Category) **Fee:** $215.25 **Benefit:** 75% = $161.45 85% = $183.00 **Extended Medicare Safety Net Cap:** $500.00
Amend 866	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.62 of explanatory notes to this Category) **Fee:** $286.80 **Benefit:** 75% = $215.10 85% = $243.80 **Extended Medicare Safety Net Cap:** $500.00
871	Attendance by a general practitioner, specialist or consultant physician as a member of a case conference team, to lead and coordinate a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 3 other medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers (See para AN.0.65 of explanatory notes to this Category)

A15. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS, MULTIDISCIPLINARY CARE PLANS	2. CASE CONFERENCES
	Fee: $82.80 **Benefit:** 75% = $62.10 85% = $70.40 **Extended Medicare Safety Net Cap:** $248.40
872	Attendance by a general practitioner, specialist or consultant physician as a member of a case conference team, to participate in a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 4 medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers (See para AN.0.65 of explanatory notes to this Category) **Fee:** $38.55 **Benefit:** 75% = $28.95 85% = $32.80 **Extended Medicare Safety Net Cap:** $115.65
Amend 880	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of geriatric or rehabilitation medicine, as a member of a case conference team, to coordinate a case conference of at least 10 minutes but less than 30 minutes-for any particular patient, one attendance only in a 7 day period (other than attendance on the same day as an attendance for which item 832, 834, 835, 837 or 838 was applicable in relation to the patient) (H) (See para AN.0.63 of explanatory notes to this Category) **Fee:** $50.20 **Benefit:** 75% = $37.65 **Extended Medicare Safety Net Cap:** $150.60

A17. DOMICILIARY AND RESIDENTIAL MANAGEMENT REVIEWS	
	Group A17. Domiciliary And Residential Management Reviews
900	Participation by a general practitioner in a Domiciliary Medication Management Review (DMMR) for a patient living in a community setting, in which the general practitioner, with the patient's consent: (a) assesses the patient as: (i) having a chronic medical condition or a complex medication regimen; and (ii) not having their therapeutic goals met; and (b) following that assessment: (i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and (ii) provides relevant clinical information required for the DMMR; and (c) discusses with the reviewing pharmacist the results of the DMMR including suggested medication management strategies; and (d) develops a written medication management plan following discussion with the patient; and (e) provides the written medication management plan to a community pharmacy chosen by the patient For any particular patient—applicable not more than once in each 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (See para AN.0.52 of explanatory notes to this Category) **Fee:** $157.30 **Benefit:** 100% = $157.30 **Extended Medicare Safety Net Cap:** $471.90
903	Participation by a general practitioner in a residential medication management review (RMMR) for a patient who is a permanent resident of a residential aged care facility-other than an RMMR for a resident

A17. DOMICILIARY AND RESIDENTIAL MANAGEMENT REVIEWS	
	in relation to whom, in the preceding 12 months, this item has applied, unless there has been a significant change in the resident's medical condition or medication management plan requiring a new RMMR (See para AN.0.52 of explanatory notes to this Category) **Fee:** $107.70 **Benefit:** 100% = $107.70 **Extended Medicare Safety Net Cap:** $323.10

A18. GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS	1. TAKING OF A CERVICAL SMEAR FROM AN UNSCREENED OR SIGNIFICANTLY UNDERSCREENED PERSON
	Group A18. General Practitioner Attendance Associated With Pip Incentive Payments
	Subgroup 1. Taking Of A Cervical Smear From An Unscreened Or Significantly Underscreened Person
	LEVEL A Professional attendance involving taking a short patient history and, if required, limited examination and management **and** at which a cervical screening test is taken from a person at least 24 years and 9 months of age but is less than 75 years of age, who has not had a cervical screening test in the last 4 years.
2497	Professional attendance at consulting rooms by a general practitioner: (a) involving taking a short patient history and, if required, limited examination and management; and (b) at which a specimen for a cervical screening service is collected from the patient; if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years. (See para AN.0.9, AN.0.53 of explanatory notes to this Category) **Fee:** $17.20 **Benefit:** 100% = $17.20 **Extended Medicare Safety Net Cap:** $51.60
	LEVEL B Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation **and** at which a cervical screening test is taken from a person at least 24 years and 9 months of age but is less than 75 years of age, who has not had a cervical screening test in the last 4 years.
2501	Professional attendance by a general practitioner at consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation;

	(d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years. (See para AN.0.9, AN.0.53 of explanatory notes to this Category) **Fee:** $37.65 **Benefit:** 100% = $37.65 **Extended Medicare Safety Net Cap:** $112.95
2503	Professional attendance by a general practitioner at a place other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years. (See para AN.0.9, AN.0.53 of explanatory notes to this Category) **Derived Fee:** The fee for item 2501, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2501 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL C Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: f) taking a detailed patient history; g) performing a clinical examination; h) arranging any necessary investigation; i) implementing a management plan; j) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation **and** at which a cervical screening test is taken from a person at least 24 years and 9 months of age but is less than 75 years of age, who has not had a cervical screening test in the last 4 years.
2504	Professional attendance by a general practitioner at consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination;

	(c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.9, AN.0.53 of explanatory notes to this Category) **Fee:** $72.85 **Benefit:** 100% = $72.85 **Extended Medicare Safety Net Cap:** $218.55
2506	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.9, AN.0.53 of explanatory notes to this Category) **Derived Fee:** The fee for item 2504, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2504 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation **and** at which a cervical screening test is taken from a person at least 24 years and 9 months of age but is less than 75 years of age, who has not had a cervical screening test in the last 4 years.
2507	Professional attendance by a general practitioner at consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history;

A18. GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS	1. TAKING OF A CERVICAL SMEAR FROM AN UNSCREENED OR SIGNIFICANTLY UNDERSCREENED PERSON
	(b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.9, AN.0.53 of explanatory notes to this Category) **Fee:** $107.25 **Benefit:** 100% = $107.25 **Extended Medicare Safety Net Cap:** $321.75
2509	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.9, AN.0.53 of explanatory notes to this Category) **Derived Fee:** The fee for item 2507, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2507 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A18. GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS	2. COMPLETION OF A CYCLE OF CARE FOR PATIENTS WITH ESTABLISHED DIABETES MELLITUS
	Group A18. General Practitioner Attendance Associated With Pip Incentive Payments
	Subgroup 2. Completion Of A Cycle Of Care For Patients With Established Diabetes Mellitus

	LEVEL B Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus.
2517	Professional attendance by a general practitioner at consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus (See para AN.0.9, AN.0.54 of explanatory notes to this Category) **Fee:** $37.65 **Benefit:** 100% = $37.65 **Extended Medicare Safety Net Cap:** $112.95
2518	Professional attendance by a general practitioner at a place other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus (See para AN.0.9, AN.0.54 of explanatory notes to this Category) **Derived Fee:** The fee for item 2517, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2517 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL C Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant:

	a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus.
2521	Professional attendance by a general practitioner at consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus (See para AN.0.9, AN.0.54 of explanatory notes to this Category) **Fee:** $72.85 **Benefit:** 100% = $72.85 **Extended Medicare Safety Net Cap:** $218.55
2522	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus (See para AN.0.9, AN.0.54 of explanatory notes to this Category) **Derived Fee:** The fee for item 2521, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2521 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation;

A18. GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS	2. COMPLETION OF A CYCLE OF CARE FOR PATIENTS WITH ESTABLISHED DIABETES MELLITUS
	d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus.
2525	Professional attendance by a general practitioner at consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus (See para AN.0.9, AN.0.54 of explanatory notes to this Category) **Fee:** $107.25 **Benefit:** 100% = $107.25 **Extended Medicare Safety Net Cap:** $321.75
2526	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus (See para AN.0.54 of explanatory notes to this Category) **Derived Fee:** The fee for item 2525, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2525 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A18. GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS	3. COMPLETION OF THE ASTHMA CYCLE OF CARE
	Group A18. General Practitioner Attendance Associated With Pip Incentive Payments
	Subgroup 3. Completion Of The Asthma Cycle Of Care

A18. GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS	3. COMPLETION OF THE ASTHMA CYCLE OF CARE
	LEVEL B Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND which <u>completes</u> the minimum requirements of the Asthma Cycle of Care.
2546	Professional attendance by a general practitioner at consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.9, AN.0.55 of explanatory notes to this Category) **Fee:** $37.65 **Benefit:** 100% = $37.65 **Extended Medicare Safety Net Cap:** $112.95
2547	Professional attendance by a general practitioner at a place other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.9, AN.0.55 of explanatory notes to this Category) **Derived Fee:** The fee for item 2546, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2546 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL C Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination;

	c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND which <u>completes</u> the minimum requirements of the Asthma Cycle of Care.
2552	Professional attendance by a general practitioner at consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.9, AN.0.55 of explanatory notes to this Category) **Fee:** $72.85 **Benefit:** 100% = $72.85 **Extended Medicare Safety Net Cap:** $218.55
2553	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.55 of explanatory notes to this Category) **Derived Fee:** The fee for item 2552, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2552 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation

A18. GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS	3. COMPLETION OF THE ASTHMA CYCLE OF CARE
	AND which completes the minimum requirements of the Asthma Cycle of Care.
2558	Professional attendance by a general practitioner at consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.9, AN.0.55 of explanatory notes to this Category) **Fee:** $107.25 **Benefit:** 100% = $107.25 **Extended Medicare Safety Net Cap:** $321.75
2559	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.9, AN.0.55 of explanatory notes to this Category) **Derived Fee:** The fee for item 2558, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2558 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A19. OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES	1. TAKING OF A CERVICAL SMEAR FROM AN UNSCREENED OR SIGNIFICANTLY UNDERSCREENED PERSON
	Group A19. Other Non-Referred Attendances Associated With Pip Incentive Payments To Which No Other Item Applies
	Subgroup 1. Taking Of A Cervical Smear From An Unscreened Or Significantly Underscreened Person
2598	Professional attendance at consulting rooms of less than 5 minutes in duration by a medical practitioner who practices in general practice (other than a general practitioner) at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years

	(See para AN.0.53 of explanatory notes to this Category) **Fee:** $11.00 **Benefit:** 100% = $11.00 **Extended Medicare Safety Net Cap:** $33.00
2600	Professional attendance at consulting rooms of more than 5, but not more than 25 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.53 of explanatory notes to this Category) **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
2603	Professional attendance at consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.53 of explanatory notes to this Category) **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00
2606	Professional attendance at consulting rooms of more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.53 of explanatory notes to this Category) **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00
2610	Professional attendance at a place other than consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.53 of explanatory notes to this Category) **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2613	Professional attendance at a place other than consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.53 of explanatory notes to this Category) **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A19. OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES	1. TAKING OF A CERVICAL SMEAR FROM AN UNSCREENED OR SIGNIFICANTLY UNDERSCREENED PERSON
2616	Professional attendance at a place other than consulting rooms of more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.53 of explanatory notes to this Category) **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A19. OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES	2. COMPLETION OF AN ANNUAL CYCLE OF CARE FOR PATIENTS WITH ESTABLISHED DIABETES MELLITUS
	Group A19. Other Non-Referred Attendances Associated With Pip Incentive Payments To Which No Other Item Applies
	Subgroup 2. Completion Of An Annual Cycle Of Care For Patients With Established Diabetes Mellitus
2620	Professional attendance at consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.0.54 of explanatory notes to this Category) **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
2622	Professional attendance at consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.0.54 of explanatory notes to this Category) **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00
2624	Professional attendance at consulting rooms of more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.0.54 of explanatory notes to this Category) **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00
2631	Professional attendance at a place other than consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.0.54 of explanatory notes to this Category) **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the

A19. OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES	2. COMPLETION OF AN ANNUAL CYCLE OF CARE FOR PATIENTS WITH ESTABLISHED DIABETES MELLITUS
	lesser amount
2633	Professional attendance at a place other than consulting rooms of more than 25 minutes but not more than 45 minutes, in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.0.54 of explanatory notes to this Category) **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2635	Professional attendance at a place other than consulting rooms of more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.0.54 of explanatory notes to this Category) **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A19. OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES	3. COMPLETION OF THE ASTHMA CYCLE OF CARE
	Group A19. Other Non-Referred Attendances Associated With Pip Incentive Payments To Which No Other Item Applies
	Subgroup 3. Completion Of The Asthma Cycle Of Care
2664	Professional attendance at consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.55 of explanatory notes to this Category) **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
2666	Professional attendance at consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.55 of explanatory notes to this Category) **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00
2668	Professional attendance at consulting rooms of more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.55 of explanatory notes to this Category)

A19. OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES	3. COMPLETION OF THE ASTHMA CYCLE OF CARE
	Fee: $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00
2673	Professional attendance at a place other than consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.55 of explanatory notes to this Category) **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $0.70 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2675	Professional attendance at a place other than consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.55 of explanatory notes to this Category) **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2677	Professional attendance at a place other than consulting rooms of more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.55 of explanatory notes to this Category) **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A20. GP MENTAL HEALTH TREATMENT	1. GP MENTAL HEALTH TREATMENT PLANS
	Group A20. GP Mental Health Treatment
	Subgroup 1. GP Mental Health Treatment Plans
2700	Professional attendance by a general practitioner (including a general practitioner who has not undertaken mental health skills training) of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.0.56 of explanatory notes to this Category) **Fee:** $72.85 **Benefit:** 75% = $54.65 100% = $72.85 **Extended Medicare Safety Net Cap:** $218.55
2701	Professional attendance by a general practitioner (including a general practitioner who has not undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.0.56 of explanatory notes to this Category) **Fee:** $107.25 **Benefit:** 75% = $80.45 100% = $107.25 **Extended Medicare Safety Net Cap:** $321.75
2712	Professional attendance by a general practitioner to review a GP mental health treatment plan which he or she, or an associated general practitioner has prepared, or to review a Psychiatrist Assessment and

A20. GP MENTAL HEALTH TREATMENT	1. GP MENTAL HEALTH TREATMENT PLANS
	Management Plan (See para AN.0.56 of explanatory notes to this Category) **Fee:** $72.85 **Benefit:** 75% = $54.65 100% = $72.85 **Extended Medicare Safety Net Cap:** $218.55
2713	Professional attendance by a general practitioner in relation to a mental disorder and of at least 20 minutes in duration, involving taking relevant history and identifying the presenting problem (to the extent not previously recorded), providing treatment and advice and, if appropriate, referral for other services or treatments, and documenting the outcomes of the consultation (See para AN.0.56 of explanatory notes to this Category) **Fee:** $72.85 **Benefit:** 100% = $72.85 **Extended Medicare Safety Net Cap:** $218.55
2715	Professional attendance by a general practitioner (including a general practitioner who has undertaken mental health skills training of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.0.56 of explanatory notes to this Category) **Fee:** $92.50 **Benefit:** 75% = $69.40 100% = $92.50 **Extended Medicare Safety Net Cap:** $277.50
2717	Professional attendance by a general practitioner (including a general practitioner who has undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.0.56 of explanatory notes to this Category) **Fee:** $136.25 **Benefit:** 75% = $102.20 100% = $136.25 **Extended Medicare Safety Net Cap:** $408.75

A20. GP MENTAL HEALTH TREATMENT	2. FOCUSSED PSYCHOLOGICAL STRATEGIES
	Group A20. GP Mental Health Treatment
	Subgroup 2. Focussed Psychological Strategies
2721	Professional attendance at consulting rooms by a general practitioner, for providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes (See para AN.0.57 of explanatory notes to this Category) **Fee:** $94.25 **Benefit:** 100% = $94.25 **Extended Medicare Safety Net Cap:** $282.75
2723	Professional attendance at a place other than consulting rooms by a general practitioner, for providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes (See para AN.0.57 of explanatory notes to this Category) **Derived Fee:** The fee for item 2721, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2721 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2725	Professional attendance at consulting rooms by a general practitioner, for providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes (See para AN.0.57 of explanatory notes to this Category)

A20. GP MENTAL HEALTH TREATMENT	2. FOCUSSED PSYCHOLOGICAL STRATEGIES
	Fee: $134.85 **Benefit:** 100% = $134.85 **Extended Medicare Safety Net Cap:** $404.55
2727	Professional attendance at a place other than consulting rooms by a general practitioner, for providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes (See para AN.0.57 of explanatory notes to this Category) **Derived Fee:** The fee for item 2725, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2725 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2729	Professional attendance at consulting rooms by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the general practitioner. (See para AN.0.57 of explanatory notes to this Category) **Fee:** $94.25 **Benefit:** 100% = $94.25 **Extended Medicare Safety Net Cap:** $282.75
2731	Professional attendance at consulting rooms by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 40 minutes if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the general practitioner (See para AN.0.57 of explanatory notes to this Category) **Fee:** $134.85 **Benefit:** 100% = $134.85 **Extended Medicare Safety Net Cap:** $404.55

A21. MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	1. CONSULTATIONS
	Group A21. Medical Practitioner (Emergency Physician) Attendances To Which No Other Item Applies
	Subgroup 1. Consultations
Amend 501	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine-attendance for the unscheduled evaluation

	and management of a patient, involving straightforward medical decision making that requires: (a) taking a problem focussed history; and (b) limited examination; and (c) diagnosis; and (d) initiation of appropriate treatment interventions (See para AN.0.60 of explanatory notes to this Category) **Fee:** $35.25 **Benefit:** 75% = $26.45 85% = $30.00 **Extended Medicare Safety Net Cap:** $105.75
Amend 503	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine-attendance for the unscheduled evaluation and management of a patient, involving medical decision making of low complexity that requires: (a) taking an expanded problem focussed history; and (b) expanded examination of one or more systems; and (c) formulation and documentation of a diagnosis and management plan in relation to one or more problems; and (d) initiation of appropriate treatment interventions (See para AN.0.60 of explanatory notes to this Category) **Fee:** $59.60 **Benefit:** 75% = $44.70 85% = $50.70 **Extended Medicare Safety Net Cap:** $178.80
Amend 507	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine-attendance for the unscheduled evaluation and management of a patient, involving medical decision making of moderate complexity that requires: (a) taking an expanded problem focussed history; and (b) expanded examination of one or more systems; and (c) ordering and evaluation of appropriate investigations; and (d) formulation and documentation of a diagnosis and management plan in relation to one or more problems; and (e) initiation of appropriate treatment interventions (See para AN.0.60 of explanatory notes to this Category) **Fee:** $100.10 **Benefit:** 75% = $75.10 85% = $85.10 **Extended Medicare Safety Net Cap:** $300.30
Amend 511	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine-attendance for the unscheduled evaluation and management of a patient, involving medical decision making of moderate complexity that requires: (a) taking a detailed history; and (b) detailed examination of one or more systems; and

A21. MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	1. CONSULTATIONS
	(c) ordering and evaluation of appropriate investigations; and (d) formulation and documentation of a diagnosis and management plan in relation to one or more problems; and (e) initiation of appropriate treatment interventions; and (f) liaison with relevant health care professionals and discussion with, as appropriate, the patient or the patient's relatives or agent (See para AN.0.60 of explanatory notes to this Category) **Fee:** $141.60 **Benefit:** 75% = $106.20 85% = $120.40 **Extended Medicare Safety Net Cap:** $424.80
Amend 515	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine-attendance for the unscheduled evaluation and management of a patient, involving medical decision making of high complexity that requires: (a) taking a comprehensive history; and (b) comprehensive examination of one or more systems; and (c) ordering and evaluation of appropriate investigations; and (d) formulation and documentation of a diagnosis and management plan in relation to one or more problems; and (e) initiation of appropriate treatment interventions; and (f) liaison with relevant health care professionals and discussion with, as appropriate, the patient or the patient's relatives or agent (See para AN.0.60 of explanatory notes to this Category) **Fee:** $219.25 **Benefit:** 75% = $164.45 85% = $186.40 **Extended Medicare Safety Net Cap:** $500.00

A21. MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	2. PROLONGED PROFESSIONAL ATTENDANCES TO WHICH NO OTHER GROUP APPLIES
	Group A21. Medical Practitioner (Emergency Physician) Attendances To Which No Other Item Applies
	Subgroup 2. Prolonged Professional Attendances To Which No Other Group Applies
Amend 519	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine-attendance for a total period (whether or not continuous) of at least 30 minutes but less than 1 hour (before the patient's admission to an in-patient hospital bed) for emergency evaluation of a critically ill patient with an immediately life threatening problem (See para AN.0.61 of explanatory notes to this Category) **Fee:** $150.75 **Benefit:** 75% = $113.10 85% = $128.15 **Extended Medicare Safety Net Cap:** $452.25
Amend 520	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine-attendance for a total period (whether or not continuous) of at least 1 hour but less than 2 hours (before the patient's admission to an in-patient

	hospital bed) for emergency evaluation of a critically ill patient with an immediately life threatening problem (See para AN.0.61 of explanatory notes to this Category) **Fee:** $289.60 **Benefit:** 75% = $217.20 85% = $246.20 **Extended Medicare Safety Net Cap:** $500.00
Amend 530	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine-attendance for a total period (whether or not continuous) of at least 2 hours but less than 3 hours (before the patient's admission to an in-patient hospital bed) for emergency evaluation of a critically ill patient with an immediately life threatening problem (See para AN.0.61 of explanatory notes to this Category) **Fee:** $474.70 **Benefit:** 75% = $356.05 85% = $403.50 **Extended Medicare Safety Net Cap:** $500.00
Amend 532	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine-attendance for a total period (whether or not continuous) of at least 3 hours but less than 4 hours (before the patient's admission to an in-patient hospital bed) for emergency evaluation of a critically ill patient with an immediately life threatening problem (See para AN.0.61 of explanatory notes to this Category) **Fee:** $659.75 **Benefit:** 75% = $494.85 85% = $575.05 **Extended Medicare Safety Net Cap:** $500.00
Amend 534	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine-attendance for a total period (whether or not continuous) of at least 4 hours but less than 5 hours (before the patient's admission to an in-patient hospital bed) for emergency evaluation of a critically ill patient with an immediately life threatening problem (See para AN.0.61 of explanatory notes to this Category) **Fee:** $844.95 **Benefit:** 75% = $633.75 85% = $760.25 **Extended Medicare Safety Net Cap:** $500.00
Amend 536	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine-attendance for a total period (whether or not continuous) of at least 5 hours (before the patient's admission to an in-patient hospital bed) for emergency evaluation of a critically ill patient with an immediately life threatening problem (See para AN.0.61 of explanatory notes to this Category) **Fee:** $937.50 **Benefit:** 75% = $703.15 85% = $852.80 **Extended Medicare Safety Net Cap:** $500.00

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

	Group A22. General Practitioner After-Hours Attendances To Which No Other Item Applies
	LEVEL A Professional attendance by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.
5000	Professional attendance at consulting rooms (other than a service to which another item applies) by a

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	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 (See para AN.0.19, AN.0.9 of explanatory notes to this Category) **Fee:** $29.45 **Benefit:** 100% = $29.45 **Extended Medicare Safety Net Cap:** $88.35
5003	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies) that requires a short patient history and, if necessary, limited examination and management-an attendance on one or more patients on one occasion-each patient (See para AN.0.19, AN.0.9, AN.0.11 of explanatory notes to this Category) **Derived Fee:** The fee for item 5000, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5010	Professional attendance (other than a service to which another 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, if the patient is accommodated in a residential aged care facility (other than 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 one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.19, AN.0.9, AN.0.15 of explanatory notes to this Category) **Derived Fee:** The fee for item 5000, plus $47.45 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus $3.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL B Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
5020	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(See para AN.0.19, AN.0.9 of explanatory notes to this Category) **Fee:** $49.80 **Benefit:** 100% = $49.80 **Extended Medicare Safety Net Cap:** $149.40
5023	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients on one occasion-each patient (See para AN.0.19, AN.0.9, AN.0.11 of explanatory notes to this Category) **Derived Fee:** The fee for item 5020, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5020 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5028	Professional attendance by a general practitioner (other than a service to which another item in the table applies), at a residential aged care facility to residents of the facility, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.19, AN.0.9, AN.0.15 of explanatory notes to this Category) **Derived Fee:** The fee for item 5020, plus $47.45 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5020 plus $3.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL C Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
5040	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance (See para AN.0.19, AN.0.9 of explanatory notes to this Category) **Fee:** $85.30 **Benefit:** 100% = $85.30 **Extended Medicare Safety Net Cap:** $255.90
5043	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients on one occasion-each patient (See para AN.0.19, AN.0.9, AN.0.11 of explanatory notes to this Category) **Derived Fee:** The fee for item 5040, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5049	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan;

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.19, AN.0.9, AN.0.15 of explanatory notes to this Category) **Derived Fee:** The fee for item 5040, plus $47.45 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus $3.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
5060	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance (See para AN.0.19, AN.0.9 of explanatory notes to this Category) **Fee:** $119.65 **Benefit:** 100% = $119.65 **Extended Medicare Safety Net Cap:** $358.95
5063	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients on one occasion-each patient

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(See para AN.0.19, AN.0.9, AN.0.11 of explanatory notes to this Category) **Derived Fee:** The fee for item 5060, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5060 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5067	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.19, AN.0.9, AN.0.15 of explanatory notes to this Category) **Derived Fee:** The fee for item 5060, plus $47.45 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5060 plus $3.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A23. OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A23. Other Non-Referred After-Hours Attendances To Which No Other Item Applies
	CONSULTATION AT CONSULTING ROOMS Professional attendance by a medical practitioner (other than a general practitioner) at consulting rooms
5200	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)-each attendance **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
5203	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)-each attendance **Fee:** $31.00 **Benefit:** 100% = $31.00 **Extended Medicare Safety Net Cap:** $93.00
5207	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)-each attendance **Fee:** $48.00 **Benefit:** 100% = $48.00

A23. OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Extended Medicare Safety Net Cap: $144.00
5208	Professional attendance at consulting rooms of more than 45 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)-each attendance **Fee:** $71.00 **Benefit:** 100% = $71.00 **Extended Medicare Safety Net Cap:** $213.00
	CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS, HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY Professional attendance by a medical practitioner (other than a general practitioner) on 1 or more patients on 1 occasion at a place other than consulting rooms, a hospital or residential aged care facility.
5220	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting not more than 5 minutes-an attendance on one or more patients on one occasion-each patient (See para AN.0.11 of explanatory notes to this Category) **Derived Fee:** An amount equal to $18.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $18.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5223	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 5 minutes, but not more than 25 minutes-an attendance on one or more patients on one occasion-each patient (See para AN.0.11 of explanatory notes to this Category) **Derived Fee:** An amount equal to $26.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $26.00 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5227	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 25 minutes, but not more than 45 minutes-an attendance on one or more patients on one occasion-each patient (See para AN.0.11 of explanatory notes to this Category) **Derived Fee:** An amount equal to $45.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $45.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5228	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 45 minutes-an attendance on one or more patients on one occasion-each patient (See para AN.0.11 of explanatory notes to this Category) **Derived Fee:** An amount equal to $67.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $67.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY Professional attendance on 1 or more patients on 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding

A23. OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	accommodation in a self-contained unit) on 1 occasion – each patient
5260	Professional attendance (other than a service to which another 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 if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of not more than 5 minutes in duration by a medical practitioner (other than a general practitioner)-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.15 of explanatory notes to this Category) **Derived Fee:** An amount equal to $18.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $18.50 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5263	Professional attendance (other than a service to which another 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 if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 5 minutes in duration but not more than 25 minutes in duration by a medical practitioner (other than a general practitioner)-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.15 of explanatory notes to this Category) **Derived Fee:** An amount equal to $26.00, plus $31.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $26.00 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5265	Professional attendance (other than a service to which another 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 if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 25 minutes in duration but not more than 45 minutes by a medical practitioner (other than a general practitioner)-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.15 of explanatory notes to this Category) **Derived Fee:** An amount equal to $45.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $45.50 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5267	Professional attendance (other than a service to which another 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 if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 45 minutes in duration by a medical practitioner (other than a general practitioner)-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.15 of explanatory notes to this Category) **Derived Fee:** An amount equal to $67.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $67.50 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
A24. PAIN AND PALLIATIVE MEDICINE	**1. PAIN MEDICINE ATTENDANCES**
	Group A24. Pain And Palliative Medicine

	Subgroup 1. Pain Medicine Attendances
Amend 2799	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist or consultant physician practising in the specialist's or consultant physician's specialty of pain medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment (See para AN.0.68 of explanatory notes to this Category) **Fee:** $116.75 **Benefit:** 85% = $99.25 **Extended Medicare Safety Net Cap:** $350.25
Amend 2801	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-initial attendance in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30 **Extended Medicare Safety Net Cap:** $466.80
Amend 2806	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each attendance (other than a service to which item 2814 applies) after the first in a single course of treatment (See para AN.0.58, AN.0.70 of explanatory notes to this Category) **Fee:** $77.90 **Benefit:** 75% = $58.45 85% = $66.25 **Extended Medicare Safety Net Cap:** $233.70
Amend 2814	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each minor attendance after the first attendance in a single course of treatment (See para AN.0.58, AN.0.70 of explanatory notes to this Category) **Fee:** $44.35 **Benefit:** 75% = $33.30 85% = $37.70 **Extended Medicare Safety Net Cap:** $133.05
Amend	Professional attendance on a patient by a specialist or consultant physician practising in the specialist's

2820	or consultant physician's specialty of pain medicine if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 2801 lasting more than 10 minutes; or (ii) provided with item 2806 or 2814; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.0.68 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 2801, 2806 or 2814. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Amend 2824	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-initial attendance in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $188.80 **Benefit:** 85% = $160.50 **Extended Medicare Safety Net Cap:** $500.00
Amend 2832	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each attendance (other than a service to which item 2840 applies) after the first in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $114.20 **Benefit:** 85% = $97.10 **Extended Medicare Safety Net Cap:** $342.60
Amend 2840	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each minor attendance after the first attendance in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $82.25 **Benefit:** 85% = $69.95

A24. PAIN AND PALLIATIVE MEDICINE	1. PAIN MEDICINE ATTENDANCES
	Extended Medicare Safety Net Cap: $246.75

A24. PAIN AND PALLIATIVE MEDICINE	2. PAIN MEDICINE CASE CONFERENCES
	Group A24. Pain And Palliative Medicine
	Subgroup 2. Pain Medicine Case Conferences
Amend 2946	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $143.45 **Benefit:** 75% = $107.60 85% = $121.95 **Extended Medicare Safety Net Cap:** $430.35
Amend 2949	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $215.25 **Benefit:** 75% = $161.45 85% = $183.00 **Extended Medicare Safety Net Cap:** $500.00
Amend 2954	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $286.80 **Benefit:** 75% = $215.10 85% = $243.80 **Extended Medicare Safety Net Cap:** $500.00
Amend 2958	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $103.00 **Benefit:** 75% = $77.25 85% = $87.55 **Extended Medicare Safety Net Cap:** $309.00
Amend 2972	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $164.30 **Benefit:** 75% = $123.25 85% = $139.70 **Extended Medicare Safety Net Cap:** $492.90
Amend 2974	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $225.60 **Benefit:** 75% = $169.20 85% = $191.80 **Extended Medicare Safety Net Cap:** $500.00
Amend 2978	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)

A24. PAIN AND PALLIATIVE MEDICINE	2. PAIN MEDICINE CASE CONFERENCES
	(See para AN.0.58 of explanatory notes to this Category) **Fee:** $143.45 **Benefit:** 75% = $107.60 85% = $121.95 **Extended Medicare Safety Net Cap:** $430.35
Amend 2984	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $215.25 **Benefit:** 75% = $161.45 85% = $183.00 **Extended Medicare Safety Net Cap:** $500.00
Amend 2988	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $286.80 **Benefit:** 75% = $215.10 85% = $243.80 **Extended Medicare Safety Net Cap:** $500.00
Amend 2992	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $103.00 **Benefit:** 75% = $77.25 85% = $87.55 **Extended Medicare Safety Net Cap:** $309.00
Amend 2996	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $164.30 **Benefit:** 75% = $123.25 85% = $139.70 **Extended Medicare Safety Net Cap:** $492.90
Amend 3000	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $225.60 **Benefit:** 75% = $169.20 85% = $191.80 **Extended Medicare Safety Net Cap:** $500.00

A24. PAIN AND PALLIATIVE MEDICINE	3. PALLIATIVE MEDICINE ATTENDANCES
	Group A24. Pain And Palliative Medicine
	Subgroup 3. Palliative Medicine Attendances
Amend 3003	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist or consultant physician practising in the specialist's or consultant physician's specialty of palliative medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and

	(c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment (See para AN.0.68 of explanatory notes to this Category) **Fee:** $116.75 **Benefit:** 85% = $99.25 **Extended Medicare Safety Net Cap:** $350.25
Amend 3005	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-initial attendance in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30 **Extended Medicare Safety Net Cap:** $466.80
Amend 3010	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each attendance (other than a service to which item 3014 applies) after the first in a single course of treatment (See para AN.0.58, AN.0.70 of explanatory notes to this Category) **Fee:** $77.90 **Benefit:** 75% = $58.45 85% = $66.25 **Extended Medicare Safety Net Cap:** $233.70
Amend 3014	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each minor attendance after the first attendance in a single course of treatment (See para AN.0.58, AN.0.70 of explanatory notes to this Category) **Fee:** $44.35 **Benefit:** 75% = $33.30 85% = $37.70 **Extended Medicare Safety Net Cap:** $133.05
Amend 3015	Professional attendance on a patient by a specialist or consultant physician practising in the specialist's or consultant physician's specialty of palliative medicine if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 3005 lasting more than 10 minutes; or

	(ii) provided with item 3010 or 3014; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.0.68 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 3005, 3010 or 3014. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Amend 3018	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-initial attendance in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $188.80 **Benefit:** 85% = $160.50 **Extended Medicare Safety Net Cap:** $500.00
Amend 3023	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each attendance (other than a service to which item 3028 applies) after the first in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $114.20 **Benefit:** 85% = $97.10 **Extended Medicare Safety Net Cap:** $342.60
Amend 3028	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each minor attendance after the first attendance in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $82.25 **Benefit:** 85% = $69.95 **Extended Medicare Safety Net Cap:** $246.75

A24. PAIN AND PALLIATIVE MEDICINE 4. PALLIATIVE MEDICINE CASE CONFERENCES

	Group A24. Pain And Palliative Medicine
	Subgroup 4. Palliative Medicine Case Conferences
Amend 3032	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to

	organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $143.45 **Benefit:** 75% = $107.60 85% = $121.95 **Extended Medicare Safety Net Cap:** $430.35
Amend 3040	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $215.25 **Benefit:** 75% = $161.45 85% = $183.00 **Extended Medicare Safety Net Cap:** $500.00
Amend 3044	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $286.80 **Benefit:** 75% = $215.10 85% = $243.80 **Extended Medicare Safety Net Cap:** $500.00
Amend 3051	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $103.00 **Benefit:** 75% = $77.25 85% = $87.55 **Extended Medicare Safety Net Cap:** $309.00
Amend 3055	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.58 of explanatory notes to this Category) **Fee:** $164.30 **Benefit:** 75% = $123.25 85% = $139.70 **Extended Medicare Safety Net Cap:** $492.90
Amend 3062	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $225.60 **Benefit:** 75% = $169.20 85% = $191.80 **Extended Medicare Safety Net Cap:** $500.00
Amend 3069	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $143.45 **Benefit:** 75% = $107.60 85% = $121.95 **Extended Medicare Safety Net Cap:** $430.35
Amend 3074	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient

	is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $215.25 **Benefit:** 75% = $161.45 85% = $183.00 **Extended Medicare Safety Net Cap:** $500.00
Amend 3078	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $286.80 **Benefit:** 75% = $215.10 85% = $243.80 **Extended Medicare Safety Net Cap:** $500.00
Amend 3083	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $103.00 **Benefit:** 75% = $77.25 85% = $87.55 **Extended Medicare Safety Net Cap:** $309.00
Amend 3088	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $164.30 **Benefit:** 75% = $123.25 85% = $139.70 **Extended Medicare Safety Net Cap:** $492.90
Amend 3093	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $225.60 **Benefit:** 75% = $169.20 85% = $191.80 **Extended Medicare Safety Net Cap:** $500.00

A26. NEUROSURGERY ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

	Group A26. Neurosurgery Attendances To Which No Other Item Applies
6004	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist practising in his or her specialty of neurosurgery if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist; or

	(ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment (See para AN.0.68 of explanatory notes to this Category) **Fee:** $100.25 **Benefit:** 85% = $85.25 **Extended Medicare Safety Net Cap:** $300.75
Amend 6007	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-an attendance (other than a second or subsequent attendance in a single course of treatment) at consulting rooms or hospital (See para AN.0.64 of explanatory notes to this Category) **Fee:** $133.65 **Benefit:** 75% = $100.25 85% = $113.65 **Extended Medicare Safety Net Cap:** $400.95
Amend 6009	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-a minor attendance after the first in a single course of treatment at consulting rooms or hospital (See para AN.0.64 of explanatory notes to this Category) **Fee:** $44.35 **Benefit:** 75% = $33.30 85% = $37.70 **Extended Medicare Safety Net Cap:** $133.05
Amend 6011	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-an attendance after the first in a single course of treatment, involving an extensive and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 15 minutes in duration but not more than 30 minutes in duration at consulting rooms or hospital (See para AN.0.64 of explanatory notes to this Category) **Fee:** $88.25 **Benefit:** 75% = $66.20 85% = $75.05 **Extended Medicare Safety Net Cap:** $264.75
Amend 6013	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-an attendance after the first in a single course of treatment, involving a detailed and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 30 minutes in duration but not more than 45 minutes in duration at consulting rooms or hospital (See para AN.0.64 of explanatory notes to this Category) **Fee:** $122.20 **Benefit:** 75% = $91.65 85% = $103.90 **Extended Medicare Safety Net Cap:** $366.60
Amend 6015	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-an attendance after the first in a single course of treatment, involving an exhaustive and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 45 minutes in duration at consulting rooms or hospital (See para AN.0.64 of explanatory notes to this Category) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30 **Extended Medicare Safety Net Cap:** $466.80

A26. NEUROSURGERY ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Professional attendance on a patient by a specialist practising in the specialist's specialty of neurosurgery if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 6007 lasting more than 10 minutes; or (ii) provided with item 6009, 6011, 6013 or 6015; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.0.68 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 6007, 6009, 6011, 6013 or 6015. Benefit: 85% of the derived fee
Amend 6016	**Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A27. PREGNANCY SUPPORT COUNSELLING	
	Group A27. Pregnancy Support Counselling
	Professional attendance of at least 20 minutes in duration at consulting rooms by a general practitioner who is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service for the purpose of providing non-directive pregnancy support counselling to a person who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item or item 81000, 81005 or 81010 applies in relation to that pregnancy Note: For items 81000, 81005 and 81010, see the determination about allied health services under subsection 3C(1) of the Act. (See para AN.0.66 of explanatory notes to this Category) **Fee:** $77.85 **Benefit:** 100% = $77.85
4001	**Extended Medicare Safety Net Cap:** $233.55

A28. GERIATRIC MEDICINE

A28. GERIATRIC MEDICINE	
	Group A28. Geriatric Medicine
Amend 141	Professional attendance of more than 60 minutes in duration at consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and (c) during the attendance: (i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail using appropriately validated assessment tools if indicated (the assessment); and (ii) the patient's various health problems and care needs are identified and prioritised (the formulation); and (iii) a detailed management plan is prepared (the management plan) setting out: (A) the prioritised list of health problems and care needs; and (B) short and longer term management goals; and (C) recommended actions or intervention strategies to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient and the patient's family and carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and (v) the management plan is communicated in writing to the referring practitioner; and (d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (e) an attendance to which this item or item 145 applies has not been provided to the patient by the same practitioner in the preceding 12 months (See para AN.0.26 of explanatory notes to this Category) **Fee:** $466.80 **Benefit:** 75% = $350.10 85% = $396.80 **Extended Medicare Safety Net Cap:** $500.00
Amend 143	Professional attendance of more than 30 minutes in duration at consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under item 141 or 145, if: (a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and (b) during the attendance: (i) the patient's health status is reassessed; and

A28. GERIATRIC MEDICINE	
	(ii) a management plan prepared under item 141 or 145 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies was not provided to the patient on the same day by the same practitioner; and (d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and (e) an attendance to which this item or item 147 applies has not been provided to the patient in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review (See para AN.0.26 of explanatory notes to this Category) **Fee:** $291.80 **Benefit:** 75% = $218.85 85% = $248.05 **Extended Medicare Safety Net Cap:** $500.00
Amend 145	Professional attendance of more than 60 minutes in duration at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and (c) during the attendance: (i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail utilising appropriately validated assessment tools if indicated (the assessment); and (ii) the patient's various health problems and care needs are identified and prioritised (the formulation); and (iii) a detailed management plan is prepared (the management plan) setting out: (A) the prioritised list of health problems and care needs; and (B) short and longer term management goals; and (C) recommended actions or intervention strategies, to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient, the patient's family and any carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and (v) the management plan is communicated in writing to the referring practitioner; and (d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (e) an attendance to which this item or item 141 applies has not been provided to the patient by the same

A28. GERIATRIC MEDICINE	
	practitioner in the preceding 12 months (See para AN.0.26 of explanatory notes to this Category) **Fee:** $566.00 **Benefit:** 85% = $481.30 **Extended Medicare Safety Net Cap:** $500.00
Amend 147	Professional attendance of more than 30 minutes in duration at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under items 141 or 145, if: (a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and (b) during the attendance: (i) the patient's health status is reassessed; and (ii) a management plan that was prepared under item 141 or 145 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and (e) an attendance to which this item or 143 applies has not been provided by the same practitioner in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review (See para AN.0.26 of explanatory notes to this Category) **Fee:** $353.80 **Benefit:** 85% = $300.75 **Extended Medicare Safety Net Cap:** $500.00
Amend 149	Professional attendance on a patient by a consultant physician or specialist practising in the consultant physician's or specialist's specialty of geriatric medicine if: (a) the attendance is by video conference; and (b) item 141 or 143 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the physician or specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of:

A28. GERIATRIC MEDICINE	
	(A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service: for which a direction made under subsection 19(2) of the Act applies (See para AN.0.68 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 141 or 143. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
A29. EARLY INTERVENTION SERVICES FOR CHILDREN WITH AUTISM, PERVASIVE DEVELOPMENTAL DISORDER OR DISABILITY	
	Group A29. Early Intervention Services For Children With Autism, Pervasive Developmental Disorder Or Disability
Amend 135	Professional attendance of at least 45 minutes in duration at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty of paediatrics, following referral of the patient to the consultant by a referring practitioner, for assessment, diagnosis and preparation of a treatment and management plan for a patient aged under 13 years with autism or another pervasive developmental disorder, if the consultant paediatrician does all of the following: (a) undertakes a comprehensive assessment and makes a diagnosis (if appropriate, using information provided by an eligible allied health provider); (b) develops a treatment and management plan, which must include the following: (i) an assessment and diagnosis of the patient's condition; (ii) a risk assessment; (iii) treatment options and decisions; (iv) if necessary-medical recommendations; (c) provides a copy of the treatment and management plan to: (i) the referring practitioner; and (ii) one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 137, 139 or 289) (See para AN.0.24 of explanatory notes to this Category) **Fee:** $272.15 **Benefit:** 75% = $204.15 85% = $231.35 **Extended Medicare Safety Net Cap:** $500.00
137	Professional attendance of at least 45 minutes duration, at consulting rooms or hospital, by a specialist or consultant physician, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with an eligible disability, who has been referred to the specialist or consultant physician by a referring practitioner, if the specialist or consultant physician does the following: (a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate) (b) develops a treatment and management plan which must include the following:

A29. EARLY INTERVENTION SERVICES FOR CHILDREN WITH AUTISM, PERVASIVE DEVELOPMENTAL DISORDER OR DISABILITY	
	(i) the outcomes of the assessment; (ii) the diagnosis or diagnoses; (iii) opinion on risk assessment; (iv) treatment options and decisions; (v) appropriate medication recommendations, where necessary. (c) provides a copy of the treatment and management plan to the: (i) referring practitioner; and (ii) relevant allied health providers (where appropriate). Not being an attendance on a child in respect of whom payment has previously been made under this item or items 135, 139 or 289. (See para AN.0.25 of explanatory notes to this Category) **Fee:** $272.15 **Benefit:** 75% = $204.15 85% = $231.35 **Extended Medicare Safety Net Cap:** $500.00
139	Professional attendance of at least 45 minutes in duration at consulting rooms only, by a general practitioner (not including a specialist or consultant physician) for assessment, diagnosis and preparation of a treatment and management plan for a patient under 13 years with an eligible disability if the general practitioner does all of the following: (a) undertakes a comprehensive assessment and makes a diagnosis (if appropriate, using information provided by an eligible allied health provider); (b) develops a treatment and management plan, which must include the following: (i) an assessment and diagnosis of the patient's condition; (ii) a risk assessment; (iii) treatment options and decisions; (iv) if necessary-medication recommendations; (c) provides a copy of the treatment and management plan to one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 137 or 289) (See para AN.0.25 of explanatory notes to this Category) **Fee:** $136.65 **Benefit:** 100% = $136.65 **Extended Medicare Safety Net Cap:** $409.95

A30. MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES	1. TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS
	Group A30. Medical Practitioner (Including A General Practitioner, Specialist Or Consultant

	Physician) Telehealth Attendances
	Subgroup 1. Telehealth Attendance At Consulting Rooms, Home Visits Or Other Institutions
2100	Professional attendance at consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service: for which a direction made under subsection 19(2) of the Act applies (See para AN.0.67 of explanatory notes to this Category) **Fee:** $23.25 **Benefit:** 100% = $23.25 **Extended Medicare Safety Net Cap:** $69.75
2122	Professional attendance not in consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.67 of explanatory notes to this Category) **Derived Fee:** The fee for item 2100 plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2100 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2126	Professional attendance at consulting rooms of less than 20 minutes in duration (whether or not

	continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.0.67 of explanatory notes to this Category) **Fee:** $50.75 **Benefit:** 100% = $50.75 **Extended Medicare Safety Net Cap:** $152.25
2137	Professional attendance not in consulting rooms of less than 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.67 of explanatory notes to this Category) **Derived Fee:** The fee for item 2126 plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2126 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2143	Professional attendance at consulting rooms of at least 20 minutes in duration (whether or not continuous) by a medical practitioner who provides clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and

	(b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service: for which a direction made under subsection 19(2) of the Act applies (See para AN.0.67 of explanatory notes to this Category) **Fee:** $98.40 **Benefit:** 100% = $98.40 **Extended Medicare Safety Net Cap:** $295.20
2147	Professional attendance not in consulting rooms of at least 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.67 of explanatory notes to this Category) **Derived Fee:** The fee for item 2143 plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2143 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2195	Professional attendance at consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either:

	(i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.0.67 of explanatory notes to this Category) **Fee:** $144.80 **Benefit:** 100% = $144.80 **Extended Medicare Safety Net Cap:** $434.40
2199	Professional attendance not in consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.67 of explanatory notes to this Category) **Derived Fee:** The fee for item 2195 plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2195 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

	Group A30. Medical Practitioner (Including A General Practitioner, Specialist Or Consultant Physician) Telehealth Attendances
	Subgroup 2. Telehealth Attendance At A Residential Aged Care Facility
2125	Professional attendance of at least 5 minutes in duration (whether or not continuous) by a general practitioner, specialist or consultant physician providing clinical support to a patient who:

	(a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.67 of explanatory notes to this Category) **Derived Fee:** The fee for item 2100 plus $47.45 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2100 plus $3.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2138	Professional attendance of less than 20 minutes in duration (whether or not continuous) by a general practitioner, specialist or consultant physician providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.67 of explanatory notes to this Category) **Derived Fee:** The fee for item 2126 plus $47.45 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2126 plus $3.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2179	Professional attendance of at least 20 minutes in duration (whether or not continuous) by a general practitioner, specialist or consultant physician providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.67 of explanatory notes to this Category) **Derived Fee:** The fee for item 2143 plus $47.45 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2143 plus $3.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2220	Professional attendance of at least 40 minutes in duration (whether or not continuous) by a general practitioner, specialist or consultant physician providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit;

	for an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.67 of explanatory notes to this Category) **Derived Fee:** The fee for item 2195 plus $47.45 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2195 plus $3.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

	Group A30. Medical Practitioner (Including A General Practitioner, Specialist Or Consultant Physician) Telehealth Attendances
	Subgroup 3. Mental Health and Well-being Video Conferencing Consultation
2121	Professional attendance at consulting rooms by a general practitioner, lasting less than 20 minutes, for providing mental health services to a patient with mental health issues, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient and the general practitioner are located within a drought affected eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the general practitioner; and (e) the patient has an existing relationship with the general practitioner. (See para AN.30.1 of explanatory notes to this Category) **Fee:** $44.90 **Benefit:** 85% = $38.20 **Extended Medicare Safety Net Cap:** $134.70
2150	Professional attendance at consulting rooms by a general practitioner, lasting at least 20 minutes, for providing mental health services to a patient with mental health issues, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient and the general practitioner are located within a drought affected eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the general practitioner; and (e) the patient has an existing relationship with the general practitioner. (See para AN.30.1 of explanatory notes to this Category) **Fee:** $86.95 **Benefit:** 85% = $73.95 **Extended Medicare Safety Net Cap:** $260.85
2196	Professional attendance at consulting rooms by a general practitioner, lasting at least 40 minutes, for providing mental health services to a patient with mental health issues, if:

A30. MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES	3. MENTAL HEALTH AND WELL-BEING VIDEO CONFERENCING CONSULTATION
	(a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient and the general practitioner are located within a drought affected eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the general practitioner; and (e) the patient has an existing relationship with the general practitioner. (See para AN.30.1 of explanatory notes to this Category) **Fee:** $128.05 **Benefit:** 85% = $108.85 **Extended Medicare Safety Net Cap:** $384.15

A30. MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES	5. GENERAL PRACTITIONER VIDEO CONFERENCING CONSULTATION ATTENDANCE FOR PATIENTS IN RURAL AND REMOTE AREAS
	Group A30. Medical Practitioner (Including A General Practitioner, Specialist Or Consultant Physician) Telehealth Attendances
	Subgroup 5. General Practitioner Video Conferencing Consultation Attendance for Patients in Rural and Remote Areas
New 2461	Professional attendance by video conference 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, only if: • the patient is not an admitted patient; and • the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and • at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and • the patient has received 3 face-to-face professional attendances from that practitioner in the preceding 12 months. **Fee:** $17.50 **Benefit:** 100% = $17.50 **Extended Medicare Safety Net Cap:** $52.50
New 2463	Professional attendance by video conference by a general practitioner (other than a service to which another item applies), lasting less than 20 minutes and including any of the following that are clinically relevant: • taking a patient history; • performing a clinical examination; • (arranging any necessary investigation; • implementing a management plan; • providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—only if: - the patient is not an admitted patient; and - the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and

	- at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and - the patient has received 3 face-to-face professional attendances from that practitioner in the preceding 12 months. **Fee:** $38.20 **Benefit:** 100% = $38.20 **Extended Medicare Safety Net Cap:** $114.60
New 2464	Professional attendance by video conference by a general practitioner (other than a service to which another item applies), lasting at least 20 minutes but less than 40 minutes and including any of the following that are clinically relevant: • taking a patient history; • performing a clinical examination; • arranging any necessary investigation; • implementing a management plan; • providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—only if: - the patient is not an admitted patient; and - the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and - at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and - the patient has received 3 face-to-face professional attendances from that practitioner in the preceding 12 months. **Fee:** $73.95 **Benefit:** 100% = $73.95 **Extended Medicare Safety Net Cap:** $221.85
New 2465	Professional attendance by video conference by a general practitioner (other than a service to which another item applies), lasting at least 40 minutes and including any of the following that are clinically relevant: • taking a patient history; • performing a clinical examination; • arranging any necessary investigation; • implementing a management plan; • providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—only if: - the patient is not an admitted patient; and - the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and - at the time of the attendance, the patient and the medical practitioner are at least 15 km by road

A30. MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES	5. GENERAL PRACTITIONER VIDEO CONFERENCING CONSULTATION ATTENDANCE FOR PATIENTS IN RURAL AND REMOTE AREAS
	from each other; and - the patient has received 3 face-to-face professional attendances from that practitioner in the preceding 12 months. **Fee:** $108.85 **Benefit:** 100% = $108.85 **Extended Medicare Safety Net Cap:** $326.55

A30. MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES	6. OTHER NON-REFERRED VIDEO CONFERENCING CONSULTATION ATTENDANCE FOR PATIENTS IN RURAL AND REMOTE AREAS
	Group A30. Medical Practitioner (Including A General Practitioner, Specialist Or Consultant Physician) Telehealth Attendances
	Subgroup 6. Other Non-Referred Video Conferencing Consultation Attendance for Patients in Rural and Remote Areas
New 2471	Professional attendance by video conference of not more than 5 minutes in duration (other than a service to which another item applies) by a medical practitioner (who is not a general practitioner), only if: (a) the patient is not an admitted patient; and (b) the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and (c) at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and (d) the patient has received 3 face-to-face professional attendances from that practitioner in the preceding 12 months. **Fee:** $11.00 **Benefit:** 100% = $11.00 **Extended Medicare Safety Net Cap:** $33.00
New 2472	Professional attendance by video conference of more than 5 minutes in duration but not more than 25 minutes (other than a service to which another item applies) by a medical practitioner (who is not a general practitioner), only if: (a) the patient is not an admitted patient; and (b) the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and (c) at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and (d) the patient has received 3 face-to-face professional attendances from that practitioner in the preceding 12 months. **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
New 2475	Professional attendance by video conference of more than 25 minutes in duration but not more than 45 minutes (other than a service to which another item applies) by a medical practitioner (who is not a

A30. MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES	6. OTHER NON-REFERRED VIDEO CONFERENCING CONSULTATION ATTENDANCE FOR PATIENTS IN RURAL AND REMOTE AREAS
	general practitioner), only if: (a) the patient is not an admitted patient; and (b) the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and (c) at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and (d) the patient has received 3 face-to-face professional attendances from that practitioner in the preceding 12 months. **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00
New 2478	Professional attendance by video conference of more than 45 minutes in duration (other than a service to which another item applies) by a medical practitioner (who is not a general practitioner), only if: (a) the patient is not an admitted patient; and (b) the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and (c) at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and (d) the patient has received 3 face-to-face professional attendances from that practitioner in the preceding 12 months. **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00

A30. MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES	7. NON SPECIALIST PRACTITIONER VIDEO CONFERENCING CONSULTTAION FOR PATIENTS IN RURAL AND REMOTE AREAS
	Group A30. Medical Practitioner (Including A General Practitioner, Specialist Or Consultant Physician) Telehealth Attendances
	Subgroup 7. Non Specialist Practitioner Video Conferencing Consulttaion for Patients in Rural and Remote Areas
New 2480	Professional attendance by video conference of not more than 5 minutes in duration by a medical practitioner, only if: (a) the patient is not an admitted patient; and (b) the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and (c) at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and (d) the patient has received 3 face-to-face professional attendances from that practitioner in the preceding 12 months. **Fee:** $14.00 **Benefit:** 100% = $14.00 **Extended Medicare Safety Net Cap:** $42.00

A30. MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES	7. NON SPECIALIST PRACTITIONER VIDEO CONFERENCING CONSULTTAION FOR PATIENTS IN RURAL AND REMOTE AREAS
New 2481	Professional attendance by video conference of more than 5 minutes in duration but not more than 25 minutes by a medical practitioner, only if: (a) the patient is not an admitted patient; and (b) the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and (c) at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and (d) the patient has received 3 face-to-face professional attendances from that practitioner in the preceding 12 months. **Fee:** $30.55 **Benefit:** 100% = $30.55 **Extended Medicare Safety Net Cap:** $91.65
New 2482	Professional attendance by video conference of more than 25 minutes in duration but not more than 45 minutes by a medical practitioner, only if: (a) the patient is not an admitted patient; and (b) the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and (c) at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and (d) the patient has received 3 face-to-face professional attendances from that practitioner in the preceding 12 months. **Fee:** $59.15 **Benefit:** 100% = $59.15 **Extended Medicare Safety Net Cap:** $177.45
New 2483	Professional attendance by video conference of more than 45 minutes in duration who is not a medical practitioner, only if: (a) the patient is not an admitted patient; and (b) the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and (c) at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and (d) the patient has received 3 face-to-face professional attendances from that practitioner in the preceding 12 months. **Fee:** $87.10 **Benefit:** 100% = $87.10 **Extended Medicare Safety Net Cap:** $261.30

A31. ADDICTION MEDICINE	1. ADDICTION MEDICINE ATTENDANCES
	Group A31. Addiction Medicine
	Subgroup 1. Addiction Medicine Attendances
Amend 6018	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty following referral of the patient to the addiction medicine specialist by a referring practitioner, if the attendance:

	(a) includes a comprehensive assessment; and (b) is the first or only time in a single course of treatment that a comprehensive assessment is provided **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
Amend 6019	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty following referral of the patient to the addiction medicine specialist by a referring practitioner, if the attendance is a patient assessment: (a) before or after a comprehensive assessment under item 6018 in a single course of treatment; or (b) that follows an initial assessment under item 6023 in a single course of treatment; or (c) that follows a review under item 6024 in a single course of treatment (See para AN.0.70 of explanatory notes to this Category) **Fee:** $77.90 **Benefit:** 75% = $58.45 85% = $66.25
Amend 6023	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to the addiction medicine specialist by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) an addiction medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions; (iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6018 or 6019 applies did not take place on the same day by the same addiction medicine specialist; and (d) neither this item nor item 132 has applied to an attendance on the patient in the preceding 12 months by the same addiction medicine specialist **Fee:** $272.15 **Benefit:** 75% = $204.15 85% = $231.35
Amend 6024	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty of at least 20 minutes, after the first attendance in a single course of treatment for a review of a patient with at least 2 morbidities if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and

	(iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified addiction medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6018 or 6019 applies did not take place on the same day by the same addiction medicine specialist; and (d) item 6023 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same addiction medicine specialist who claimed item 6023 or by a locum tenens; and (f) this item has not applied more than twice in any 12 month period **Fee:** $136.25 **Benefit:** 75% = $102.20 85% = $115.85
Amend 6025	Initial professional attendance of 10 minutes or less, on a patient by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 km by road from the addiction medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment **Fee:** $116.75 **Benefit:** 85% = $99.25
Amend 6026	Professional attendance on a patient by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, if: (a) the attendance is by video conference; and (b) the attendance is for a service:

A31. ADDICTION MEDICINE	1. ADDICTION MEDICINE ATTENDANCES
	(i) provided with item 6018 or 6019 and lasting more than 10 minutes; or (ii) provided with item 6023 or 6024; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 km by road from the addiction medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19 (2) of the Act applies **Derived Fee:** 50% of the fee for item 6018, 6019, 6023, or 6024 Benefit: 85% of the derived fee

A31. ADDICTION MEDICINE	2. GROUP THERAPY
	Group A31. Addiction Medicine
	Subgroup 2. Group Therapy
Amend 6028	Group therapy (including any associated consultation with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hour, given under the continuous direct supervision of an addiction medicine specialist in the practice of the addiction medicine specialist's specialty for a group of 2 to 9 unrelated patients, or a family group of more than 2 patients, each of whom is referred to the addiction medicine specialist by a referring practitioner-for each patient **Fee:** $50.85 **Benefit:** 75% = $38.15 85% = $43.25

A31. ADDICTION MEDICINE	3. ADDICTION MEDICINE CASE CONFERENCES
	Group A31. Addiction Medicine
	Subgroup 3. Addiction Medicine Case Conferences
Amend 6029	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of less than 15 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $44.05 **Benefit:** 75% = $33.05 85% = $37.45
Amend 6031	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $77.90 **Benefit:** 75% = $58.45 85% = $66.25

A31. ADDICTION MEDICINE	3. ADDICTION MEDICINE CASE CONFERENCES
Amend 6032	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $116.85 **Benefit:** 75% = $87.65 85% = $99.35
Amend 6034	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate the multidisciplinary case conference of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
Amend 6035	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of less than 15 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $35.20 **Benefit:** 75% = $26.40 85% = $29.95
Amend 6037	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $62.30 **Benefit:** 75% = $46.75 85% = $53.00
Amend 6038	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $93.45 **Benefit:** 75% = $70.10 85% = $79.45
Amend 6042	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $124.50 **Benefit:** 75% = $93.40 85% = $105.85

A32. SEXUAL HEALTH MEDICINE	1. SEXUAL HEALTH MEDICINE ATTENDANCES
	Group A32. Sexual Health Medicine
	Subgroup 1. Sexual Health Medicine Attendances
Amend 6051	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner, if the attendance: (a) includes a comprehensive assessment; and

	(b) is the first or only time in a single course of treatment that a comprehensive assessment is provided **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
Amend 6052	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner, if the attendance is a patient assessment: (a) before or after a comprehensive assessment under item 6051 in a single course of treatment; or (b) that follows an initial assessment under item 6057 in a single course of treatment; or (c) that follows a review under item 6058 in a single course of treatment (See para AN.0.70 of explanatory notes to this Category) **Fee:** $77.90 **Benefit:** 75% = $58.45 85% = $66.25
Amend 6057	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to the sexual health medicine specialist by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) a sexual health medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions; (iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6051 or 6052 applies did not take place on the same day by the same sexual health medicine specialist; and (d) neither this item nor item 132 has applied to an attendance on the patient in the preceding 12 months by the same sexual health medicine specialist **Fee:** $272.15 **Benefit:** 75% = $204.15 85% = $231.35
Amend 6058	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty of at least 20 minutes, after the first attendance in a single course of treatment for a review of a patient with at least 2 morbidities if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and

	(iv) review of original and differential diagnoses; and (b) the modified sexual health medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient, being an attendance to which item 104, 105, 110, 116, 119, 132, 133, 6051 or 6052 applies did not take place on the same day by the same sexual health medicine specialist; and (d) item 6057 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same sexual health medicine specialist who claimed item 6057 or by a locum tenens; and (f) this item has not applied more than twice in any 12 month period **Fee:** $136.25 **Benefit:** 75% = $102.20 85% = $115.85
Amend 6059	Initial professional attendance of 10 minutes or less, on a patient by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 km by road from the sexual health medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment **Fee:** $116.75 **Benefit:** 85% = $99.25
Amend 6060	Professional attendance on a patient by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty if: (a) the attendance is by video conference; and

A32. SEXUAL HEALTH MEDICINE	1. SEXUAL HEALTH MEDICINE ATTENDANCES
	(b) the attendance is for a service: (i) provided with item 6051 or 6052 and lasting more than 10 minutes; or (ii) provided with item 6057 or 6058; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 km by road from the sexual health medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19 (2) of the Act applies **Derived Fee:** 50% of the fee for item 6051, 6052, 6057 or 6058 Benefit: 85% of the derived fee

A32. SEXUAL HEALTH MEDICINE	2. HOME VISITS
	Group A32. Sexual Health Medicine
	Subgroup 2. Home Visits
Amend 6062	Professional attendance at a place other than consulting rooms or a hospital by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner-initial attendance in a single course of treatment **Fee:** $188.80 **Benefit:** 85% = $160.50
Amend 6063	Professional attendance at a place other than consulting rooms or a hospital by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner-each attendance after the attendance under item 6062 in a single course of treatment **Fee:** $114.20 **Benefit:** 85% = $97.10

A32. SEXUAL HEALTH MEDICINE	3. SEXUAL HEALTH MEDICINE CASE CONFERENCES
	Group A32. Sexual Health Medicine
	Subgroup 3. Sexual Health Medicine Case Conferences
Amend 6064	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of less than 15 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category)

	Fee: $44.05 **Benefit:** 75% = $33.05 85% = $37.45
Amend 6065	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $77.90 **Benefit:** 75% = $58.45 85% = $66.25
Amend 6067	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $116.85 **Benefit:** 75% = $87.65 85% = $99.35
Amend 6068	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
Amend 6071	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of less than 15 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $35.20 **Benefit:** 75% = $26.40 85% = $29.95
Amend 6072	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $62.30 **Benefit:** 75% = $46.75 85% = $53.00
Amend 6074	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $93.45 **Benefit:** 75% = $70.10 85% = $79.45
Amend 6075	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $124.50 **Benefit:** 75% = $93.40 85% = $105.85

A33. TRANSCATHETER AORTIC VALVE IMPLANTATION CASE CONFERENCE	
	Group A33. Transcatheter Aortic Valve Implantation Case Conference
6080	Coordination of a TAVI Case Conference by a TAVI Practitioner where the TAVI Case Conference has a duration of 10 minutes or more. (Not payable more than once per patient in a five year period.) (See para AN.33.1, TN.8.135 of explanatory notes to this Category) **Fee:** $51.70 **Benefit:** 75% = $38.80 85% = $43.95
6081	Attendance at a TAVI Case Conference by a specialist or consultant physician who does not also perform the service described in item 6080 for the same case conference where the TAVI Case Conference has a duration of 10 minutes or more. (Not payable more than twice per patient in a five year period.) (See para AN.33.1, TN.8.135 of explanatory notes to this Category) **Fee:** $38.55 **Benefit:** 75% = $28.95 85% = $32.80

A34. HEALTH CARE HOMES	
	Group A34. Health Care Homes
6087	A professional attendance, including by telephone or videoconference, on a patient participating in the Health Care Homes Program by or on behalf of a medical practitioner (including a general practitioner but not including a specialist or consultant physician) or participating nurse practitioner employed or otherwise engaged by the Health Care Home trial site at which the patient is enrolled - each patient. The service must be provided to the patient for the purposes of the Health Care Homes Program and the service may be provided to the patient individually or as part of a group. (See para AN.34.1 of explanatory notes to this Category) **Fee:** $1.15 **Benefit:** 85% = $1.00

A35. SERVICES FOR PATIENTS IN RESIDENTIAL AGED CARE FACILITIES	1. FLAG FALL AMOUNT FOR RESIDENTIAL AGED CARE FACILITIES
	Group A35. Services For Patients in Residential Aged Care Facilities
	Subgroup 1. Flag Fall Amount For Residential Aged Care Facilities
90001	A flag fall service to which item 90020, 90035, 90043 or 90051 applies. For the initial attendance at one residential aged care facility on one occasion, applicable to a maximum of one patient attended on. (See para AN.35.1 of explanatory notes to this Category) **Fee:** $55.90 **Benefit:** 100% = $55.90
90002	A flag fall service to which item 90092, 90093, 90095, 90096, 90183, 90188, 90202 or 90212 applies. For the initial attendance at one residential aged care facility on one occasion, applicable to a maximum of one patient attended on. (See para AN.35.2 of explanatory notes to this Category) **Fee:** $40.65 **Benefit:** 100% = $40.65

A35. SERVICES FOR PATIENTS IN RESIDENTIAL AGED CARE FACILITIES	2. GENERAL PRACTITIONER NON-REFERRED ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
	Group A35. Services For Patients in Residential Aged Care Facilities

	Subgroup 2. General Practitioner Non-Referred Attendance At A Residential Aged Care Facility
90020	Professional attendance (other than a service to which another 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 if the patient is accommodated in a residential aged care facility (other than 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 one or more patients at one residential aged care facility on one occasion - each patient. (See para AN.35.1, AN.0.9 of explanatory notes to this Category) **Fee:** $17.50 **Benefit:** 100% = $17.50
90035	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.35.1, AN.0.9 of explanatory notes to this Category) **Fee:** $38.20 **Benefit:** 100% = $38.20
90043	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.35.1, AN.0.9 of explanatory notes to this Category) **Fee:** $73.95 **Benefit:** 100% = $73.95
90051	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant:

	(a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.35.1, AN.0.9 of explanatory notes to this Category) **Fee:** $108.85 **Benefit:** 100% = $108.85

	Group A35. Services For Patients in Residential Aged Care Facilities
	Subgroup 3. Other Medical Practitioner Non-Referred Attendance At A Residential Aged Care Facility
Amend 90092	Professional attendance (other than 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 (that is not accommodation in a self-contained unit) of not more than 5 minutes in duration—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, by a medical practitioner who is not a general practitioner. (See para AN.7.1, AN.35.2 of explanatory notes to this Category) **Fee:** $8.50 **Benefit:** 100% = $8.50
Amend 90093	Professional attendance (other than 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 (that is not accommodation in a self-contained unit) of more than 5 minutes in duration but not more than 25 minutes—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, by a medical practitioner who is not a general practitioner. (See para AN.7.1, AN.35.2 of explanatory notes to this Category) **Fee:** $16.00 **Benefit:** 100% = $16.00
Amend 90095	Professional attendance (other than 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 (that is not accommodation in a self-contained unit) of more than 25 minutes in duration but not more than 45 minutes—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, by a medical practitioner who is not a general practitioner. (See para AN.7.1, AN.35.2 of explanatory notes to this Category) **Fee:** $35.50 **Benefit:** 100% = $35.50
Amend 90096	Professional attendance (other than 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 (that is not accommodation in a self-contained unit) of more than 45 minutes in duration—an attendance on one or more patients at one residential aged care facility on one occasion—

	each patient, by a medical practitioner who is not a general practitioner. (See para AN.7.1, AN.35.2 of explanatory notes to this Category) **Fee:** $57.50 **Benefit:** 100% = $57.50

	Group A35. Services For Patients in Residential Aged Care Facilities
	Subgroup 4. Non-Specialist Practitioner Non-Referred Attendance At A Residential Aged Care Facility
90183	Professional attendance (other than 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 (that is not accommodation in a self-contained unit) of not more than 5 minutes in duration—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, by medical practitioner in an eligible area. (See para AN.7.1, AN.35.2 of explanatory notes to this Category) **Fee:** $14.00 **Benefit:** 100% = $14.00
90188	Professional attendance (other than 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 (that is not accommodation in a self-contained unit) of more than 5 minutes in duration but not more than 25 minutes—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, by a medical practitioner in an eligible area. (See para AN.7.1, AN.35.2 of explanatory notes to this Category) **Fee:** $30.55 **Benefit:** 100% = $30.55
90202	Professional attendance (other than 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 (that is not accommodation in a self-contained unit) of more than 25 minutes in duration but not more than 45 minutes—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, by a medical practitioner in an eligible area. (See para AN.7.1, AN.35.2 of explanatory notes to this Category) **Fee:** $59.15 **Benefit:** 100% = $59.15
90212	Professional attendance (other than 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 (that is not accommodation in a self-contained unit) of more than 45 minutes in duration—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, by a medical practitioner in an eligible area. (See para AN.7.1, AN.35.2 of explanatory notes to this Category) **Fee:** $87.10 **Benefit:** 100% = $87.10

	Group A36. Eating Disorder Services
	Subgroup 1. GP and medical practitioner eating disorders treatment plan
New 90250	Professional attendance by a general practitioner who has not undertaken mental health skills training (not including a specialist or consultant physician), of at least 20 minutes but less than 40 minutes in duration for the preparation of a written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the general practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder (See para AN.36.1, AN.36.2 of explanatory notes to this Category) **Fee:** $72.85 **Benefit:** 100% = $72.85 **Extended Medicare Safety Net Cap:** $218.55
New 90251	Professional attendance by a general practitioner who has not undertaken mental health skills training (not including a specialist or consultant physician), of at least 40 minutes in duration for the preparation of a written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the general practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder (See para AN.36.1, AN.36.2 of explanatory notes to this Category) **Fee:** $107.25 **Benefit:** 100% = $107.25 **Extended Medicare Safety Net Cap:** $321.75
New 90252	Professional attendance by a general practitioner who has undertaken mental health skills training (not including a specialist or consultant physician), of at least 20 minutes but less than 40 minutes in duration for the preparation of a written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and

	(b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the general practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder (See para AN.36.1, AN.36.2 of explanatory notes to this Category) **Fee:** $92.50 **Benefit:** 100% = $92.50 **Extended Medicare Safety Net Cap:** $277.50
New 90253	Professional attendance by a general practitioner who has undertaken mental health skills training (not including a specialist or consultant physician), of at least 40 minutes in duration for the preparation of a written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the general practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder (See para AN.36.1, AN.36.2 of explanatory notes to this Category) **Fee:** $136.25 **Benefit:** 100% = $136.25 **Extended Medicare Safety Net Cap:** $408.75
New 90254	Professional attendance by a medical practitioner who has not undertaken mental health skills training, of at least 20 minutes but less than 40 minutes in duration for the preparation of a written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the medical practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and

	(ii) suitable education about the eating disorder (See para AN.36.1, AN.36.2 of explanatory notes to this Category) **Fee:** $58.30 **Benefit:** 100% = $58.30 **Extended Medicare Safety Net Cap:** $174.90
New 90255	Professional attendance by a medical practitioner who has not undertaken mental health skills training, of at least 40 minutes in duration for the preparation of a written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the medical practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder (See para AN.36.1, AN.36.2 of explanatory notes to this Category) **Fee:** $85.80 **Benefit:** 100% = $85.80 **Extended Medicare Safety Net Cap:** $257.40
New 90256	Professional attendance by a medical practitioner who has undertaken mental health skills training, of at least 20 minutes but less than 40 minutes in duration for the preparation of a written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the medical practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder (See para AN.36.1, AN.36.2 of explanatory notes to this Category) **Fee:** $74.00 **Benefit:** 100% = $74.00 **Extended Medicare Safety Net Cap:** $222.00
New 90257	Professional attendance by a medical practitioner who has undertaken mental health skills training, of at least 40 minutes in duration for the preparation of a written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the

A36. EATING DISORDER SERVICES	1. GP AND MEDICAL PRACTITIONER EATING DISORDERS TREATMENT PLAN
	following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the medical practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder (See para AN.36.1, AN.36.2 of explanatory notes to this Category) **Fee:** $109.00 **Benefit:** 100% = $109.00 **Extended Medicare Safety Net Cap:** $327.00

A36. EATING DISORDER SERVICES	2. CONSULTANT PSYCHIATRIST AND PAEDIATRICIAN EATING DISORDERS TREATMENT PLANS
	Group A36. Eating Disorder Services
	Subgroup 2. Consultant psychiatrist and paediatrician eating disorders treatment plans
	Professional attendance of at least 45 minutes in duration at consulting rooms by a consultant physician in the practice of the consultant physician's specialty of psychiatry for the preparation of an eating disorder treatment and management plan for an eligible patient, if: (a) the patient has been referred by a referring practitioner; and (b) during the attendance, the consultant psychiatrist: (i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (c) within 2 weeks after the attendance, the consultant psychiatrist: (i) prepares a written diagnosis of the patient; and (ii) prepares a written management plan for the patient that: (A) covers the next 12 months; and (B) is appropriate to the patient's diagnosis; and (C) comprehensively evaluates the patient's biological, psychological and social issues; and (D) addresses the patient's diagnostic psychiatric issues; and (E) makes management recommendations addressing the patient's biological, psychological and social issues; and
New 90260	(iii) gives the referring practitioner a copy of the diagnosis and the management plan; and

	(iv) if clinically appropriate, explains the diagnosis and management plan, and a gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees. (See para AN.36.1, AN.36.2 of explanatory notes to this Category) **Fee:** $466.80 **Benefit:** 85% = $396.80 **Extended Medicare Safety Net Cap:** $500.00
New 90261	Professional attendance of at least 45 minutes in duration at consulting rooms by a consultant physician in the practice of the consultant physician's specialty of paediatrics for the preparation of an eating disorder treatment and management plan for an eligible patient, if: (a) the patient has been referred by a referring practitioner; and (b) during the attendance, the consultant paediatrician undertakes an assessment that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) comprehensive multi or detailed single organ system assessment; and (iii) the formulation of diagnoses; and (c) within 2 weeks after the attendance, the consultant paediatrician: (i) prepares a written diagnosis of the patient; and (ii) prepares a written management plan for the patient that involves: (A) an opinion on diagnosis and risk assessment; and (B) treatment options and decisions; and (C) medication recommendations; and (iii) gives the referring practitioner a copy of the diagnosis and the management plan; and (iv) if clinically appropriate, explains the diagnosis and management plan, and a gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees (See para AN.36.1, AN.36.2 of explanatory notes to this Category) **Fee:** $272.15 **Benefit:** 85% = $231.35 **Extended Medicare Safety Net Cap:** $500.00
New 90262	Professional attendance of at least 45 minutes in duration by video conference by a consultant physician in the practice of the consultant physician's specialty of psychiatry for the preparation of an eating disorder treatment and management plan for an eligible patient, if: (a) the patient has been referred by a referring practitioner; and (b) during the attendance, the consultant psychiatrist: (i) uses an outcome tool (if clinically appropriate); and

	(ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (c) within 2 weeks after the attendance, the consultant psychiatrist: (i) prepares a written diagnosis of the patient; and (ii) prepares a written management plan for the patient that: (A) covers the next 12 months; and (B) is appropriate to the patient's diagnosis; and (C) comprehensively evaluates the patient's biological, psychological and social issues; and (D) addresses the patient's diagnostic psychiatric issues; and (E) makes management recommendations addressing the patient's biological, psychological and social issues; and (iii) gives the referring practitioner a copy of the diagnosis and the management plan; and (iv) if clinically appropriate, explains the diagnosis and management plan, and a gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees (See para AN.36.1, AN.36.2, AN.36.6 of explanatory notes to this Category) **Fee:** $466.80 **Benefit:** 85% = $396.80 **Extended Medicare Safety Net Cap:** $500.00
New 90263	Professional attendance of at least 45 minutes in duration by video conference by a consultant physician in the practice of the consultant physician's specialty of paediatrics for the preparation of an eating disorder treatment and management plan for an eligible patient, if: (a) the patient has been referred by a referring practitioner; and (b) during the attendance, the consultant paediatrician undertakes an assessment that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) comprehensive multi or detailed single organ system assessment; and (iii) the formulation of diagnoses; and (c) within 2 weeks after the attendance, the consultant paediatrician: (i) prepares a written diagnosis of the patient; and (ii) prepares a written management plan for the patient that involves: (A) an opinion on diagnosis and risk assessment; and (B) treatment options and decisions; and

A36. EATING DISORDER SERVICES	2. CONSULTANT PSYCHIATRIST AND PAEDIATRICIAN EATING DISORDERS TREATMENT PLANS
	(C) medication recommendations; and (iii) gives the referring practitioner a copy of the diagnosis and the management plan; and (iv) if clinically appropriate, explains the diagnosis and management plan, and a gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees (See para AN.36.1, AN.36.2, AN.36.6 of explanatory notes to this Category) **Fee:** $272.15 **Benefit:** 85% = $231.35 **Extended Medicare Safety Net Cap:** $500.00

A36. EATING DISORDER SERVICES	3. REVIEW OF EATING DISORDER TREATMENT PLANS
	Group A36. Eating Disorder Services
	Subgroup 3. Review of eating disorder treatment plans
New 90264	Professional attendance by a general practitioner to review an eligible patient's eating disorder treatment and management plan prepared by the general practitioner, an associated medical practitioner working in general practice, or a consultant physician practising in the specialty of psychiatry or paediatrics, if: (a) the general practitioner reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) modifications are made to the eating disorder treatment and management plan, recorded in writing, including: (i) recommendations to continue with treatment options detailed in the plan; or (ii) recommendations to alter the treatment options detailed in the plan, with the new arrangements documented in the plan; and (c) initiates referrals for a review by a consultant physician practising in the specialty of psychiatry or paediatrics, where appropriate; and (d) the general practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder (See para AN.36.1, AN.36.3 of explanatory notes to this Category) **Fee:** $72.85 **Benefit:** 100% = $72.85 **Extended Medicare Safety Net Cap:** $218.55
New 90265	Professional attendance by a medical practitioner to review an eligible patient's eating disorder treatment and management plan prepared by the medical practitioner, an associated medical practitioner working in general practice, or a consultant physician practising in the specialty of psychiatry or paediatrics, if:

	(a) the medical practitioner reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) modifications are made to the eating disorder treatment and management plan, recorded in writing, including: (i) recommendations to continue with treatment options detailed in the plan; or (ii) recommendations to alter the treatment options detailed in the plan, with the new arrangements documented in the plan; and (c) initiates referrals for a review by a consultant physician practising in the specialty of psychiatry or paediatrics, where appropriate; and (d) the medical practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder. (See para AN.36.1, AN.36.3 of explanatory notes to this Category) **Fee:** $58.30 **Benefit:** 100% = $58.30 **Extended Medicare Safety Net Cap:** $174.90
New 90266	Professional attendance of at least 30 minutes in duration at consulting rooms by a consultant physician in the practice of the consultant physician's specialty of psychiatry for an eligible patient, if: (a) the consultant psychiatrist reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) the patient has been referred by a referring practitioner; and (c) during the attendance, the consultant psychiatrist: (i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (iv) reviews the eating disorder treatment and management plan; and (d) within 2 weeks after the attendance, the consultant psychiatrist: (i) prepares a written diagnosis of the patient; and (ii) revises the eating disorder treatment and management; and (iii) gives the referring practitioner a copy of the diagnosis and the revised management plan; and (iv) if clinically appropriate, explains the diagnosis and the revised management plan, and gives a copy, to::

	(A) the patient; and (B) is the patient's carer (if any), if the patient agrees. (See para AN.36.1, AN.36.3 of explanatory notes to this Category) **Fee:** $291.80 **Benefit:** 85% = $248.05 **Extended Medicare Safety Net Cap:** $500.00
New 90267	Professional attendance of at least 20 minutes in duration at consulting rooms by a consultant physician in the practice of the consultant physician's specialty of paediatrics for an eligible patient, if: (a) the consultant paediatrician reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) the patient has been referred by a referring practitioner; and (c) during the attendance, the consultant paediatrician reviews the eating disorder treatment and management plan, including a: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (d) within 2 weeks after the attendance, the consultant paediatrician: (i) prepares a written diagnosis of the patient; and (ii) revises the eating disorder treatment and management; and (iii) gives the referring practitioner a copy of the diagnosis and the revised management plan; and (iv) if clinically appropriate, explains the diagnosis and the revised management plan, and gives a copy, to: (A) the patient; and (B) is the patient's carer (if any), if the patient agrees. (See para AN.36.1, AN.36.3 of explanatory notes to this Category) **Fee:** $136.25 **Benefit:** 85% = $115.85 **Extended Medicare Safety Net Cap:** $408.75
New 90268	Professional attendance of at least 30 minutes in duration by video conference by a consultant physician in the practice of the consultant physician's specialty of psychiatry for an eligible patient, if: (a) the consultant psychiatrist reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) the patient has been referred by a referring practitioner; and

	(c) during the attendance, the consultant psychiatrist: (i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (iv) reviews the eating disorder treatment and management plan; and (d) within 2 weeks after the attendance, the consultant psychiatrist: (i) prepares a written diagnosis of the patient; and (ii) revises the eating disorder treatment and management; and (iii) gives the referring practitioner a copy of the diagnosis and the revised management plan; and (iv) if clinically appropriate, explains the diagnosis and the revised management plan, and gives a copy, to: (A) the patient; and (B) is the patient's carer (if any), if the patient agrees. (See para AN.36.1, AN.36.3, AN.36.6 of explanatory notes to this Category) **Fee:** $291.80 **Benefit:** 85% = $248.05 **Extended Medicare Safety Net Cap:** $500.00
New 90269	Professional attendance of at least 20 minutes in duration by video conference by a consultant physician in the practice of the consultant physician's specialty of paediatrics for an eligible patient, if: (a) the consultant paediatrician reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) the patient has been referred by a referring practitioner; and (c) during the attendance, the consultant paediatrician reviews the eating disorder treatment and management plan, including a: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (d) within 2 weeks after the attendance, the consultant paediatrician: (i) prepares a written diagnosis of the patient; and (ii) revises the eating disorder treatment and management; and (iii) gives the referring practitioner a copy of the diagnosis and the revised management plan; and

A36. EATING DISORDER SERVICES	3. REVIEW OF EATING DISORDER TREATMENT PLANS
	(iv) if clinically appropriate, explains the diagnosis and the revised management plan, and gives a copy, to: (A) the patient; and (B) is the patient's carer (if any), if the patient agrees. (See para AN.36.1, AN.36.3, AN.36.6 of explanatory notes to this Category) **Fee:** $136.25 **Benefit:** 85% = $115.85 **Extended Medicare Safety Net Cap:** $408.75

A36. EATING DISORDER SERVICES	4. GP AND MEDICAL PRACTITIONER EATING DISORDERS PSYCHOLOGICAL TREATMENT SERVICES
	Group A36. Eating Disorder Services
	Subgroup 4. GP and medical practitioner eating disorders psychological treatment services
New 90271	Professional attendance at consulting rooms by a general practitioner, for providing eating disorder psychological treatment services by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes but less than 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan. (See para AN.36.1, AN.36.4 of explanatory notes to this Category) **Fee:** $94.25 **Benefit:** 100% = $94.25 **Extended Medicare Safety Net Cap:** $282.75
New 90272	Professional attendance at a place other than consulting rooms by a general practitioner, for providing eating disorder psychological treatment services by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes but less than 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan (See para AN.36.1, AN.36.4 of explanatory notes to this Category) **Derived Fee:** The fee for item 90271, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 90271 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
New 90273	Professional attendance at consulting rooms by a general practitioner, for providing eating disorder psychological treatment services by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan. (See para AN.36.1, AN.36.4 of explanatory notes to this Category) **Fee:** $134.85 **Benefit:** 100% = $134.85 **Extended Medicare Safety Net Cap:** $404.55
New 90274	Professional attendance at a place other than consulting rooms by a general practitioner, for providing eating disorder psychological treatment services by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan. (See para AN.36.1, AN.36.4 of explanatory notes to this Category) **Derived Fee:** The fee for item 90273, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 90273 plus $2.05 per patient.

	Extended Medicare Safety Net Cap: 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
New 90275	Professional attendance at consulting rooms by a medical practitioner, for providing eating disorder psychological treatment services by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes but less than 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan. (See para AN.36.1, AN.36.4 of explanatory notes to this Category) **Fee:** $75.40 **Benefit:** 100% = $75.40 **Extended Medicare Safety Net Cap:** $226.20
New 90276	Professional attendance at a place other than consulting rooms by a medical practitioner, for providing eating disorder psychological treatment services by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes but less than 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan. (See para AN.36.1, AN.36.4 of explanatory notes to this Category) **Derived Fee:** The fee for item 90275, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 90273 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
New 90277	Professional attendance at consulting rooms by a medical practitioner, for providing eating disorder psychological treatment services by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan. (See para AN.36.1, AN.36.4 of explanatory notes to this Category) **Fee:** $107.90 **Benefit:** 100% = $107.90 **Extended Medicare Safety Net Cap:** $323.70
New 90278	Professional attendance at a place other than consulting rooms by a medical practitioner, for providing eating disorder psychological treatment services by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan. (See para AN.36.1, AN.36.4 of explanatory notes to this Category) **Derived Fee:** The fee for item 90277, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 90273 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
New 90279	Professional attendance at consulting rooms by a general practitioner, for providing eating disorder psychological treatment services by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes but less than 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient is located within a telehealth eligible area; and

	(d) the patient is, at the time of the attendance, at least 15 kilometres by road from the general practitioner. (See para AN.36.1, AN.36.4, AN.36.5 of explanatory notes to this Category) **Fee:** $94.25 **Benefit:** 100% = $94.25 **Extended Medicare Safety Net Cap:** $282.75
New 90280	Professional attendance at consulting rooms by a general practitioner, for providing eating disorder psychological treatment services by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the general practitioner (See para AN.36.1, AN.36.4, AN.36.5 of explanatory notes to this Category) **Fee:** $134.85 **Benefit:** 100% = $134.85 **Extended Medicare Safety Net Cap:** $404.55
New 90281	Professional attendance at consulting rooms by a medical practitioner, for providing eating disorder psychological treatment services by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes but less than 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the medical practitioner. (See para AN.36.1, AN.36.4, AN.36.5 of explanatory notes to this Category) **Fee:** $75.40 **Benefit:** 100% = $75.40 **Extended Medicare Safety Net Cap:** $226.20
New 90282	Professional attendance at consulting rooms by a medical practitioner, for providing eating disorder psychological treatment services by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient is located within a telehealth eligible area; and

	(d) the patient is, at the time of the attendance, at least 15 kilometres by road from the medical practitioner. (See para AN.36.1, AN.36.4, AN.36.5 of explanatory notes to this Category) **Fee:** $107.90 **Benefit:** 100% = $107.90 **Extended Medicare Safety Net Cap:** $323.70

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CATEGORY 2: DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

SUMMARY OF CHANGES FROM 01/11/2019

The 01/11/2019 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

Description Amended

11507 11508 11512 12205 12207 12208

Anaesthesia MBS Changes from 1 November 2019

MBS items for anaesthesia services are changing to reflect contemporary anaesthesia practice. These changes are a result of the MBS Review Taskforce recommendations and consultation with stakeholders. The revised structure contains twenty eight amended items, proposes ten new items and deletes thirty one items.

Sleep study items 12205 and 12207

From 1 November 2019, minor amendments will be made to items 12205 and 12207 to provide more clarity on the clinical circumstances to which these items apply.

Sleep study item 12208

On 1 November 2019, a minor update will be made to improve the readability of the item descriptor.

DIAGNOSTIC PROCEDURES AND INVESTIGATIONS NOTES

DN.1.1 Electroencephalography (EEG), Prolonged Recording - (item 11003)

Item 11003 covers an extended EEG recording of at least 3 hours duration, other than ambulatory or video recording.

DN.1.2 Electroencephalography (EEG), Ambulatory or Video - (Items 11004 and 11005)

Items 11004 and 11005 cover prolonged ambulatory or video EEG, recording of at least 3 hours duration for:

- Diagnosing the basis of episodic neurological dysfunction;
- Characterising the nature of a patient's epileptic seizures;
- Localising seizures in patients with uncontrolled epilepsy, with a view to surgery; or
- Assessing treatment response where subclinical seizures are suspected.

DN.1.3 Neuromuscular Diagnosis - (Item 11012)

Based on advice from the Australian Association of Neurologists, Medicare benefits are not payable under Item 11012 for quantitative sensory nerve testing using "Neurometer CPT" diagnostic devices. The advice indicated that the device was still in the evaluation and research stage and did not have widespread clinical application.

DN.1.4 Investigation of Central Nervous System Evoked Responses - (Items 11024 and 11027)

In the context of these items a study refers to one or more averaged samples of electrical activity recorded from one or more sites in the central nervous system in response to the same stimulus.

Second or subsequent studies refer to either stimulating the point of stimulation (e.g. right eye or left median nerve) with a different stimulus or stimulating another point of stimulation (e.g. left eye or right median nerve).

NOTE: Items 11024 and 11027 are not intended to cover bio-feedback techniques.

DN.1.5 Electroretinography - (Items 11204, 11205, 11210 and 11211)

Current professional guidelines and standards for electroretinography, electroculography and pattern retinography are produced by the International Society for Clinical Electrophysiology of Vision (ISCEV).

DN.1.6 Computerised Perimetry Printed Results - (Items 11221 and 11224)

Computerised perimetry performed by optometrists is covered by MBS items 10940 and 10941. Items 11221 and 11224 should not be used to repeat perimetry unless clinically necessary - such as where the results of the perimetry have been provided by the optometrist referring the patient to an ophthalmologist.

DN.1.7 Computerised Perimetry - (Items 11221 and 11224)

Item 11221 for bilateral procedures cannot be claimed for patients who are totally blind in one eye. In this instance, item 11224 for unilateral procedures should be claimed, where appropriate.

DN.1.8 Orbital Contents - (Items 11240, 11241, 11242 and 11243)

Items 11240 and 11241 may only be utilised once per patient per practitioner. Where an additional service is necessary items 11242 and 11243 should be utilised.

Partial coherence interferometry may also be referred to as optical (or ocular) coherence biometry or laser Doppler interferometry.

DN.1.9 Brain Stem Evoked Response Audiometry - (Item 11300)
Item 11300 can be claimed for the programming of a cochlear speech processor.

DN.1.10 Electrocochleography - (Item 11304)
Item 11304 refers to electrocochleography with insertion of electrodes through the tympanic membrane.

DN.1.11 Non-determinate Audiometry - (Item 11306)
This refers to screening audiometry covering those services, one or more, referred to in Items 11309-11318 when not performed under the conditions set out in paragraph D1.13.

DN.1.12 Audiology Services - (Items 11309 to 11318)
A medical service specified in Items 11309 to 11318 shall be taken to be a medical service for the purposes of payment of benefits if, and only if, it is rendered:

(a) in conditions that allow the establishment of determinate thresholds;

(b) in a sound attenuated environment with background noise conditions that comply with Australian Standard AS/NZS 1269.3-2005; and

(c) using calibrated equipment that complies with Australian Standard AS IEC 60645.1-22002, AS IEC 60645.2-2002 and AS IEC 60645.3-2002.

DN.1.13 Oto-Acoustic Emission Audiometry - (Item 11332)
Medicare benefits are not payable under Item 11332 for routine screening of infants. The equipment used to provide this service must be capable of displaying the recorded emission and not just a pass/fail indicator.

DN.1.14 Respiratory Function Tests - (Item 11503)
Fractional exhaled nitric oxide (FeNO) testing cannot be claimed under item 11503.

When laboratory based spirometry (item 11512) is performed on the same day as a test approved under item 11503, then only 11503 must be claimed. When spirometry is the only laboratory test performed then 11512 must be claimed.

Maximum inspiratory and expiratory flow-volume loop testing for the purpose of diagnosing central airways obstruction is to be performed under item 11512 not 11503. Item 11503 is not for the purpose of investigation of sleep disorders. Polygraphic data obtained as part of a sleep study item in the range 12203 to 12250 cannot be used for the purpose of claiming item 11503.

DN.1.15 Capsule Endoscopy - (Item 11820 and 11823)
Capsule endoscopy is primarily used to view the small bowel, which cannot be viewed by upper gastrointestinal endoscopy and colonoscopy.

Capsule endoscopy imaging must be kept in a manner that facilitates retrieval on the basis of the patient's name and date of service. Records must be retained for a period of 2 years commencing on the day on which the service was rendered.

Conjoint committee

The Conjoint Committee comprises representatives from the Gastroenterological Society of Australia (GESA), the Royal Australasian College of Physicians (RACP) and the Royal Australasian College of Surgeons (RACS). For the purposes of Items 11820 and 11823, specialists or consultant physicians performing this procedure must have

endoscopic training recognised by The Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy, and the Department of Human Services notified of that recognition.

DN.1.16 Administration of Thyrotropin Alfa-rch for the Detection of Recurrent Well-differentiated Thyroid Cancer - (Item 12201)

Thyrotropin alfa-rch is a diagnostic agent that allows patients to remain on thyroid hormone therapy while being assessed for recurrent cancer. This item was introduced following an assessment by the Medical Services Advisory Committee (MSAC) of the available evidence relating to the safety, effectiveness and cost-effectiveness of thyrotropin alfa-rch. MSAC found that the use of thyrotropin alfa-rch is associated with a lower diagnostic accuracy than when the patient has withdrawn from thyroid hormone therapy. Accordingly, benefits are payable under the item only for patients in whom thyroid hormone therapy withdrawal is medically contraindicated and where concurrent whole body study using radioactive iodine and serum thyroglobulin are undertaken. Services provided to patients who do not demonstrate the indications set out in item 12201 do not attract benefits under the item.

"**Severe psychiatric illness**" is defined as patients with a severe pre-existing psychiatric illness who are currently under specialist psychiatric care.

The item includes the cost of supplying thyrotropin alfa-rch and the equivalent of a subsequent specialist attendance. "Administration" means an attendance by the specialist or consultant physician (the administering practitioner) that includes:

- an assessment that the patient meets the criteria prescribed by the item;

the supply of thyrotropin alfa-rch;

- ensuring that thyrotropin alfa-rch is injected (either by the administering practitioner or by another practitioner) in two doses at 24 hour intervals, with the second dose being administered 72 hours prior to whole body study with radioactive iodine and serum thyroglobulin test; and

- arranging the whole body radioactive iodine study and the serum thyroglobulin test.

Where thyrotropin alfa-rch is injected by the administering practitioner, benefits are not payable for an attendance on the day the second dose is administered. Where thyrotropin alfa-rch is injected by: a general practitioner - benefits are payable under a Level A consultation (item 3); other practitioners - benefits are payable under item 52.

DN.1.17 Investigations for sleep disorders (Items 12203 to 12250)

Items 12203 and 12250 are applicable for patients who require a diagnostic sleep study. They enable direct GP referral to testing without personal assessment by a sleep or respiratory physician, when validated screening questionnaires suggest a high pre-test probability for diagnosis of symptomatic, moderate to severe obstructive sleep apnoea (OSA). The screening questionnaires should be administered by the referring practitioner. Alternatively, the need for testing can be determined by a sleep or respiratory physician following direct clinical assessment (either face-to-face or by video conference).

Screening Questionnaires

For the purpose of items 12203 or 12250, a high probability for symptomatic, moderate to severe OSA would be indicated by one of the following clinical screening tool outcomes:

- STOP-Bang score of 4 or more AND an Epworth Sleepiness Scale score of 8 or more;

OR

- OSA50 score of 5 or more AND an Epworth Sleepiness Scale score of 8 or more;

OR

- high risk score on the Berlin Questionnaire AND an Epworth Sleepiness Scale score of 8 or more.

The STOP-Bang, OSA50, Berlin questionnaires and Epworth Sleepiness Scale can be accessed at Douglas et al, Guidelines for sleep studies in adults - a position statement of the Australasian Sleep Association. Sleep Med. 2017 Aug; 36 Suppl 1:S2-S22 (www.sleep.org.au/documents/item/2980) or on the American Thoracic Society website (www.thoracic.org/members/assemblies/assemblies/srn/questionaires/).

Evidence of the screening tests being administered to the patient in full, including screening test scores must be recorded in the patient's clinical record as this may be subject to audit.

Out-dated or incomplete referrals (Items 12203 and 12250)

Referrals made prior to 1 November 2018 (or after 1 November 2018 but without the screening questionnaires) remain valid for the purposes of a service performed under items 12203 and 12250 from 1 November 2018 – providing:

- The patient is assessed by a qualified sleep medicine practitioner or consultant respiratory physician to determine the necessity for the sleep study; or
- The validated screening questionnaires are administered to the patient by the sleep medicine practitioner, sleep technician or other practice staff. If the screening questionnaires indicate a high pre-test probability for the diagnosis of symptomatic, moderate to severe OSA, the patient can proceed to testing. If there remains any uncertainty about the necessity for the study, a qualified sleep medicine practitioner or consultant respiratory physician should assess the patient.

Referrals for attended (Level 1) diagnostic studies

Where a patient with suspected OSA has been directly referred for a Level 1 sleep study under item 12203, but there is insufficient information to indicate if there are any contraindications for a Level 2 study, the following options are available:

- The patient can be assessed by a qualified sleep medicine practitioner or consultant respiratory physician to determine the most suitable study (i.e. Level 1 or Level 2); or
- The validated screening questionnaires can be administered to the patient by the sleep medicine practitioner, sleep technician or practice staff. If the screening questionnaires indicate a high pre-test probability for the diagnosis of symptomatic, moderate to severe OSA, the sleep provider can either – arrange for the patient to have a Level 2 study (notifying the referring practitioner of this decision); or seek additional information from the referring practitioner on why a Level 1 study is required (e.g. whether the patient has any contraindications for a Level 2 study). If there remains any uncertainty about the type of study which the patient should receive, a qualified sleep medicine practitioner or consultant respiratory physician should assess the patient.

Referrals made without (or incomplete) screening questionnaires (Items 12203 and 12250)

If a patient has been directly referred for testing without the use of the screening questionnaires, they can be administered to the patient by the sleep provider (e.g. by a sleep technician or other practice staff). Where the screening questionnaires have been provided with the referral but they are incomplete, the sleep provider may wish to contact the patient to determine what their responses were to the relevant questions.

Attended versus unattended sleep studies

Determination of the need for testing should conform with Australasian Sleep Association guidelines.

Unattended sleep studies are suitable for many patients with suspected OSA but patients with other sleep disorders should undergo an attended study. Assessment for potential contraindications to an unattended sleep study can be undertaken by either the referring practitioner, qualified adult sleep medicine practitioner or consultant respiratory physician. Standardised referrals should request sufficient information to enable such assessment.

In accordance with the Australasian Sleep Association's Guidelines for Sleep Studies in Adults, relative contraindications for an unattended sleep study to investigate suspected OSA include but are not limited to:

(a) intellectual disability or cognitive impairment;

(b) physical disability with inadequate carer attendance;

(c) significant co-morbid conditions including neuromuscular disease, heart failure or advanced respiratory disease where more complex disorders are likely;

(d) suspected respiratory failure where attended measurements are required, including measurement of carbon dioxide partial pressures;

(e) suspected parasomnia or seizure disorder;

(f) suspected condition where recording of body position is considered to be essential and would not be recorded as part of an unattended sleep study;

(g) previously failed or inconclusive unattended sleep study;

(h) unsuitable home environment including unsafe environments or where patients are homeless; and

(i) consumer preference based on a high level of anxiety about location of study or where there is unreasonable cost or disruption based on distance to be travelled, or home circumstances.

Patients who have these features may be suitable for either attended (Level 1) or unattended (Level 2) studies.

Treatment options following testing

The results and treatment options following any diagnostic sleep study should be discussed during a professional attendance with a medical practitioner before the initiation of any therapy. If there is uncertainty about the significance of test results or the appropriate management for that individual then referral to a sleep or respiratory medicine specialist is recommended.

Any professional attendance by a qualified adult sleep medicine practitioner or consultant respiratory physician associated with this service may be undertaken face-to-face or by video conference.

Meaning of 'at least 8 hours duration'

The requirement 'for a period of at least 8 hours duration' means the overnight investigation (including patient set-up time and actual period of recording) must be of at least 8 hours duration. Providers must keep evidence of the duration of the overnight investigation (including set-up time and period of recording) as part of their administrative records for MBS sleep studies.

Polygraphic data

Item 11503 is not for the purpose of investigation of sleep disorders. Polygraphic data obtained as part of a sleep study item in the range 12203 to 12250 cannot be used for the purpose of claiming item 11503.

Billing requirements for sleep studies

Items 12203 to 12250 do not support a figurehead billing arrangement. Figurehead or 'headline' billing is where one practitioner's provider number is used to bill patients for the services provided by other practitioners.

While individual components of the sleep study service (e.g. supervision of the investigation and interpretation and preparation of a permanent report) do not need to be performed by the same qualified sleep medicine practitioner, it is an MBS requirement that the qualified sleep medicine practitioner who prepared the report on the results of the investigation bill the relevant item.

Benefits are not payable for items 12203 to 12250 where the interpretation and preparation of a permanent report is provided by a technician or supervised staff rather than by a qualified adult sleep medicine practitioner.

Where the date of service for a sleep study item is the same as the date of service of any items 11000 to 11005, 11503, 11700 to 11709, 11713 and 12203/12250, for a benefit to be payable, there must be written notification on the account identifying that the service under any of those items was not provided on the same occasion as the sleep study item.

The date of service for the purposes of items 12203 to 12250 is deemed to be the day of the morning the overnight investigation is completed. Billing for the service must only occur once all of the requirements of the item have been fulfilled.

DN.1.18 Bone Densitometry - (Items 12306 to 12322)

Definitions

Low bone mineral density is present when the bone (organ) mineral density falls more than 1.5 standard deviations below the age matched mean or more than 2.5 standard deviations below the young normal mean at the same site and in the same gender.

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.

Items 12320 and 12322 enable the payment of a Medicare benefit for a bone densitometry service performed on a patient aged 70 years or over. Patients 70 years and over are eligible for an initial screening study.

Patients assessed as having a normal study or mild osteopenia as measured by a t-score down to -1.5 are eligible for one scan every 5 years (item 12320).

Patients with moderate to marked osteopenia as measured by a T-score of -1.5 to -2.5 are eligible for one scan every two years (item 12322).

An examination under any of these items covers the measurement of 2 or more sites, interpretation and provision of a report; all performed by a specialist or consultant physician in the practice of his or her specialty. Two or more sites must include the measurement of bone density of the lumbar spine and proximal femur. The measurement of bone mineral density at either forearms or both heels or in combination is excluded for the purpose of Medicare benefit, unless necessary for specific clinical indications (see below).

Patients unable to have a lumbar spine or proximal femur measurement taken

The recommended alternative measurement for patients who have been referred for a dual energy x-ray absorptiometry (DEXA) bone densitometry scan who are unable to have a lumbar spine or proximal femur measurement taken is the distal forearm, e.g. patients with spinal fusions or bilateral hip prostheses. Patients unable to have a lumbar spine or proximal femur measurement taken who have been referred for a quantitative computed tomography (QCT) scan are not subject to the two site measurements requirement. For these patients one site for which a QCT measurement can be appropriately referenced is sufficient.

Professional Supervision and Interpretation and Reporting

The interpretation and report for all bone densitometry services must be provided by a specialist or consultant physician.

Items 12306, 12312, 12315, 12321 and Items 12320 and 12322 (when performed using Dual Energy X-ray Absorptiometry) must be performed by a:

(a) specialist or consultant physician; or

(b) person who holds a State or Territory radiation license, and who is under the supervision of a specialist or consultant physician.

Items 12320 and 12322 (when performed using Quantitative Computed Tomography) must be performed by a:

(a) specialist or consultant physician; or

(b) a radiation licence holder who is registered as a medical radiation practitioner under a law of a State or Territory; and the specialist or consultant physician is available to monitor and influence the conduct and diagnostic quality of the examination and, if necessary, to attend on the patient personally.

Referrals

Bone densitometry services are available on the basis of referral by a medical practitioner to a specialist or consultant physician. However, providers of bone densitometry to whom a patient is referred for management may determine that a bone densitometry service is required in line with the provisions of Items 12306, 12312, 12315, 12320, 12321 and 12322.

For Item 12306 the referral should specify the indication for the test, namely:

(a) 1 or more fractures occurring after minimal trauma; or

(b) monitoring of low bone mineral density proven by previous bone densitometry.

For Item 12312 the referral should specify the indication for the test, namely:

(a) prolonged glucocorticoid therapy;

(b) conditions associated with excess glucocorticoid secretion;

(c) male hypogonadism; or

(d) female hypogonadism lasting more than 6 months before the age of 45.

For Item 12315 the referral should specify the indication for the test, namely:

(a) primary hyperparathyroidism;

(b) chronic liver disease;

(c) chronic renal disease;

(d) proven malabsorptive disorders;

(e) rheumatoid arthritis; or

(f) conditions associated with thyroxine excess.

For Item 12312

(a) 'Prolonged glucocorticoid therapy' is defined as the commencement of a dosage of inhaled glucocorticoid equivalent to or greater than 800 micrograms beclomethasone dipropionate or budesonide per day; or

(b) a supraphysiological glucocorticoid dosage equivalent to or greater than 7.5 mg prednisolone in an adult taken orally per day;

for a period anticipated to last for at least 4 months.

Glucocorticoid therapy must be contemporaneous with the current scan. Patients no longer on steroids would not qualify for benefits.

For Item 12312

(a) Male hypogonadism is defined as serum testosterone levels below the age matched normal range.

(b) Female hypogonadism is defined as serum oestrogen levels below the age matched normal range.

For Item 12315

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.

DN.1.19 Retinal Photography with a Non-Mydriatic Retinal Camera

This service is separated into two items, MBS item 12325 and MBS item 12326, in line with NHMRC guidelines' recommended frequency of repeat testing in persons of Aboriginal andTorres Strait Islander descent and the general population.

This item is intended for the provision of retinal photography with a non-mydriatic retinal camera. Mydriasis is permitted if adequate photographs cannot be obtained through an undiated pupil.

Presenting distance vision means unaided distance vision or the vision obtained with the current spectacles or contact lenses, if normally worn for distance vision.

Detection of any diabetic retinopathy should be followed by referral to an optometrist or ophthalmologist in accordance with the NHMRC guidelines.

Where images are inadequate quality for detection of diabetic retinopathy, referral to an optometrist or ophthalmologist for further assessment is indicated.

Any element(s) of the service may be performed by appropriately trained or qualified personnel under the direction of the medical practitioner co-ordinating the patient’s care, who retains overall responsibility for claiming of the service.

DN.1.20 Spirometry (Items 11505, 11506 and 11512)

Spirometry services billed to the MBS should meet international quality standards (Eur Respir J 2005; 26: 319–338).

The National Asthma Council’s Australian Asthma Handbook (2016) and Lung Foundation Australia’s and Thoracic Society of Australia and New Zealand’s COPD-X Plan (2016) advise that properly performed spirometry is required to confirm airflow limitation and the diagnosis of asthma and/or COPD. Reversibility testing is the standard required for asthma diagnosis. The diagnosis of COPD is confirmed with post bronchodilator spirometry. Item 11505 should not be repeated when diagnosis has been previously confirmed by properly performed spirometry. To meet quality requirements patients must have three acceptable tests for each testing period (pre/post bronchodilator), and meet repeatability criteria with the best effort recorded. Spirometry should be performed by a person who has undergone training and is qualified to perform it to recommended standards (see Spirometry Handbook, National Asthma Council of Australia (https://www.nationalasthma.org.au/living-with-asthma/resources/health-professionals/information-paper/spirometry-handbook) and ATS/ERS Standardisation of spirometry paper (http://erj.ersjournals.com/content/erj/26/2/319.full.pdf).

DN.1.21 Fraction of Exhaled Nitric Oxide (Item 11507) and Cardiopulmonary Exercise Testing (Item 11508)

Services billed to item 11507 should meet the following quality standards:

g. An Official ATS Clinical Practice Guideline: Interpretation of Exhaled Nitric Oxide Levels (FENO) for Clinical Applications: Am J Respir Crit Care Med Vol 184. pp 602–615, 2011 DOI: 10.1164/rccm.912011ST.
h. ATS/ERS Recommendations for Standardized Procedures for the Online and Offline Measurement of Exhaled Lower Respiratory Nitric Oxide and Nasal Nitric Oxide, 2005: Am J Respir Crit Care Med Vol 171. pp 912–930, 2005 DOI: 10.1164/rccm.200406-710ST
   Fewer than three traces will be accepted as billable under item 11507 if three reproducible loops are difficult to achieve for clinical reasons. The clinical reason(s) for not achieving three reproducible loops must be documented.

Services billed to item 11508 should meet the following quality standards:

g. ATS/ACCP Statement on Cardiopulmonary Exercise Testing: Am J Respir Crit Care Med Vol 167. pp 211–277, 2003 DOI: 10.1164/rccm.167.2.211.

DN.1.22 Skin Prick Testing (items 12000-12005)

Skin prick testing and Intradermal testing should always be performed in a medical setting with the ready availability of medical practitioners competent to treat systemic allergic reactions, and appropriate resuscitation equipment. Because intradermal testing carries a higher risk of anaphylaxis it should only be performed in a hospital setting (or equivalent) by either a specialist or consultant physician with proficiency and experience in all aspects of skin testing for allergy.

Item 12003 should only be used by appropriately trained doctors such as allergist immunologists or equivalently trained medical practitioners. An alternative to Skin Prick Testing (SPT) is serum specific IgE food allergen testing. Serum specific IgE (ssIgE) allergy blood testing to food panels is not recommended.

Item 12004 should only be used by appropriately trained doctors such as allergist immunologists or equivalently trained medical practitioners.

Item 12005 should only be used by appropriately trained doctors such as allergist immunologists, anaesthetists or equivalently trained medical practitioners.

DN.1.23 Multiple sleep latency testing and Maintenance of wakefulness testing

Determination of the need for testing and testing procedures should be performed in accordance with current Australasian Sleep Association guidelines. Not to be used as part of an occupational health service or pre-employment assessment.

The date of service for the purposes of items 12254 to 12272 is deemed to be the day on which the daytime investigation component of the test is completed. Billing for the service must only occur once all of the requirements of the item have been fulfilled.

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	1. NEUROLOGY
	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 1. Neurology
11000	ELECTROENCEPHALOGRAPHY, not being a service: (a) associated with a service to which item 11003, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices (Anaes.) **Fee:** $125.05 **Benefit:** 75% = $93.80 85% = $106.30
11003	ELECTROENCEPHALOGRAPHY, prolonged recording of at least 3 hours duration, not being a service: (a) associated with a service to which item 11000, 11004, 11005, 11006 or 11009 applies; and (b) involving quantitative topographic mapping using neurometrics or similar devices (See para DN.1.1 of explanatory notes to this Category) **Fee:** $330.90 **Benefit:** 75% = $248.20 85% = $281.30
11004	ELECTROENCEPHALOGRAPHY, ambulatory or video, prolonged recording of at least 3 hours duration up to 24 hours duration, recording on the first day, not being a service: (a) associated with a service to which item 11000, 11003, 11005, 11006 or 11009 applies; and (b) involving quantitative topographic mapping using neurometrics or similar devices (See para DN.1.2 of explanatory notes to this Category) **Fee:** $330.90 **Benefit:** 75% = $248.20 85% = $281.30
11005	ELECTROENCEPHALOGRAPHY, ambulatory or video, prolonged recording of at least 3 hours duration up to 24 hours duration, recording on each day subsequent to the first day, not being a service: (a) associated with a service to which item 11000, 11003, 11004, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices (See para DN.1.2 of explanatory notes to this Category) **Fee:** $330.90 **Benefit:** 75% = $248.20 85% = $281.30
11006	ELECTROENCEPHALOGRAPHY, temporosphenoidal, not being a service involving quantitative topographic mapping using neurometrics or similar devices **Fee:** $169.65 **Benefit:** 75% = $127.25 85% = $144.25
11009	ELECTROCORTICOGRAPHY **Fee:** $231.40 **Benefit:** 75% = $173.55 85% = $196.70
11012	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 1 nerve OR ELECTROMYOGRAPHY of 1 or more muscles using concentric needle electrodes OR both these examinations (not being a service associated with a service to which item 11015 or 11018 applies) (See para DN.1.3 of explanatory notes to this Category) **Fee:** $113.80 **Benefit:** 75% = $85.35 85% = $96.75
11015	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 2 or 3 nerves with or without electromyography (not being a service associated with a service to which item 11012 or 11018 applies) **Fee:** $152.30 **Benefit:** 75% = $114.25 85% = $129.50

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	1. NEUROLOGY
11018	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 4 or more nerves with or without electromyography OR recordings from single fibres of nerves and muscles OR both of these examinations (not being a service associated with a service to which item 11012 or 11015 applies) **Fee:** $227.55 **Benefit:** 75% = $170.70 85% = $193.45
11021	NEUROMUSCULAR ELECTRODIAGNOSIS repetitive stimulation for study of neuromuscular conduction OR electromyography with quantitative computerised analysis OR both of these examinations **Fee:** $152.30 **Benefit:** 75% = $114.25 85% = $129.50
11024	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials or multifocal multichannel objective perimetry - 1 or 2 studies (See para DN.1.4 of explanatory notes to this Category) **Fee:** $115.65 **Benefit:** 75% = $86.75 85% = $98.35
11027	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials or multifocal multichannel objective perimetry - 3 or more studies (See para DN.1.4 of explanatory notes to this Category) **Fee:** $171.60 **Benefit:** 75% = $128.70 85% = $145.90

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	2. OPHTHALMOLOGY
	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 2. Ophthalmology
11200	PROVOCATIVE TEST OR TESTS FOR OPEN ANGLE GLAUCOMA, including water drinking **Fee:** $41.45 **Benefit:** 75% = $31.10 85% = $35.25
11204	ELECTRORETINOGRAPHY of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards, performed by or on behalf of a specialist or consultant physician in the practice of his or her speciality. (See para DN.1.5 of explanatory notes to this Category) **Fee:** $110.00 **Benefit:** 75% = $82.50 85% = $93.50
11205	ELECTROOCULOGRAPHY of one or both eyes performed according to current professional guidelines or standards, performed by or on behalf of a specialist or consultant physician in the practice of his or her speciality. (See para DN.1.5 of explanatory notes to this Category) **Fee:** $110.00 **Benefit:** 75% = $82.50 85% = $93.50
11210	PATTERN ELECTRORETINOGRAPHY of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards (See para DN.1.5 of explanatory notes to this Category) **Fee:** $110.00 **Benefit:** 75% = $82.50 85% = $93.50
11211	DARK ADAPTOMETRY of one or both eyes with a quantitative (log cd/m2) estimation of threshold in log lumens at 45 minutes of dark adaptations (See para DN.1.5 of explanatory notes to this Category) **Fee:** $110.00 **Benefit:** 75% = $82.50 85% = $93.50
11215	RETINAL ANGIOGRAPHY, multiple exposures of 1 eye with intravenous dye injection **Fee:** $124.95 **Benefit:** 75% = $93.75 85% = $106.25

11218	RETINAL ANGIOGRAPHY, multiple exposures of both eyes with intravenous dye injection **Fee:** $154.40 **Benefit:** 75% = $115.80 85% = $131.25
11219	OPTICAL COHERENCE TOMOGRAPHY for diagnosis of ocular conditions for which a medication is listed on the Pharmaceutical Benefits Scheme for intraocular administration Maximum of one service in a 12 month period **Fee:** $40.65 **Benefit:** 75% = $30.50 85% = $34.60
11220	OPTICAL COHERENCE TOMOGRAPHY for the assessment of the need for treatment following provision of pharmaceutical benefits scheme-subsidised ocriplasmin. Maximum of one service per eye per lifetime. **Fee:** $40.65 **Benefit:** 75% = $30.50 85% = $34.60
11221	Full quantitative computerised perimetry (automated absolute static threshold), other than a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, if 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 3 examinations (including examinations to which item 11224 applies) in any 12 month period (See para DN.1.6, DN.1.7 of explanatory notes to this Category) **Fee:** $68.85 **Benefit:** 75% = $51.65 85% = $58.55
11224	Full quantitative computerised perimetry (automated absolute static threshold), other than a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, if 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 3 examinations (including examinations to which item 11221 applies) in any 12 month period (See para DN.1.6, DN.1.7 of explanatory notes to this Category) **Fee:** $41.50 **Benefit:** 75% = $31.15 85% = $35.30
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 **Fee:** $124.70 **Benefit:** 75% = $93.55 85% = $106.00
11237	OCULAR CONTENTS, simultaneous ultrasonic echography by both unidimensional and bidimensional techniques, for the diagnosis, monitoring or measurement of choroidal and ciliary body melanomas, retinoblastoma or suspicious naevi or simulating lesions, one eye, not being a service associated with a service to which items in Group I1 of Category 5 apply **Fee:** $82.75 **Benefit:** 75% = $62.10 85% = $70.35
11240	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of one eye prior to lens surgery on that eye, not being a service associated with a service to which items in Group I1 of Category 5 apply. (See para DN.1.8 of explanatory notes to this Category) **Fee:** $82.75 **Benefit:** 75% = $62.10 85% = $70.35
11241	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for bilateral eye measurement prior to lens surgery on both eyes, not being a service associated with a service to which items in Group I1 apply (See para DN.1.8 of explanatory notes to this Category)

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	2. OPHTHALMOLOGY
	Fee: $105.30 **Benefit:** 75% = $79.00 85% = $89.55
11242	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of an eye previously measured and on which lens surgery has been performed, and where further lens surgery is contemplated in that eye, not being a service associated with a service to which items in Group I1 apply (See para DN.1.8 of explanatory notes to this Category) **Fee:** $81.40 **Benefit:** 75% = $61.05 85% = $69.20
11243	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of a second eye where surgery for the first eye has resulted in more than 1 dioptre of error or where more than 3 years have elapsed since the surgery for the first eye, not being a service associated with a service to which items in Group I1 apply (See para DN.1.8 of explanatory notes to this Category) **Fee:** $81.40 **Benefit:** 75% = $61.05 85% = $69.20
11244	Orbital contents, diagnostic B-scan of, by a specialist practising in his or her speciality of ophthalmology, not being a service associated with a service to which an item in Group I1 of the diagnostic imaging services table applies. **Fee:** $78.25 **Benefit:** 75% = $58.70 85% = $66.55

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	3. OTOLARYNGOLOGY
	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 3. Otolaryngology
11300	BRAIN stem evoked response audiometry (Anaes.) (See para DN.1.9 of explanatory notes to this Category) **Fee:** $195.55 **Benefit:** 75% = $146.70 85% = $166.25
11303	ELECTROCOCHLEOGRAPHY, extratympanic method, 1 or both ears **Fee:** $195.55 **Benefit:** 75% = $146.70 85% = $166.25
11304	ELECTROCOCHLEOGRAPHY, transtympanic membrane insertion technique, 1 or both ears (See para DN.1.10 of explanatory notes to this Category) **Fee:** $322.00 **Benefit:** 75% = $241.50 85% = $273.70
11306	Nondeterminate AUDIOMETRY (See para DN.1.11 of explanatory notes to this Category) **Fee:** $22.25 **Benefit:** 75% = $16.70 85% = $18.95
11309	AUDIOGRAM, air conduction (See para DN.1.12, DN.1.11 of explanatory notes to this Category) **Fee:** $26.70 **Benefit:** 75% = $20.05 85% = $22.70
11312	AUDIOGRAM, air and bone conduction or air conduction and speech discrimination (See para DN.1.12, DN.1.11 of explanatory notes to this Category) **Fee:** $37.75 **Benefit:** 75% = $28.35 85% = $32.10
11315	AUDIOGRAM, air and bone conduction and speech (See para DN.1.12, DN.1.11 of explanatory notes to this Category) **Fee:** $50.00 **Benefit:** 75% = $37.50 85% = $42.50
11318	AUDIOGRAM, air and bone conduction and speech, with other Cochlear tests (See para DN.1.12, DN.1.11 of explanatory notes to this Category)

	Fee: $61.70 **Benefit:** 75% = $46.30 85% = $52.45
11324	IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, where the patient is referred by a medical practitioner - not being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies **Fee:** $33.40 **Benefit:** 75% = $25.05 85% = $28.40
11327	IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, where the patient is referred by a medical practitioner - being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies **Fee:** $20.05 **Benefit:** 75% = $15.05 85% = $17.05
11330	IMPEDANCE AUDIOGRAM where the patient is not referred by a medical practitioner - 1 examination in any 4 week period **Fee:** $8.05 **Benefit:** 75% = $6.05 85% = $6.85
11332	OTO-ACOUSTIC EMISSION AUDIOMETRY for the detection of permanent congenital hearing impairment, performed by or on behalf of a specialist or consultant physician, on an infant or child who is at risk due to one or more of the following factors:- (i) admission to a neonatal intensive care unit; or (ii) family history of hearing impairment; or (iii) intra-uterine or perinatal infection (either suspected or confirmed); or (iv) birthweight less than 1.5kg; or (v) craniofacial deformity: or (vi) birth asphyxia; or (vii) chromosomal abnormality, including Down's Syndrome; or (viii) exchange transfusion; and where:- - the patient is referred by another medical practitioner; and - middle ear pathology has been excluded by specialist opinion (See para DN.1.13 of explanatory notes to this Category) **Fee:** $59.50 **Benefit:** 75% = $44.65 85% = $50.60
11333	CALORIC TEST OF LABYRINTH OR LABYRINTHS **Fee:** $45.30 **Benefit:** 75% = $34.00 85% = $38.55

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	3. OTOLARYNGOLOGY
11336	SIMULTANEOUS BITHERMAL CALORIC TEST OF LABYRINTHS **Fee:** $45.30 **Benefit:** 75% = $34.00 85% = $38.55
11339	ELECTRONYSTAGMOGRAPHY **Fee:** $45.30 **Benefit:** 75% = $34.00 85% = $38.55

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	4. RESPIRATORY
	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 4. Respiratory
	Complex measurement of properties of the respiratory system, including the lungs and respiratory muscles, that is performed: (a) in a respiratory laboratory; and (b) under the supervision of a consultant respiratory physician who is responsible for staff training, supervision, quality assurance and the issuing of written reports on tests performed; and (c) using any of the following tests: (i) measurement of absolute lung volumes by any method; (ii) measurement of carbon monoxide diffusing capacity by any method; (iii) measurement of airway or pulmonary resistance by any method; (iv) inhalation provocation testing, including pre-provocation spirometry and the construction of a dose response curve, using a recognised direct or indirect bronchoprovocation agent and post-bronchodilator spirometry; (v) provocation testing involving sequential measurement of lung function at baseline and after exposure to specific sensitising agents, including drugs, or occupational asthma triggers; (vi) spirometry performed before and after simple exercise testing undertaken as a provocation test for the investigation of asthma, in premises equipped with resuscitation equipment and personnel trained in Advanced Life Support; (vii) measurement of the strength of inspiratory and expiratory muscles at multiple lung volumes; (viii) simulated altitude test involving exposure to hypoxic gas mixtures and oxygen saturation at rest and/or during exercise with or without an observation of the effect of supplemental oxygen; (ix) calculation of pulmonary or cardiac shunt by measurement of arterial oxygen partial pressure and haemoglobin concentration following the breathing of an inspired oxygen concentration of 100% for a duration of 15 minutes or greater; (x) if the measurement is for the purpose of determining eligibility for pulmonary arterial hypertension medications subsidised under the Pharmaceutical Benefits Scheme or eligibility for the provision of portable oxygen—functional exercise test by any method (including 6 minute walk test and shuttle walk test); each occasion at which one or more tests are performed
11503	Not applicable to a service performed in association with a spirometry or sleep study service to which

	item 11505, 11506, 11507, 11508, 11512, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Not applicable to a service to which item 11507 applies (See para DN.1.14 of explanatory notes to this Category) **Fee:** $140.85 **Benefit:** 75% = $105.65 85% = $119.75
11505	Measurement of spirometry, that: (a) involves a permanently recorded tracing, performed before and after inhalation of a bronchodilator; and (b) is performed to confirm diagnosis of: (i) asthma; or (ii) chronic obstructive pulmonary disease (COPD); or (iii) another cause of airflow limitation; each occasion at which 3 or more recordings are made Applicable only once in any 12 month period (See para DN.1.20 of explanatory notes to this Category) **Fee:** $41.75 **Benefit:** 75% = $31.35 85% = $35.50
11506	Measurement of spirometry, that: (a) involves a permanently recorded tracing, performed before and after inhalation of a bronchodilator; and (b) is performed to: (i) confirm diagnosis of chronic obstructive pulmonary disease (COPD); or (ii) assess acute exacerbations of asthma; or (iii) monitor asthma and COPD; or (iv) assess other causes of obstructive lung disease or the presence of restrictive lung disease; each occasion at which recordings are made (See para DN.1.20 of explanatory notes to this Category) **Fee:** $20.90 **Benefit:** 75% = $15.70 85% = $17.80
Amend 11507	Measurement of spirometry: (a) that includes continuous measurement of the relationship between flow and volume during expiration or during expiration and inspiration, performed before and after inhalation of a bronchodilator; and (b) fractional exhaled nitric oxide (FeNO) concentration in exhaled breath; if: (c) the measurement is performed:

	(i) under the supervision of a specialist or consultant physician; and (ii) with continuous attendance by a respiratory scientist; and (iii) in a respiratory laboratory equipped to perform complex lung function tests; and (d) a permanently recorded tracing and written report is provided; and (e) 3 or more spirometry recordings are performed unless difficult to achieve for clinical reasons; each occasion at which one or more such tests are performed Not applicable to a service associated with a service to which item 11503 or 11512 applies (See para DN.1.21 of explanatory notes to this Category) **Fee:** $101.80 **Benefit:** 75% = $76.35 85% = $86.55
Amend 11508	Maximal symptom-limited incremental exercise test using a calibrated cycle ergometer or treadmill, if: (a) the test is performed for the evaluation of: (i) breathlessness of uncertain cause from tests performed at rest; or (ii) breathlessness out of proportion with impairment due to known conditions; or (iii) functional status and prognosis in a patient with significant cardiac or pulmonary disease for whom complex procedures such as organ transplantation are considered; or (iv) anaesthetic and perioperative risks in a patient undergoing major surgery who is assessed as substantially above average risk after standard evaluation; and (b) the test has been requested by a specialist or consultant physician following professional attendance on the patient by the specialist or consultant physician; and (c) a respiratory scientist and a medical practitioner are in constant attendance during the test; and (d) the test is performed in a respiratory laboratory equipped with airway management and defibrillator equipment; and (e) there is continuous measurement of at least the following: (i) work rate; (ii) pulse oximetry; (iii) respired oxygen and carbon dioxide partial pressures and respired volumes; (iv) ECG; (v) heart rate and blood pressure; and (f) interpretation and preparation of a permanent report is provided by a consultant respiratory physician who is also responsible for the supervision of technical staff and quality assurance (See para DN.1.21 of explanatory notes to this Category) **Fee:** $295.45 **Benefit:** 75% = $221.60 85% = $251.15
Amend 11512	Measurement of spirometry:

	(a) that includes continuous measurement of the relationship between flow and volume during expiration or during expiration and inspiration, performed before and after inhalation of a bronchodilator; and (b) that is performed with a respiratory scientist in continuous attendance; and (c) that is performed in a respiratory laboratory equipped to perform complex lung function tests; and (d) that is performed under the supervision of a consultant physician practising respiratory medicine who is responsible for staff training, supervision, quality assurance and the issuing of written reports; and (e) for which a permanently recorded tracing and written report is provided; and (f) for which 3 or more spirometry recordings are performed; each occasion at which one or more such tests are performed Not applicable for a service associated with a service to which item 11503 or 11507 applies (See para DN.1.20 of explanatory notes to this Category) **Fee:** $62.75 **Benefit:** 75% = $47.10 85% = $53.35

	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 5. Vascular
11600	BLOOD PRESSURE MONITORING (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - once only for each type of pressure on any calendar day up to a maximum of 4 pressures (not being a service to which item 13876 applies and where not performed in association with the administration of general anaesthesia) (See para TN.1.11, TN.1.10 of explanatory notes to this Category) **Fee:** $70.40 **Benefit:** 75% = $52.80 85% = $59.85
11602	Investigation of venous reflux or obstruction in one or more limbs at rest by CW Doppler or pulsed Doppler involving examination at multiple sites along each limb using intermittent limb compression or Valsalva manoeuvres, or both, to detect prograde and retrograde flow, other than a service associated with a service to which item 32500 applies—hard copy trace and written report, the report component of which must be performed by a medical practitioner, maximum of 2 examinations in a 12 month period, not to be used in conjunction with sclerotherapy **Fee:** $58.65 **Benefit:** 75% = $44.00 85% = $49.90
11604	Investigation of chronic venous disease in the upper and lower extremities, one or more limbs, by plethysmography (excluding photoplethysmography)—examination, hard copy trace and written report, not being a service associated with a service to which item 32500 applies **Fee:** $76.90 **Benefit:** 75% = $57.70 85% = $65.40
11605	Investigation of complex chronic lower limb reflux or obstruction, in one or more limbs, by infrared photoplethysmography, during and following exercise to determine surgical intervention or the conservative management of deep venous thrombotic disease—hard copy trace, calculation of 90% recovery time and written report, not being a service associated with a service to which item 32500 applies **Fee:** $76.90 **Benefit:** 75% = $57.70 85% = $65.40
11610	MEASUREMENT OF ANKLE: BRACHIAL INDICES AND ARTERIAL WAVEFORM ANALYSIS, measurement of posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of ankle (or toe) brachial systolic pressure

	indices and assessment of arterial waveforms for the evaluation of lower extremity arterial disease, examination, hard copy trace and report. **Fee:** $64.75 **Benefit:** 75% = $48.60 85% = $55.05
11611	MEASUREMENT OF WRIST: BRACHIAL INDICES AND ARTERIAL WAVEFORM ANALYSIS, measurement of radial and ulnar (or finger) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of the wrist (or finger) brachial systolic pressure indices and assessment of arterial waveforms for the evaluation of upper extremity arterial disease, examination, hard copy trace and report. **Fee:** $64.75 **Benefit:** 75% = $48.60 85% = $55.05
11612	EXERCISE STUDY FOR THE EVALUATION OF LOWER EXTREMITY ARTERIAL DISEASE, measurement of posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of ankle (or toe) brachial systolic pressure indices for the evaluation of lower extremity arterial disease at rest and following exercise using a treadmill or bicycle ergometer or other such equipment where the exercise workload is quantifiably documented, examination and report. **Fee:** $114.20 **Benefit:** 75% = $85.65 85% = $97.10
11614	TRANSCRANIAL DOPPLER, examination of the intracranial arterial circulation using CW Doppler or pulsed Doppler with hard copy recording of waveforms, examination and report, not associated with a service to which items 55229 or 55280 n Group I1 of Category 5 apply. **Fee:** $76.90 **Benefit:** 75% = $57.70 85% = $65.40
11615	MEASUREMENT OF DIGITAL TEMPERATURE, 1 or more digits, (unilateral or bilateral) and report, with hard copy recording of temperature before and for 10 minutes or more after cold stress testing. **Fee:** $77.10 **Benefit:** 75% = $57.85 85% = $65.55
11627	PULMONARY ARTERY pressure monitoring during open heart surgery, in a person under 12 years of age **Fee:** $232.30 **Benefit:** 75% = $174.25 85% = $197.50

	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 6. Cardiovascular
11700	TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing and report **Fee:** $31.75 **Benefit:** 75% = $23.85 85% = $27.00 **Extended Medicare Safety Net Cap:** $25.40
11701	TWELVE-LEAD ELECTROCARDIOGRAPHY, report only where the tracing has been forwarded to another medical practitioner, not in association with a consultation on the same occasion **Fee:** $15.80 **Benefit:** 75% = $11.85 85% = $13.45
11702	TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing only **Fee:** $15.80 **Benefit:** 75% = $11.85 85% = $13.45
11708	Continuous ECG recording of ambulatory patient for 12 or more hours (including resting ECG and the recording of parameters), not in association with ambulatory blood pressure monitoring, involving microprocessor based analysis equipment, interpretation and report of recordings by a specialist physician or consultant physician.

	Not being a service to which item 11709 applies. The changing of a tape or batteries does not constitute a separate service. Where a recording is analysed and reported on and a decision is made to undertake a further period of monitoring, the second episode is regarded as a separate service. **Fee:** $129.95 **Benefit:** 75% = $97.50 85% = $110.50
11709	Continuous ECG recording (Holter) of ambulatory patient for 12 or more hours (including resting ECG and the recording of parameters), not in association with ambulatory blood pressure monitoring, utilising a system capable of superimposition and full disclosure printout of at least 12 hours of recorded ECG data, microprocessor based scanning analysis, with interpretation and report by a specialist physician or consultant physician. The changing of a tape or batteries does not constitute a separate service. Where a recording is analysed and reported on and a decision is made to undertake a further period of monitoring, the second episode is regarded as a separate service. **Fee:** $170.15 **Benefit:** 75% = $127.65 85% = $144.65
11710	AMBULATORY ECG MONITORING, patient activated, single or multiple event recording, utilising a looping memory recording device which is connected continuously to the patient for 12 hours or more and is capable of recording for at least 20 seconds prior to each activation and for 15 seconds after each activation, including transmission, analysis, interpretation and report - payable once in any 4 week period **Fee:** $52.75 **Benefit:** 75% = $39.60 85% = $44.85
11711	AMBULATORY ECG MONITORING for 12 hours or more, patient activated, single or multiple event recording, utilising a memory recording device which is capable of recording for at least 30 seconds after each activation, including transmission, analysis, interpretation and report - payable once in any 4 week period **Fee:** $28.75 **Benefit:** 75% = $21.60 85% = $24.45
11712	MULTI CHANNEL ECG MONITORING AND RECORDING during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts) or pharmacological stress, involving the continuous attendance of a medical practitioner for not less than 20 minutes, with resting ECG, and with or without continuous blood pressure monitoring and the recording of other parameters, on premises equipped with mechanical respirator and defibrillator **Fee:** $154.60 **Benefit:** 75% = $115.95 85% = $131.45
11713	SIGNAL AVERAGED ECG RECORDING involving not more than 300 beats, using at least 3 leads with data acquisition at not less than 1000Hz of at least 100 QRS complexes, including analysis, interpretation and report of recording by a specialist physician or consultant physician **Fee:** $70.85 **Benefit:** 75% = $53.15 85% = $60.25
11715	BLOOD DYE DILUTION INDICATOR TEST **Fee:** $122.70 **Benefit:** 75% = $92.05 85% = $104.30
11718	IMPLANTED PACEMAKER TESTING involving electrocardiography, measurement of rate, width and amplitude of stimulus, including reprogramming when required, not being a service associated with a service to which item 11700, 11719, 11720, 11721, 11725 or 11726 applies

	Fee: $35.30 **Benefit:** 75% = $26.50 85% = $30.05
11719	IMPLANTED PACEMAKER (including cardiac resynchronisation pacemaker) REMOTE MONITORING involving reviews (without patient attendance) or arrhythmias, lead and device parameters, if at least one remote review is provided in a 12 month period. Payable only once in any 12 month period **Fee:** $67.90 **Benefit:** 75% = $50.95 85% = $57.75
11720	IMPLANTED PACEMAKER TESTING, with patient attendance, following detection of abnormality by remote monitoring involving electrocardiography, measurement of rate, width and amplitude of stimulus including reprogramming when required, not being a service associated with a service to which item 11718 or 11721 applies. **Fee:** $67.90 **Benefit:** 75% = $50.95 85% = $57.75
11721	IMPLANTED PACEMAKER TESTING of atrioventricular (AV) sequential, rate responsive, or antitachycardia pacemakers, including reprogramming when required, not being a service associated with a service to which Item 11700, 11718 11719, 11720, 11725 or 11726 applies **Fee:** $70.85 **Benefit:** 75% = $53.15 85% = $60.25
11722	IMPLANTED ECG LOOP RECORDING, for the investigation of recurrent unexplained syncope if: (a) a diagnosis has not been achieved through all other available cardiac investigations; and (b) a neurogenic cause is not suspected; and (c) the patient to whom the service is provided does not have a structural heart defect associated with a high risk of sudden cardiac death; including reprogramming when required, retrieval of stored data, analysis, interpretation and report, not being a service to which item 38285 applies **Fee:** $35.30 **Benefit:** 75% = $26.50 85% = $30.05
11724	UP-RIGHT TILT TABLE TESTING for the investigation of syncope of suspected cardiothoracic origin, including blood pressure monitoring, continuous ECG monitoring and the recording of the parameters, and involving an established intravenous line and the continuous attendance of a specialist or consultant physician - on premises equipped with a mechanical respirator and defibrillator **Fee:** $171.60 **Benefit:** 75% = $128.70 85% = $145.90
11725	IMPLANTED DEFIBRILLATOR (including cardiac resynchronisation defibrillator) REMOTE MONITORING involving reviews (without patient attendance) of arrhythmias, lead and device parameters, if at least 2 remote reviews are provided in a 12 month period. Payable only once in any 12 month period **Fee:** $192.55 **Benefit:** 75% = $144.45 85% = $163.70
11726	IMPLANTED DEFIBRILLATOR TESTING with patient attendance following detection of abnormality by remote monitoring involving electrocardiography, measurement of rate, width and amplitude of stimulus, not being a service associated with a service to which item 11727 applies. **Fee:** $96.25 **Benefit:** 75% = $72.20 85% = $81.85
11727	IMPLANTED DEFIBRILLATOR TESTING involving electrocardiography, assessment of pacing and sensing thresholds for pacing and defibrillation electrodes, download and interpretation of stored events and electrograms, including programming when required, not being a service associated with a service to

	which item 11700, 11718, 11719, 11720, 11721, 11725 or 11726 applies **Fee:** $96.25 **Benefit:** 75% = $72.20 85% = $81.85
11728	Implanted loop recording for the investigation of atrial fibrillation if the patient to whom the service is provided has been diagnosed as having had an embolic stroke of undetermined source, including reprogramming when required, retrieval of stored data, analysis, interpretation and report, other than a service to which item 38288 applies For any particular patient—applicable not more than 4 times in any 12 months **Fee:** $35.30 **Benefit:** 75% = $26.50 85% = $30.05

	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 7. Gastroenterology & Colorectal
11800	OESOPHAGEAL MOTILITY TEST, manometric **Fee:** $177.25 **Benefit:** 75% = $132.95 85% = $150.70
11801	CLINICAL ASSESSMENT OF GASTRO-OESOPHAGEAL REFLUX DISEASE that involves 48 hour catheter-free wireless ambulatory oesophageal pH monitoring including administration of the device and associated endoscopy procedure for placement, analysis and interpretation of the data and all attendances for providing the service, if (a) a cathetter-based ambulatory oesophageal pH-mnitoring: (i) has been attempted on the patient but failed due to clinical complications, or (ii) is not clinically appropriate for the patient due to anatomical reasons (nasopharyngeal anatomy) preventing the use of catheter-based pH monitoring; and (b) the services is performed by a specialist or consultant physician with endoscopic training that is recognised by The Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy. Not in association with another item in Category 2, sub-group 7 (Anaes.) **Fee:** $267.20 **Benefit:** 75% = $200.40 85% = $227.15
11810	CLINICAL ASSESSMENT of GASTRO-OESOPHAGEAL REFLUX DISEASE involving 24 hour pH monitoring, including analysis, interpretation and report and including any associated consultation **Fee:** $177.25 **Benefit:** 75% = $132.95 85% = $150.70
11820	Capsule endoscopy to investigate an episode of obscure gastrointestinal bleeding, using a capsule endoscopy device (including administration of the capsule, associated endoscopy procedure if required for placement, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if: (a) the service is provided to a patient who: (i) has overt gastrointestinal bleeding; or (ii) has gastrointestinal bleeding that is recurrent or persistent, and iron deficiency anaemia that is not due to coeliac disease, and, if the patient also has menorrhagia, has had the menorrhagia

	considered and managed; and (b) an upper gastrointestinal endoscopy and a colonoscopy have been performed on the patient and have not identified the cause of the bleeding; and (c) the service has not been provided to the same patient on more than 2 occasions in the preceding 12 months; and (d) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and (e) the service is not associated with a service to which item 30680, 30682, 30684 or 30686 applies (See para DN.1.15 of explanatory notes to this Category) **Fee:** $1,249.00 **Benefit:** 75% = $936.75 85% = $1164.30
11823	Capsule endoscopy to conduct small bowel surveillance of a patient diagnosed with Peutz-Jeghers Syndrome, using a capsule endoscopy device approved by the Therapeutic Goods Administration (including administration of the capsule, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if: (a) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and (b) the item is performed only once in any 2 year period; and (c) the service is not associated with balloon enteroscopy. (See para DN.1.15 of explanatory notes to this Category) **Fee:** $1,249.00 **Benefit:** 75% = $936.75 85% = $1164.30
11830	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR involving anal manometry or measurement of anorectal sensation or measurement of the rectosphincteric reflex **Fee:** $189.80 **Benefit:** 75% = $142.35 85% = $161.35
11833	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency **Fee:** $253.75 **Benefit:** 75% = $190.35 85% = $215.70

	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 8. Genito/Urinary Physiological Investigations
11900	URINE FLOW STUDY including peak urine flow measurement, not being a service associated with a service to which item 11919 applies

	Fee: $28.00 **Benefit:** 75% = $21.00 85% = $23.80
11903	CYSTOMETROGRAPHY, not being a service associated with a service to which any of items 11012-11027, 11912, 11915, 11919, 11921 and 36800 or any item in Group I3 of Category 5 applies **Fee:** $112.90 **Benefit:** 75% = $84.70 85% = $96.00
11906	URETHRAL PRESSURE PROFILOMETRY, not being a service associated with a service to which any of items 11012-11027, 11909, 11919, 11921 and 36800 or any item in Group I3 of Category 5 applies **Fee:** $112.90 **Benefit:** 75% = $84.70 85% = $96.00
11909	URETHRAL PRESSURE PROFILOMETRY WITH simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which item 11906, 11915, 11919, 36800 or any item in Group I3 of Category 5 applies **Fee:** $167.80 **Benefit:** 75% = $125.85 85% = $142.65
11912	CYSTOMETROGRAPHY with simultaneous measurement of rectal pressure, not being a service associated with a service to which any of items 11012-11027, 11903, 11915, 11919, 11921 and 36800 or any item in Group I3 of Category 5 applies (Anaes.) **Fee:** $167.80 **Benefit:** 75% = $125.85 85% = $142.65
11915	CYSTOMETROGRAPHY with simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which any of items 11012-11027, 11903, 11909, 11912, 11919, 11921 and 36800 or any item in Group I3 of Category 5 applies (Anaes.) **Fee:** $167.80 **Benefit:** 75% = $125.85 85% = $142.65
11917	CYSTOMETROGRAPHY IN CONJUNCTION WITH ULTRASOUND OF 1 OR MORE COMPONENTS OF THE URINARY TRACT, with measurement of any 1 or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography; including all imaging associated with cystometrography, not being a service associated with a service to which items 11012-11027, 11900-11915, 11919, 11921 and 36800 apply. (Anaes.) **Fee:** $435.20 **Benefit:** 75% = $326.40 85% = $369.95
11919	CYSTOMETROGRAPHY IN CONJUNCTION WITH CONTRAST MICTURATING CYSTOURETHROGRAPHY, with measurement of any 1 or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography; including all imaging associated with cystometrography, not being a service associated with a service to which items 11012-11027, 11900-11917, 11921 and 36800 apply (Anaes.) **Fee:** $435.20 **Benefit:** 75% = $326.40 85% = $369.95
11921	BLADDER WASHOUT TEST for localisation of urinary infection not including bacterial counts for organisms in specimens **Fee:** $76.25 **Benefit:** 75% = $57.20 85% = $64.85

	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 9. Allergy Testing
12000	Skin prick testing for aeroallergens by a specialist or consultant physician in the practice of the specialist or consultant physician's specialty, including all allergens tested on the same day, not being a service associated with a service to which item 12001, 12002, 12005, 12012, 12017, 12021, 12022 or 12024 applies (See para DN.1.22 of explanatory notes to this Category) **Fee:** $39.55 **Benefit:** 75% = $29.70 85% = $33.65

12001	Skin prick testing for aeroallergens, including all allergens tested on the same day, not being a service associated with a service to which item 12000, 12002, 12005, 12012, 12017, 12021, 12022 or 12024 applies. Applicable only once in any 12 month period (See para DN.1.22 of explanatory notes to this Category) **Fee:** $39.55 **Benefit:** 75% = $29.70 85% = $33.65
12002	Repeat skin prick testing of a patient for aeroallergens, including all allergens tested on the same day, if: (a) further testing for aeroallergens is indicated in the same 12 month period to which item 12001 applies to a service for the patient; and (b) the service is not associated with a service to which item 12000, 12001, 12005, 12012, 12017, 12021, 12022 or 12024 applies Applicable only once in any 12 month period (See para DN.1.22 of explanatory notes to this Category) **Fee:** $39.55 **Benefit:** 75% = $29.70 85% = $33.65
12003	Skin prick testing for food and latex allergens, including all allergens tested on the same day, not being a service associated with a service to which item 12012, 12017, 12021, 12022 or 12024 applies (See para DN.1.22 of explanatory notes to this Category) **Fee:** $39.55 **Benefit:** 75% = $29.70 85% = $33.65
12004	Skin testing for medication allergens (antibiotics or non general anaesthetics agents) and venoms (including prick testing and intradermal testing with a number of dilutions), including all allergens tested on the same day, not being a service associated with a service to which item 12012, 12017, 12021, 12022 or 12024 applies (See para DN.1.22 of explanatory notes to this Category) **Fee:** $59.80 **Benefit:** 75% = $44.85 85% = $50.85
12005	Skin testing: (a) performed by or on behalf of a specialist or consultant physician in the practice of the specialist or consultant physician's specialty; and (b) for agents used in the perioperative period (including prick testing and intradermal testing with a number of dilutions), to investigate anaphylaxis in a patient with a history of prior anaphylactic reaction or cardiovascular collapse associated with the administration of an anaesthetic; and (c) including all allergens tested on the same day; and (d) not being a service associated with a service to which item 12000, 12001, 12002, 12003, 12012, 12017, 12021, 12022 or 12024 applies (See para DN.1.22 of explanatory notes to this Category) **Fee:** $80.45 **Benefit:** 75% = $60.35 85% = $68.40
12012	Epicutaneous patch testing in the investigation of allergic dermatitis using not more than 25 allergens **Fee:** $21.15 **Benefit:** 75% = $15.90 85% = $18.00
12017	Epicutaneous patch testing in the investigation of allergic dermatitis using more than 25 allergens but not more than 50 allergens **Fee:** $71.40 **Benefit:** 75% = $53.55 85% = $60.70
12021	Epicutaneous patch testing in the investigation of allergic dermatitis, performed by or on behalf of a

	specialist, or consultant physician, in the practice of his or her specialty, using more than 50 allergens but not more than 75 allergens **Fee:** $117.35 **Benefit:** 75% = $88.05 85% = $99.75
12022	Epicutaneous patch testing in the investigation of allergic dermatitis, performed by or on behalf of a specialist, or consultant physician, in the practice of his or her specialty, using more than 75 allergens but not more than 100 allergens **Fee:** $137.80 **Benefit:** 75% = $103.35 85% = $117.15
12024	Epicutaneous patch testing in the investigation of allergic dermatitis, performed by or on behalf of a specialist, or consultant physician, in the practice of his or her specialty, using more than 100 allergens **Fee:** $156.95 **Benefit:** 75% = $117.75 85% = $133.45

	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 10. Other Diagnostic Procedures And Investigations
12200	COLLECTION OF SPECIMEN OF SWEAT by iontophoresis **Fee:** $37.80 **Benefit:** 75% = $28.35 85% = $32.15
12201	Administration, by a specialist or consultant physician in the practice of the specialist's or consultant physician's specialty, of thyrotropin alfa-rch (recombinant human thyroid-stimulating hormone), and arranging services to which both items 61426 and 66650 apply, for the detection of recurrent well-differentiated thyroid cancer in a patient if: (a) the patient has had a total thyroidectomy and 1 ablative dose of radioactive iodine; and (b) the patient is maintained on thyroid hormone therapy; and (c) the patient is at risk of recurrence; and (d) on at least 1 previous whole body scan or serum thyroglobulin test when withdrawn from thyroid hormone therapy, the patient did not have evidence of well-differentiated thyroid cancer; and (e) either: (i) withdrawal from thyroid hormone therapy resulted in severe psychiatric disturbances when hypothyroid; or (ii) withdrawal is medically contra-indicated because the patient has: (a) unstable coronary artery disease; or (b) hypopituitarism; or (c) a high risk of relapse or exacerbation of a previous severe psychiatric illness applicable once only in a 12 month period (See para DN.1.16 of explanatory notes to this Category) **Fee:** $2,431.20 **Benefit:** 75% = $1823.40 85% = $2346.50
12203	Overnight diagnostic assessment of sleep, for a period of at least 8 hours duration, for a patient aged 18 years or more, to confirm diagnosis of a sleep disorder, if: (a) either: (i) the patient has been referred by a medical practitioner to a qualified sleep medicine practitioner or a consultant respiratory physician who has determined that the patient has a high probability for symptomatic, moderate to severe obstructive sleep apnoea based on a STOP-Bang score of 4 or more, an OSA50 score of 5 or more or a high risk score on the Berlin Questionnaire, and an Epworth Sleepiness Scale score of 8 or more; or (ii) following professional attendance on the patient (either face-to-face or by video conference) by a qualified sleep medicine practitioner or a consultant respiratory physician, the qualified sleep medicine practitioner or consultant respiratory physician determines that assessment is necessary to confirm the diagnosis of a sleep disorder; and (b) the overnight diagnostic assessment is performed to investigate: (i) suspected obstructive sleep apnoea syndrome where the patient is assessed as not suitable for an

unattended sleep study; or

(ii) suspected central sleep apnoea syndrome; or

(iii) suspected sleep hypoventilation syndrome; or

(iv) suspected sleep-related breathing disorders in association with non-respiratory co-morbid conditions including heart failure, significant cardiac arrhythmias, neurological disease, acromegaly or hypothyroidism; or

(v) unexplained hypersomnolence which is not attributed to inadequate sleep hygiene or environmental factors; or

(vi) suspected parasomnia or seizure disorder where clinical diagnosis cannot be established on clinical features alone (including associated atypical features, vigilance behaviours or failure to respond to conventional therapy); or

(vii) suspected sleep related movement disorder, where the diagnosis of restless legs syndrome is not evident on clinical assessment; and

(c) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and

(d) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures:

(i) airflow;

(ii) continuous EMG;

(iii) anterior tibial EMG;

(iv) continuous ECG;

(v) continuous EEG;

(vi) EOG;

(vii) oxygen saturation;

(viii) respiratory movement (chest and abdomen);

(ix) position; and

(e) polygraphic records are:

(i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and

(ii) stored for interpretation and preparation of report; and

(f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and

(g) the overnight diagnostic assessment is not provided to the patient on the same occasion that a service

	mentioned in any of items 11000 to 11005, 11503, 11700 to 11709, 11713 or 12250 is provided to the patient Applicable only once in any 12 month period (See para DN.1.17 of explanatory notes to this Category) **Fee:** $597.40 **Benefit:** 75% = $448.05 85% = $512.70
12204	Overnight assessment of positive airway pressure, for a period of at least 8 hours duration, for a patient aged 18 years or more, if: (a) the necessity for an intervention sleep study is determined by a qualified sleep medicine practitioner or consultant respiratory physician where a diagnosis of a sleep-related breathing disorder has been made; and (b) the patient has not undergone positive airway pressure therapy in the previous 6 months; and (c) following professional attendance on the patient by a qualified sleep medicine practitioner or a consultant respiratory physician (either face-to-face or by video conference), the qualified sleep medicine practitioner or consultant respiratory physician establishes that the sleep-related breathing disorder is responsible for the patient's symptoms; and (d) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement; (ix) position; and (f) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (g) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from

	the patient; and (h) the overnight assessment is not provided to the patient on the same occasion that a service mentioned in any of items 11000 to 11005, 11503, 11700 to 11709, 11713 or 12250 is provided to the patient Applicable only once in any 12 month period (See para DN.1.17 of explanatory notes to this Category) **Fee:** $597.40 **Benefit:** 75% = $448.05 85% = $512.70
Amend 12205	Follow-up study for a patient aged 18 years or more with a sleep-related breathing disorder, following professional attendance on the patient by a qualified sleep medicine practitioner or consultant respiratory physician (either face-to-face or by video conference), if: (a) any of the following subparagraphs applies: (i) there has been a recurrence of symptoms not explained by known or identifiable factors such as inadequate usage of treatment, sleep duration or significant recent illness; (ii) there has been a significant change in weight or changes in co-morbid conditions that could affect sleep-related breathing disorders, and other means of assessing treatment efficacy (including review of data stored by a therapy device used by the patient) are unavailable or have been equivocal; (iii) the patient has undergone a therapeutic intervention (including, but not limited to, positive airway pressure, upper airway surgery, positional therapy, appropriate oral appliance, weight loss of more than 10% in the previous 6 months or oxygen therapy), and there is either clinical evidence of sub-optimal response or uncertainty about control of sleep-disordered breathing; and (b) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (c) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (d) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of

	not more than 1 minute; and (ii) stored for interpretation and preparation of report; and (e) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (f) the follow-up study is not provided to the patient on the same occasion that a service mentioned in any of items 11000 to 11005, 11503, 11700 to 11709, 11713 or 12250 is provided to the patient Applicable only once in any 12 month period (See para DN.1.17 of explanatory notes to this Category) **Fee:** $597.40 **Benefit:** 75% = $448.05 85% = $512.70
Amend 12207	Overnight investigation, for a patient aged 18 years or more, for a sleep-related breathing disorder, following professional attendance by a qualified sleep medicine practitioner or a consultant respiratory physician (either face-to-face or by video conference), if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (c) there is continuous monitoring and recording, in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen) (ix) position; and (d) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) 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 (ii) stored for interpretation and preparation of report; and (f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine

	practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the investigation is not provided to the patient on the same occasion that a service mentioned in any of items 11000 to 11005, 11503, 11700 to 11709, 11713 or 12250 is provided to the patient; and (h) previous studies have demonstrated failure of continuous positive airway pressure or oxygen; and (i) if the patient has severe respiratory failure—a further investigation is indicated in the same 12 month period to which items 12204 and 12205 apply to a service for the patient, for the adjustment or testing, or both, of the effectiveness of a positive pressure ventilatory support device (other than continuous positive airway pressure) in sleep Applicable only once in the same 12 month period to which item 12204 or 12205 applies (See para DN.1.17 of explanatory notes to this Category) **Fee:** $597.40 **Benefit:** 75% = $448.05 85% = $512.70
Amend 12208	Overnight investigation for sleep apnoea for a period of at least 8 hours duration, for a patient aged 18 years or more, if: (a) a qualified sleep medicine practitioner or consultant respiratory physician has determined that the investigation is necessary to confirm the diagnosis of a sleep disorder; and (b) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (c) there is continuous monitoring and recording, in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (d) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of report; and (e) interpretation and preparation of a permanent report is provided by a qualified sleep medicine

	practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (f) a further investigation is indicated in the same 12 month period to which item 12203 applies to a service for the patient because insufficient sleep was acquired, as evidenced by a sleep efficiency of 25% or less, during the previous investigation to which that item applied; and (g) the investigation is not provided to the patient on the same occasion that a service mentioned in any of items 11000 to 11005, 11503, 11700 to 11709, 11713 or 12250 is provided to the patient Applicable only once in any 12 month period (See para DN.1.17 of explanatory notes to this Category) **Fee:** $597.40 **Benefit:** 75% = $448.05 85% = $512.70
	Overnight paediatric investigation, for a period of at least 8 hours in duration, for a patient less than 12 years of age, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and 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 (ii) stored for interpretation and preparation of report; and
12210	(f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing

	the direct original recording of polygraphic data from the patient For each particular patient—applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period (See para DN.1.17 of explanatory notes to this Category) **Fee:** $713.10 **Benefit:** 75% = $534.85 85% = $628.40
12213	Overnight paediatric investigation, for a period of at least 8 hours in duration, for a patient aged at least 12 years but less than 18 years, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and 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 (ii) stored for interpretation and preparation of report; and (f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient For each particular patient—applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period (See para DN.1.17 of explanatory notes to this Category) **Fee:** $642.40 **Benefit:** 75% = $481.80 85% = $557.70

	Overnight paediatric investigation, for a period of at least 8 hours in duration, for a patient less than 12 years of age, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and 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 (ii) stored for interpretation and preparation of report; and (f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and (g) a further investigation is indicated in the same 12 month period to which item 12210 applies to a service for the patient, for a patient using Continuous Positive Airway Pressure (CPAP) or non-invasive or invasive ventilation, or supplemental oxygen, in either or both of the following circumstances: (i) there is ongoing hypoxia or hypoventilation on the third study to which item 12210 applied for the patient, and further titration of respiratory support is needed to optimise therapy; (ii) there is clear and significant change in clinical status (for example lung function or functional status) or an intervening treatment that may affect ventilation in the period since the third study to which item 12210 applied for the patient, and repeat study is therefore required to determine the need for or the adequacy of respiratory support
12215	

	Applicable only once in the same 12 month period to which item 12210 applies (See para DN.1.17 of explanatory notes to this Category) **Fee:** $713.10 **Benefit:** 75% = $534.85 85% = $628.40
12217	Overnight paediatric investigation for a period of at least 8 hours in duration for a patient aged at least 12 years but less than 18 years, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and 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 (ii) stored for interpretation and preparation of report; and (f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and (g) a further investigation is indicated in the same 12 month period to which item 12213 applies to a service for the patient, for a patient using Continuous Positive Airway Pressure (CPAP) or non-invasive or invasive ventilation, or supplemental oxygen, in either or both of the following circumstances: (i) there is ongoing hypoxia or hypoventilation on the third study to which item 12213 applied for the patient, and further titration is needed to optimise therapy; (ii) there is clear and significant change in clinical status (for example lung function or functional

status) or an intervening treatment that may affect ventilation in the period since the third study to which item 12213 applied for the patient, and repeat study is therefore required to determine the need for or the adequacy of respiratory support

Applicable only once in the same 12 month period to which item 12213 applies

(See para DN.1.17 of explanatory notes to this Category)
Fee: $642.40 **Benefit:** 75% = $481.80 85% = $557.70

12250

Overnight investigation of sleep for a period of at least 8 hours of a patient aged 18 years or more to confirm diagnosis of obstructive sleep apnoea, if:

(a) either:

(i) the patient has been referred by a medical practitioner to a qualified sleep medicine practitioner or a consultant respiratory physician who has determined that the patient has a high probability for symptomatic, moderate to severe obstructive sleep apnoea based on a STOP-Bang score of 4 or more, an OSA50 score of 5 or more or a high risk score on the Berlin Questionnaire, and an Epworth Sleepiness Scale score of 8 or more; or

(ii) following professional attendance on the patient (either face-to-face or by video conference) by a qualified sleep medicine practitioner or a consultant respiratory physician, the qualified sleep medicine practitioner or consultant respiratory physician determines that investigation is necessary to confirm the diagnosis of obstructive sleep apnoea; and

(b) during a period of sleep, there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures:

(i) airflow;

(ii) continuous EMG;

(iii) continuous ECG;

(iv) continuous EEG;

(v) EOG;

(vi) oxygen saturation;

(vii) respiratory effort; and

(c) the investigation is performed under the supervision of a qualified sleep medicine practitioner; and

(d) either:

(i) the equipment is applied to the patient by a sleep technician; or

(ii) if this is not possible—the reason it is not possible for the sleep technician to apply the equipment to the patient is documented and the patient is given instructions on how to apply the equipment by a sleep technician supported by written instructions; and

(e) polygraphic records are:

(i) analysed (for assessment of sleep stage, arousals, respiratory events and cardiac abnormalities) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1

	minute; and (ii) stored for interpretation and preparation of report; and (f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the investigation is not provided to the patient on the same occasion that a service mentioned in any of items 11000 to 11005, 11503, 11700 to 11709, 11713 and 12203 is provided to the patient Applicable only once in any 12 month period (See para DN.1.17 of explanatory notes to this Category) **Fee:** $340.65 **Benefit:** 75% = $255.50 85% = $289.60
12254	Multiple sleep latency test for the assessment of unexplained hypersomnolence in a patient aged 18 years or more, if: (a) a qualified sleep medicine practitioner or neurologist determines that testing is necessary to confirm the diagnosis of a central disorder of hypersomnolence or to determine whether the eligibility criteria for drugs relevant to treat that condition under the Pharmaceutical Benefits Scheme are fulfilled; and (b) an overnight diagnostic assessment of sleep, for a period of at least 8 hours duration is performed, with continuous monitoring and recording, in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (c) immediately following the overnight investigation a daytime investigation is performed where at least 4 nap periods are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of

	not more than 1 minute; and (ii) stored for interpretation and preparation of report; and (f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service mentioned in any of items 11003, 12203, 12204, 12205, 12208, 12250 or 12258 is provided to the patient Applicable only once in a 12 month period (See para DN.1.23 of explanatory notes to this Category) **Fee:** $928.30 **Benefit:** 75% = $696.25 85% = $843.60
12258	Maintenance of wakefulness test for the assessment of the ability to maintain wakefulness in a patient aged 18 years or more, if: (a) a qualified sleep medicine practitioner or neurologist determines that testing is necessary to objectively confirm the ability to maintain wakefulness; and (b) an overnight diagnostic assessment of sleep, for a period of at least 8 hours duration is performed, with continuous monitoring and recording, in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (c) immediately following the overnight investigation, a daytime investigation is performed where at least 4 wakefulness trials are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of

	not more than 1 minute; and (ii) stored for interpretation and preparation of report; and (f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service mentioned in any of items 11003, 12203, 12204, 12205, 12208, 12250 or 12254 is provided to the patient Applicable only once in a 12 month period (See para DN.1.23 of explanatory notes to this Category) **Fee:** $928.30 **Benefit:** 75% = $696.25 85% = $843.60
12261	Multiple sleep latency test for the assessment of unexplained hypersomnolence in a patient aged at least 12 years but less than 18 years, if: (a) a qualified sleep medicine practitioner determines that testing is necessary to confirm the diagnosis of a central disorder of hypersomnolence or to determine whether the eligibility criteria for drugs relevant to treat that condition under the Pharmaceutical Benefits Scheme are fulfilled; and (b) an overnight diagnostic assessment of sleep, for a period of at least 8 hours duration where continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and (c) immediately following the overnight investigation, a daytime investigation is performed where at least 4 nap periods are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and 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 (ii) stored for interpretation and preparation of report; and (f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service mentioned in any of items 11003, 12213, 12217 or 12265 is provided to the patient Applicable only once in a 12 month period (See para DN.1.23 of explanatory notes to this Category) **Fee:** $973.35 **Benefit:** 75% = $730.05 85% = $888.65
12265	Maintenance of wakefulness test for the assessment of the ability to maintain wakefulness in a patient aged at least 12 years but less than 18 years, if: (a) a qualified sleep medicine practitioner determines that testing to objectively confirm the ability to maintain wakefulness is necessary; and (b) an overnight diagnostic assessment of sleep, for a period of at least 8 hours duration where continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and (c) immediately following the overnight investigation, a daytime investigation is performed where at least 4 wakefulness trials are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of

not more than 1 minute; and

(ii) stored for interpretation and preparation of report; and

(f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and

(g) the diagnostic assessment is not provided to the patient on the same occasion that a service mentioned in any of items 11003, 12213, 12217 or 12261 or is provided to the patient

Applicable only once in a 12 month period

(See para DN.1.23 of explanatory notes to this Category)
Fee: $973.35 **Benefit:** 75% = $730.05 85% = $888.65

12268

Multiple sleep latency test for the assessment of unexplained hypersomnolence for a patient less than 12 years of age, if:

(a) a qualified sleep medicine practitioner determines that testing is necessary to confirm the diagnosis of a central disorder of hypersomnolence or to determine whether the eligibility criteria for drugs relevant to treat that condition under the Pharmaceutical Benefits Scheme are fulfilled; and

(b) an overnight diagnostic assessment of sleep, for a period of at least 8 hours duration where there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines:

(i) airflow;

(ii) continuous EMG;

(iii) ECG;

(iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads);

(v) EOG;

(vi) oxygen saturation;

(vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen);

(viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and

(c) immediately following the overnight investigation, a daytime investigation is performed where at least 4 nap periods are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and

(d) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and

(e) polygraphic records are:

(i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of

	not more than 1 minute; and (ii) stored for interpretation and preparation of report; and (f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service mentioned in any of items 11003, 12210, 12215 or 12272 is provided to the patient Applicable only once in a 12 month period (See para DN.1.23 of explanatory notes to this Category) **Fee:** $1,044.00 **Benefit:** 75% = $783.00 85% = $959.30
12272	Maintenance of wakefulness test for the assessment of the ability to maintain wakefulness for a patient less than 12 years of age, if: (a) a qualified sleep medicine practitioner determines that testing to objectively confirm the ability to maintain wakefulness is necessary; and (b) an overnight diagnostic assessment of sleep, for a period of at least 8 hours duration where there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and (c) immediately following the overnight investigation, a daytime investigation is performed where at least 4 wakefulness trials are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and

	(ii) stored for interpretation and preparation of report; and (f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service mentioned in any of items 11003, 12210, 12215 or 12268 is provided to the patient Applicable only once in a 12 month period (See para DN.1.23 of explanatory notes to this Category) **Fee:** $1,044.00 **Benefit:** 75% = $783.00 85% = $959.30
12306	Bone densitometry, using dual energy X-ray absorptiometry, involving the measurement of 2 or more sites (including interpretation and reporting), for: (a) confirmation of a presumptive diagnosis of low bone mineral density made on the basis of one or more fractures occurring after minimal trauma; or (b) monitoring of low bone mineral density proven by bone densitometry at least 12 months previously; other than a service associated with a service to which item 12312, 12315 or 12321 applies For any particular patient, once only in a 24 month period (See para DN.1.18 of explanatory notes to this Category) **Fee:** $104.05 **Benefit:** 75% = $78.05 85% = $88.45
12312	Bone densitometry, using dual energy X-ray absorptiometry, involving the measurement of 2 or more sites (including interpretation and reporting) for diagnosis and monitoring of bone loss associated with one or more of the following: (a) prolonged glucocorticoid therapy; (b) any condition associated with excess glucocorticoid secretion; (c) male hypogonadism; (d) female hypogonadism lasting more than 6 months before the age of 45; other than a service associated with a service to which item 12306, 12315 or 12321 applies For any particular patient, once only in a 12 month period (See para DN.1.18 of explanatory notes to this Category) **Fee:** $104.05 **Benefit:** 75% = $78.05 85% = $88.45
12315	Bone densitometry, using dual energy X-ray absorptiometry, involving the measurement of 2 or more sites (including interpretation and reporting) for diagnosis and monitoring of bone loss associated with one or more of the following conditions: (a) primary hyperparathyroidism; (b) chronic liver disease; (c) chronic renal disease; (d) any proven malabsorptive disorder;

	(e) rheumatoid arthritis; (f) any condition associated with thyroxine excess; other than a service associated with a service to which item 12306, 12312 or 12321 applies For any particular patient, once only in a 24 month period (See para DN.1.18 of explanatory notes to this Category) **Fee:** $104.05 **Benefit:** 75% = $78.05 85% = $88.45
12320	Bone densitometry, using dual energy X-ray absorptiometry or quantitative computed tomography, involving the measurement of 2 or more sites (including interpretation and reporting) for measurement of bone mineral density, if: (a) the patient is 70 years of age or over, and (b) either: (i) the patient has not previously had bone densitometry; or (ii) the t-score for the patient's bone mineral density is -1.5 or more; other than a service associated with a service to which item 12306, 12312, 12315, 12321 or 12322 applies For any particular patient, once only in a 5 year period (See para DN.1.18 of explanatory notes to this Category) **Fee:** $104.05 **Benefit:** 75% = $78.05 85% = $88.45
12321	Bone densitometry, using dual energy X-ray absorptiometry, involving the measurement of 2 or more sites at least 12 months after a significant change in therapy (including interpretation and reporting), for: (a) established low bone mineral density; or (b) confirming a presumptive diagnosis of low bone mineral density made on the basis of one or more fractures occurring after minimal trauma; other than a service associated with a service to which item 12306, 12312 or 12315 applies For any particular patient, once only in a 12 month period (See para DN.1.18 of explanatory notes to this Category) **Fee:** $104.05 **Benefit:** 75% = $78.05 85% = $88.45
12322	Bone densitometry, using dual energy X-ray absorptiometry or quantitative computed tomography, involving the measurement of 2 or more sites (including interpretation and reporting) for measurement of bone mineral density, if: (a) the patient is 70 years of age or over; and (b) the t-score for the patient's bone mineral density is less than -1.5 but more than -2.5; other than a service associated with a service to which item 12306, 12312, 12315, 12320 or 12321

	applies For any particular patient, once only in a 2 year period (See para DN.1.18 of explanatory notes to this Category) **Fee:** $104.05 **Benefit:** 75% = $78.05 85% = $88.45
12325	Assessment of visual acuity and bilateral retinal photography with a non mydriatic retinal camera, including analysis and reporting of the images for initial or repeat assessment for presence or absence of diabetic retinopathy, in a patient with medically diagnosed diabetes, if: (a) the patient is of Aboriginal and Torres Strait Islander descent; and (b) the assessment is performed by the medical practitioner (other than an optometrist or ophthalmologist) providing the primary glycaemic management of the patient's diabetes; and (c) this item and item 12326 have not applied to the patient in the preceding 12 months; and (d) the patient does not have: (i) an existing diagnosis of diabetic retinopathy; or (ii) visual acuity of less than 6/12 in either eye; or (iii) a difference of more than 2 lines of vision between the 2 eyes at the time of presentation (See para DN.1.19 of explanatory notes to this Category) **Fee:** $50.80 **Benefit:** 75% = $38.10 85% = $43.20
12326	Assessment of visual acuity and bilateral retinal photography with a non-mydriatic retinal camera, including analysis and reporting of the images for initial or repeat assessment for presence or absence of diabetic retinopathy, in a patient with medically diagnosed diabetes, if: (a) the assessment is performed by the medical practitioner (other than an optometrist or ophthalmologist) providing the primary glycaemic management of the patient's diabetes; and (b) this item and item 12325 have not applied to the patient in the preceding 24 months; and (c) the patient does not have: (i) an existing diagnosis of diabetic retinopathy; or (ii) visual acuity of less than 6/12 in either eye; or (iii) a difference of more than 2 lines of vision between the 2 eyes at the time of presentation (See para DN.1.19 of explanatory notes to this Category) **Fee:** $50.80 **Benefit:** 75% = $38.10 85% = $43.20

D2. NUCLEAR MEDICINE (NON-IMAGING)

	Group D2. Nuclear Medicine (Non-Imaging)
12500	BLOOD VOLUME ESTIMATION **Fee:** $220.10 **Benefit:** 75% = $165.10 85% = $187.10

D2. NUCLEAR MEDICINE (NON-IMAGING)	
12503	ERYTHROCYTE RADIOACTIVE UPTAKE SURVIVAL TIME TEST OR IRON KINETIC TEST **Fee:** $431.55 **Benefit:** 75% = $323.70 85% = $366.85
12506	GASTROINTESTINAL BLOOD LOSS ESTIMATION involving examination of stool specimens **Fee:** $308.15 **Benefit:** 75% = $231.15 85% = $261.95
12509	GASTROINTESTINAL PROTEIN LOSS **Fee:** $220.10 **Benefit:** 75% = $165.10 85% = $187.10
12512	RADIOACTIVE B12 ABSORPTION TEST 1 isotope **Fee:** $106.75 **Benefit:** 75% = $80.10 85% = $90.75
12515	RADIOACTIVE B12 ABSORPTION TEST 2 isotopes **Fee:** $233.55 **Benefit:** 75% = $175.20 85% = $198.55
12518	THYROID UPTAKE (using probe) **Fee:** $106.75 **Benefit:** 75% = $80.10 85% = $90.75
12521	PERCHLORATE DISCHARGE STUDY **Fee:** $128.70 **Benefit:** 75% = $96.55 85% = $109.40
12524	RENAL FUNCTION TEST (without imaging procedure) **Fee:** $160.90 **Benefit:** 75% = $120.70 85% = $136.80
12527	RENAL FUNCTION TEST (with imaging and at least 2 blood samples) **Fee:** $86.30 **Benefit:** 75% = $64.75 85% = $73.40
12530	WHOLE BODY COUNT not being a service associated with a service to which another item applies **Fee:** $128.70 **Benefit:** 75% = $96.55 85% = $109.40
12533	CARBON-LABELLED UREA BREATH TEST using oral C-13 or C-14 urea, performed by a specialist or consultant physician, including the measurement of exhaled 13CO2 or 14CO2, for either:- (a)the confirmation of Helicobacter pylori colonisation, OR (b)the monitoring of the success of eradication of Helicobacter pylori in patients with peptic ulcer disease. not being a service to which 66900 applies **Fee:** $86.00 **Benefit:** 75% = $64.50 85% = $73.10

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CATEGORY 3: THERAPEUTIC PROCEDURES

SUMMARY OF CHANGES FROM 01/11/2019

The 01/11/2019 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

Deleted Items

20705	20805	20953	21927	22001	22018	22040	22045	22050	22070	23021	23022	23023
23031	23032	23033	23041	23042	23043	23051	23052	23053	23061	23062	23063	23071
23072	23073	23081	23082	23083	32088	32089	32090	32093	41846			

New Items

18297	22041	22042	23025	23035	23045	23055	23065	23075	23085	32222	32223	32224
32225	32226	32227	32228	32229	41501	45627						

Description Amended

18216	18219	18226	18227	20160	20162	20706	20745	20750	20790	20840	20902	21952
22002	22012	22014	22025	22031	25015	30075	30078	30275	30329	30330	32084	32087
35551	35664	35670	45626	51051	51052	51053	51061	51062	51063	51064	51065	51066

Fee Amended

20142	20144	20145	20410	20745	20750	21922	21926	21936	21952

Anaesthesia MBS Changes from 1 November 2019

MBS items for anaesthesia services are changing to reflect contemporary anaesthesia practice. These changes are a result of the MBS Review Taskforce recommendations and consultation with stakeholders. The revised structure contains twenty eight amended items, proposes ten new items and deletes thirty one items.

New Items for Colonoscopy

Amending existing colonoscopy services to distinguish eligible patient cohorts by appropriate interval screenings, as recommended by the Taskforce.

Minor amendments to items 30075, 30078, 30275, 30329, 30330, 35551, 35664, 35670 and 52027

Terminology for these items has been improved by replacing references to "lymph gland/s" with the term “lymph node/s”.

Split of item 45626 to delineate between trachomatous and non-trachomatous cause

Splitting MBS item 45626 into two items to be able to identify utilisation of this procedure to treat delineating ectropion / entropion repair for trachoma and non-trachomatous causes

Minor amendments to spinal surgery items from 1 November 2019

Items 51051, 51052 and 51053
The term ‘motion segment’ will be replaced with the appropriate clinical term ‘vertebra’ or ‘vertebrae’.

Items 51061 to 51066
The term 'spine fusion' will be replaced with the appropriate clinical term “spinal fusion”.

Items 51113 and 51114
The co-claiming restrictions for items 51113 and 51114 will be revised to enable appropriate co-claiming of these items with the paediatric scoliosis or kyphosis items (50600 to 50644).

Item 51145
The item will enable a second medical practitioner to be remunerated for providing assistance at the operation through the inclusion of the term (Assist.) in the item descriptor.

THERAPEUTIC PROCEDURES NOTES

TN.1.1 Hyperbaric Oxygen Therapy - (Items 13015, 13020, 13025 and 13030)

Hyperbaric Oxygen Therapy not covered by these items would attract benefits on an attendance basis. For the purposes of these items, a comprehensive hyperbaric medicine facility means a separate hospital area that, on a 24 hour basis:

(a) is equipped and staffed so that it is capable of providing to a patient:

(i) hyperbaric oxygen therapy at a treatment pressure of at least 2.8 atmospheric pressure absolute (180 kilopascal gauge pressure); and

(ii) mechanical ventilation and invasive cardiovascular monitoring within a monoplace or multiplace chamber for the duration of the hyperbaric treatment; and

(b) is under the direction of at least 1 medical practitioner who is rostered, and immediately available, to the facility during the facility's ordinary working hours if the practitioner:

(i) is a specialist with training in diving and hyperbaric medicine; or

(ii) holds a Diploma of Diving and Hyperbaric Medicine of the South Pacific Underwater Medicine Society; and

(c) is staffed by:

(i) at least 1 medical practitioner with training in diving and hyperbaric medicine who is present in the facility and immediately available at all times when patients are being treated at the facility; and

(ii) at least 1 registered nurse with specific training in hyperbaric patient care to the published standards of the Hyperbaric Technicians and Nurses Association, who is present during hyperbaric oxygen therapy; and

(d) has admission and discharge policies in operation.

TN.1.2 Haemodialysis - (Items 13100 and 13103)

Item 13100 covers the supervision in hospital by a medical specialist for the management of dialysis, haemofiltration, haemoperfusion or peritoneal dialysis in the patient who is not stabilised where the total attendance time by the supervising medical specialist exceeds 45 minutes.

Item 13103 covers the supervision in hospital by a medical specialist for the management of dialysis, haemofiltration, haemoperfusion or peritoneal dialysis in a stabilised patient, or in the case of an unstabilised patient, where the total attendance time by the supervising medical specialist does not exceed 45 minutes.

TN.1.3 Consultant Physician Supervision of Home Dialysis - (Item 13104)

Item 13104 covers the planning and management of dialysis and the supervision of a patient on home dialysis by a consultant physician in the practice of his or her specialty of renal medicine. Planning and management would cover the consultant physician participating in patient management discussions coordinated by renal centres. Supervision of the patient at home can be undertaken by telephone or other electronic medium, and includes:

- Regular ordering, performance and interpretation of appropriate biochemical and haematological studies

(generally monthly);

- Feed-back of results to the home patient and his or her treating general physician;

- Adjustments to medications and dialysis therapies based upon these results;

- Co-ordination of regular investigations required to keep patient on active transplantation lists, where relevant;

- Referral to, and communication with, other specialists involved in the care of the patient; and

- Being available to advise the patient or the patient's agent.

A record of the services provided should be made in the patient's clinical notes.

The schedule fee equates to one hour of time spent undertaking these activities. It is expected that the item will be claimed once per month, to a maximum of 12 claims per year. The patient should be informed that he or she will incur a charge for which a Medicare rebate will be payable.

This item includes dialysis conducted in a residential aged care facility. In remote areas, where a patient's home is an unsuitable environment for home dialysis due to a lack of space, or the absence of telecommunication, electricity and water utilities, the item includes dialysis in a community facility such as the local primary health care clinic.

TN.1.4 Assisted Reproductive Technology ART Services - (Items 13200 to 13221)

Medicare benefits are not payable in respect of ANY other item in the Medicare Benefits Schedule (including Pathology and Diagnostic Imaging) in lieu of or in connection with items 13200 - 13221. Specifically, Medicare benefits are not payable for these items in association with items 104, 105, 14203, 14206, 35637, pathology tests or diagnostic imaging.

A treatment cycle that is a series of treatments for the purposes of ART services is defined as beginning either on the day on which treatment by superovulatory drugs is commenced or on the first day of the patient's menstrual cycle, and ending either; not more than 30 days later, or if a service mentioned in item 13212, 13215 or 13221 is provided in connection with the series of treatments-on the day after the day on which the last of those services is provided.

The date of service in respect of treatment covered by Items 13200, 13201, 13203, 13206, 13209 and 13218 is **DEEMED** to be the **FIRST DAY** of the treatment cycle.

Items 13200, 13201, 13202 and 13203 are linked to the supply of hormones under the Section 100 (National Health Act) arrangements. Providers must notify the Department of Human Services of Medicare card numbers of patients using hormones under this program, and hormones are only supplied for patients claiming one of these four items.

Medicare benefits are not payable for assisted reproductive services rendered in conjunction with surrogacy arrangements where surrogacy is defined as 'an arrangement whereby a woman agrees to become pregnant and to bear a child for another person or persons to whom she will transfer guardianship and custodial rights at or shortly after birth'.

NOTE: Items 14203 and 14206 are not payable for artificial insemination.

TN.1.5 Intracytoplasmic Sperm Injection - (Item 13251)

Item 13251 provides for intracytoplasmic sperm injection for male factor infertility under the following circumstances:

- where fertilisation with standard IVF is highly unlikely to be successful; or

- where in a previous cycle of IVF, the fertilisation rate has failed due to low or no fertilisation.

Item 13251 excludes a service to which item 13218 applies. Sperm retrieval procedures associated with intracytoplasmic sperm injection are covered under items 37605 and 37606.

Items 13251, 37605, 37606 do not include services provided in relation to artificial insemination using the husband's or donated sperm.

TN.1.6 Peripherally Inserted Central Catheters

Peripherally inserted central catheters (PICC) are an alternative to standard percutaneous central venous catheter placement or surgically placed intravenous catheters where long-term venous access is required for ongoing patient therapy.

Medicare benefits for PICC can be claimed under central vein catheterisation items 13318, 13319, 13815 and 22020.

These items are for central vein catheterisation (where the tip of the catheter is positioned in a central vein) and cannot be used for venous catheters where the tip is positioned in a peripheral vein.

TN.1.7 Administration of Blood or Bone Marrow already Collected (Item 13706)

Item 13706 is payable for the transfusion of blood, or platelets or white blood cells or bone marrow or gamma globulins. This item is not payable when gamma globulin is administered intramuscularly.

TN.1.8 Collection of Blood - (Item 13709)

Medicare benefits are payable under Item 13709 for collection of blood for autologous transfusions in respect of an impending operation (whether or not the blood is used), or when homologous blood is required in an emergency situation.

Medicare benefits are not payable under Item 13709 for collection of blood for long-term storage for possible future autologous transfusion, or for other forms of directed blood donation.

TN.1.9 Intensive Care Units - (Items 13870 to 13888)

'Intensive Care Unit' means a separate hospital area that:

(a) is equipped and staffed so as to be capable of providing to a patient:

(i) mechanical ventilation for a period of several days; and

(ii) invasive cardiovascular monitoring; and

(b) is supported by:

(i) at least one specialist or consultant physician in the specialty of intensive care who is immediately available and exclusively rostered to the ICU during normal working hours; and

(ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and

(iii) a registered nurse for at least 18 hours in each day; and

(c) has defined admission and discharge policies.

"**immediately available**" means that the intensivist must be predominantly present in the ICU during normal working hours. Reasonable absences from the ICU would be acceptable to attend conferences, meetings and other commitments which might involve absences of up to 2 hours during the working day.

"**exclusively rostered**" means that the specialist's sole clinical commitment is to intensive care associated activities and is not involved in any other duties that may preclude immediate availability to intensive care if required.

For Neonatal Intensive Care Units an 'Intensive Care Unit' means a separate hospital area that:

(a) is equipped and staffed so as to be capable of providing to a patient, being a newly-born child:

(i) mechanical ventilation for a period of several days; and

(ii) invasive cardiovascular monitoring; and

(b) is supported by:

(i) at least one consultant physician in the specialty of paediatric medicine, appointed to manage the unit, and who is immediately available and exclusively rostered to the ICU during normal working hours; and

(ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and

(iii)a registered nurse for at least 18 hours in each day; and

(c) has defined admission and discharge policies.

Medicare benefits are payable under the 'management' items only once per day irrespective of the number of intensivists involved with the patient on that day. However, benefits are also payable for an attendance by another specialist/consultant physician who is not managing the patient but who has been asked to attend the patient. Where appropriate, accounts should be endorsed to the effect that the consultation was not part of the patient's intensive care management in order to identify which consultations should attract benefits in addition to the intensive care items.

In respect of Neonatal Intensive Care Units, as defined above, benefits are payable for admissions of babies who meet the following criteria:-

(i) all babies weighing less than 1000gms;

(ii) all babies with an endotracheal tube, and for the 24 hours following endotracheal tube removal;

(iii) all babies requiring Constant Positive Airway Pressure (CPAP) for acute respiratory instability;

(iv) all babies requiring more than 40% oxygen for more than 4 hours;

(v) all babies requiring an arterial line for blood gas or pressure monitoring; or

(vi) all babies having frequent seizures.

Cases may arise where babies admitted to a Neonatal Intensive Care Unit under the above criteria who, because they no longer satisfy the criteria are ready for discharge, in accordance with accepted discharge policies, but who are physically retained in the Neonatal Intensive Care Unit for other reasons. For benefit purposes such babies must be deemed as being discharged from the Neonatal Intensive Care Unit and not eligible for benefits under items 13870, 13873, 13876, 13881, 13882, 13885 and 13888.

Likewise, Medicare benefits are not payable under items 13870, 13873, 13876, 13881 13882, 13885 and 13888 in respect of babies not meeting the above criteria, but who, for whatever other reasons, are physically located in a Neonatal Intensive Care Unit.

Medicare benefits are payable for admissions to an Intensive Care Unit following surgery only where clear clinical justification for post-operative intensive care exists.

TN.1.10 Procedures Associated with Intensive Care - (Items 13818, 13842, 13847, 13848 and 13857)

Item 13818 covers the insertion of a right heart balloon catheter (Swan-Ganz catheter). Benefits are payable under this item only once per day except where a second discrete operation is performed on that day.

Benefits are payable under items 13876 (within an ICU) and 11600 (outside an ICU) once only for each type of pressure, up to a maximum of 4 pressures per patient per calendar day, and irrespective of the number of the practitioners involoved in monitoring the pressures.

If a service covered by Item 13842 is provided outside of an ICU, in association with, for example, an anaesthetic, benefits are payable for Item 13842 in addition to Item 13870 where the services are performed on the same day. Where this occurs, accounts should be endorsed "performed outside of an Intensive Care Unit" against Item 13842.

Items 13847 and 13848

Item 13847 covers management of counterpulsation by intraaortic balloon on the first day and includes initial and subsequent consultations and monitoring of parameters. Insertion of the intraaortic balloon is covered under item 38609 Management on each day subsequent to the first is covered under item 13848.

"management" of counterpulsation of intraaortic balloon means full heamodynamic assessment and management on several occasions during the day.

Item 13857 covers the establishment of airway access and initiation of ventilation on a patient outside intensive care for the purpose of subsequent ventilatory support in intensive care. Benefits are not payable under Item 13857 where airway access and ventilation is initiated in the context of an anaesthetic for surgery even if it is likely that following surgery the patient will be ventilated in an ICU. In such cases the appropriate anaesthetic item/s should be itemised.

Medicare benefits are not payable for sampling by arterial puncture under Item 13839 in addition to Item 13870 (and 13873) on the same day. Benefits are payable under Item 13842 (Intra-arterial cannulation) in addition to Item 13870 (and 13873) when performed on the same day.

TN.1.11 Management and Procedures in Intensive Care Unit - (Items 13870, 13873, 13876)

Medicare benefits are only payable for management and procedures in intensive care covered by items 13870, 13873, 13876, 13882, 13885 and 13888 where the service is provided by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care.

Items 13870 and 13873

Medicare Benefits Schedule fees for Items 13870 and 13873 represent global daily fees covering all attendances by the intensivist in the ICU (and attendances provided by support medical personnel) and all electrocardiographic monitoring, arterial sampling and, bladder catheterisation.performed on the patient on the one day. If a patient is transferred from one ICU to another it would be necessary for an arrangement to be made between the two ICUs regarding the billing of the patient.

Items 13870 and 13873 should be itemised on accounts according to each calendar day and not per 24 hour period. For periods when patients are in an ICU for very short periods (say less than 2 hours) with minimal ICU management during that time, a fee should not be raised.

Item 13876

Item 13876 covers the monitoring of pressures in an ICU. Benefits are paid only once for each type of pressure, up to a maximum of 4 pressures per patient per calendar day and irrespective of the number of medical practitioners involved in the monitoring of pressures in an ICU.

Item 11600

Item 11600 covers the monitoring of pressures outside the ICU by practitioners not associated with the ICU. Benefits are paid only once for each type of pressure, up to a maximum of 4 pressures per patient per calendar day and irrespective of the number of practitioners involved in monitoring the pressures.

TN.1.12 Cytotoxic Chemotherapy Administration - (Item 13915)

Following a recommendation of a National Health and Medical Research Council review committee in 2005, Medicare benefits are no longer payable for professional services rendered for the purpose of administering microwave (UHF radiowave) cancer therapy, including the intravenous injection of drugs used in the therapy.

TN.1.13 Implanted Pump or Reservoir/Drug Delivery Device - (Items 13939 and 13942)

The schedule fee for Items 13939 and 13942 includes a component to cover accessing of the drug delivery device. Accordingly, benefits are not payable under Item 13945 (Long-term implanted drug delivery device, accessing of) in addition to Items 13939 and 13942.

TN.1.14 PUVA or UVB Therapy - (Item 14050)

A component for any necessary subsequent consultation has been included in the Schedule fee for this item. However, the initial consultation preceding commencement of a course of therapy would attract benefits.

Phototherapy should only be used when:

- Topical therapy has failed or is inappropriate.
- The severity of the condition as assessed by specialist opinion (including symptoms, extent of involvement and quality of life impairment) warrants its use.

Narrow band UVB should be the preferred option for phototherapy unless there is documented evidence of superior efficacy of UVA phototherapy for the condition being treated.

Phototherapy treatment for psoriasis and palmoplantar pustulosis should consider the National Institute of Health and Care Excellence's Guidelines at https://pathways.nice.org.uk/pathways/psoriasis

Involvement by a specialist in the specialty of dermatology at a minimum should include a letter stating the diagnosis, need for phototherapy, estimated time of treatment and review date.

TN.1.15 Laser Photocoagulation - (Items 14100 to 14124)

All laser equipment used for services under items 14100-14124 must be listed on the Australian Register of Therapeutic Goods.

The Australasian College of Dermatologists has advised that the following ranges (applicable to an average 4 year old child and an adult) should be used as a reference to the treatment areas specified in Items 14106 - 14124:

Entire forehead	50 -75 cm^2
Cheek	55 - 85 cm^2
Nose	10 -25 cm^2
Chin	10 - 30 cm^2
Unilateral midline anterior - posterior neck	60 - 220 cm^2
Dorsum of hand	25 - 80 cm^2
Forearm	100 - 250 cm^2
Upper arm	105 - 320 cm^2

TN.1.16 Facial Injections of Poly-L-Lactic Acid - (Items 14201 and 14202)

Poly-L-lactic acid is listed within the standard arrangements on the Pharmaceutical Benefits Scheme (PBS) as an Authority Required listing for initial and maintenance treatments, for facial administration only, of severe facial lipoatrophy caused by therapy for HIV infection.

TN.1.17 Hormone and Living Tissue Implantation - (Items 14203 and 14206)

Items 14203 and 14206 are not payable for artificial insemination.

TN.1.18 Implantable Drug Delivery System for the Treatment of Severe Chronic Spasticity - (Items 14227 to 14242)

Baclofen is provided under Section 100 of the Pharmaceutical Benefits Scheme for the following indications: Severe chronic spasticity, where oral agents have failed or have caused unacceptable side effects, in patients with chronic spasticity:

(a) of cerebral origin; or

(b) due to multiple sclerosis; or

(c) due to spinal cord injury; or

(d) due to spinal cord disease.

Items 14227 to 14242 should be used in accordance with these restrictions.

TN.1.19 Immunomodulating Agent - (Item 14245)

Item 14245 applies only to a service provided by a medical practitioner who is registered by the Department of Human Services CEO to participate in the arrangements made, under paragraph 100 (1) (b) of the National Health Act 1953, for the purpose of providing an adequate pharmaceutical service for persons requiring treatment with an immunomodulating agent.

These drugs are associated with risk of anaphylaxis which must be treated by a medical practitioner. For this reason a medical practitioner needs to be available at all times during the infusion in case of an emergency.

TN.1.20 Therapeutic procedures may be provided by a specialist trainee (Items 13015 to 51318)

(1) Items 13015 to 51318 (excluding 13209 (T1) 16400 to 16500 (T4), 16590 to 16591 (T4), 17610 to 17690 (T6) and 18350 to 18373 (T11) apply to a medical service provided by;

(a) A medical practitioner, or;

(b) A specialist trainee under the direct supervision of a medical practitioner.

(2) For paragraph (1) (b), a medical service provided by a specialist trainee is taken to have been provided by the supervising medical practitioner.

(3) In this rule: Specialist trainee means a medical practitioner who is undertaking an Australian Medical Council (AMC) accredited Medical College Training Program. Direct Supervision means personal and continuous attendance for the duration of the service.

TN.1.21 Telehealth Specialist Services

These notes provide information on the telehealth MBS video consultation items by specialists, consultant physicians and psychiatrists. A video consultation involves a single specialist, consultant physician or psychiatrist attending a patient, with the possible support of another medical practitioner, a participating optometrist, a participating nurse practitioner, a participating midwife, practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker at the patient end of the video conference. The decision as to whether the patient requires clinical support at the patient end of the specialist service is based on whether the support is necessary for the provision of the specialist service. Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

MBS items numbers 99, 112, 149, 288, 389, 2820, 3015, 6016, 13210, 16399 and 17609 allow a range of existing MBS attendance items to be provided via video conferencing. These items have a derived fee which is equal to 50% of the schedule fee for the consultation item claimed (e.g. 50% of the schedule fee for item 104) when billed with one of the associated consultation items (such as 104). A patient rebate of 85% for the derived fee is payable.

Six MBS item numbers (113, 114, 384, 2799, 3003 and 6004) provide for an initial attendance via videoconferencing by a specialist, consultant physician, consultant occupational physician, pain medicine specialist/consultant physician, palliative medicine specialist/consultant physician or neurosurgeon where the service is 10 minutes or less. The items are stand-alone items and do not have a derived fee.

Where an attendance is more than 10 minutes, practitioners should use the existing item numbers consistent with the current arrangements. Normal restrictions which apply for initial consultations will also apply for these items. For example, if a patient has an initial consultation via telehealth, they cannot also claim an initial face-to-face consultation as part of the same course of treatment.

Clinical indications

The specialist, consultant physician or psychiatrist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the specialist, consultant physician or psychiatrist.

Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

Restrictions

The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes hospital in the home patients). Benefits are not payable for telephone or email consultations. In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Billing Requirements

All video consultations provided by specialists, consultant physicians or psychiatrists must be **separately billed**. That is, only the relevant telehealth MBS consultation item and the associated derived item are to be itemised on the account/bill/voucher. Any other service/item billed should be itemised on a separate account/bill/voucher. This will ensure the claim is accurately assessed as being a video consultation and paid accordingly.

Practitioners should not use the notation 'telehealth', 'verbal consent' or 'Patient unable to sign' to overcome administrative difficulties to obtaining a patient signature for bulk billed claims (for further information see mbsonline.gov.au/telehealth).

Eligible Geographical Areas

Geographic eligibility for telehealth services funded under Medicare are determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are areas that are outside a Major City (RA1) according to ASGC-RA (RA2-5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

This rule will not apply to specialist video consultation with patients who are a care recipient in a residential care service; or at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the *Health Insurance Act 1973* as these patients are able to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at www.mbsonline.gov.au/ telehealth eligible areas

Record Keeping

Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Extended Medicare Safety Net (EMSN)

All telehealth consultations (with the exception of the participating optometrist telehealth items) are subject to EMSN caps. The EMSN caps for ART and Obstetric telehealth items 13210 and 16399 were set in reference to the EMSN caps applying to the base ART and Obstetric consultation items.

The EMSN caps for all other telehealth consultation items are equal to 300% of the schedule fee (to a maximum of $500). The maximum EMSN benefit for a telehealth consultation is equal to the sum of the EMSN cap for the base item and the EMSN cap for the telehealth items.

Aftercare Rule

Video consultations are subject to the same aftercare rules as practitioners providing face-to-face consultations.

Multiple attendances on the same day

In some situations a patient may receive a telehealth consultation and a face to face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Referrals

The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Technical requirements

In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

TN.1.22 Cryopreservation of semen (Item 13260)

A semen cycle collection process involves obtaining up to 3 semen samples on alternate days producing up to 50 cryopreserved straws of frozen sperm.

Maximum of two semen collection cycles, one cycle collected prior to a patient undergoing the first cytotoxic/radiation treatment and the second cycle to be collected if the patient has relapsed and requires treatment.

TN.1.23 MBS Item 13105 - Haemodialysis in very remote areas

The purpose of item 13105 is for the management of haemodialysis to a person with end-stage renal disease. The service is provided in very remote areas (defined as Modified Monash 7) by a registered nurse, an Aboriginal health

worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner. The service is supervised by a medical practitioner (either in person or remotely).

As a condition of receiving the Medicare-funded dialysis treatment, the patient's care must be managed by a nephrologist, with the patient being treated or reviewed by the nephrologist every 3 to 6 months (either in person or remotely).

The patient is not an admitted patient of a hospital and the service is provided in a primary care setting.

Item 13104 should not be claimed if item 13105 is claimed.

TN.2.1 Radiation Oncology - General

The level of benefits for radiotherapy depends on the number of fields irradiated and the number of times treatment is given.

Treatment by rotational therapy (including rotational therapy using volumetric modulated arc therapy or intensity modulated arc therapy) is considered to be equivalent to the irradiation of three fields (i.e., irradiation of one field plus two additional fields). For example, each attendance for orthovoltage rotational therapy at the rate of 3 or more treatments per week would attract benefit under Item 15100 plus twice Item 15103. Similarly, each attendance for arc therapy of the prostate using a dual photon linear accelerator would attract benefits under 15248 plus twice 15263. Benefits are payable once only per attendance for treatment irrespective of whether one or more arcs are involved.

Benefits for consultations rendered on the same day as treatment and/or planning services are only payable where they are clinically relevant. A clinically relevant service is one that is generally accepted by the relevant profession as being necessary for the appropriate treatment of the patient.

From 1 January 2016, separate items were listed for intensity-modulated radiotherapy (IMRT) and image-guided radiotherapy (IGRT). Previously, these services were delivered and billed against the existing MBS three-dimensional radiotherapy items.

Definitions have been inserted into the Health Insurance (General Medical Services Table) Regulation as follows:

In items 15275, 15555, 15565 and 15715:

IMRT means intensity modulated radiation therapy, being a form of external beam radiation therapy that uses high energy megavoltage x rays to allow the radiation dose to conform more closely to the shape of a tumour by changing the intensity of the radiation beam.

In item 15275:

IGRT means image guided radiation therapy, being a process in which frequent 2 and 3 dimensional imaging is captured as close as possible to the time of treatment by using x rays and scans (similar to CT scans) before and during radiotherapy treatment, in order to show the size, shape and position of a cancer as well as the surrounding tissues and bones.

TN.2.2 Brachytherapy of the Prostate - (Item 15338)

One of the requirements of item 15338 is that patients have a Gleason score of less than or equal to 7. However, where the patient has a score of 7, comprising a primary score of 4 and a secondary score of 3 (ie. 4+3=7), it is recommended that low dose rate brachytherapy form part of a combined modality treatment.

Low dose brachytherapy of the prostate should be performed in patients with favourable anatomy allowing adequate access to the prostate without pubic arch interference and who have a life expectancy of at least greater than 10 years.

An 'approved site' for the purposes of this item is one at which radiation oncology services may be performed lawfully under the law of the State or Territory in which the site is located.

TN.2.3 Planning Services - (Items 15500 to 15565 and 15850)

A planning episode involves field setting and dosimetry. One plan only will attract Medicare benefits in a course of treatment. However, benefits are payable for a plan for brachytherapy and a plan for megavoltage or teletherapy treatment, when rendered in the same course of treatment.

- further planning items where planning is undertaken in respect of a different tumour site to that (or those) specified in the original prescription by the radiation oncologist; and
- a plan for brachytherapy and a plan for megavoltage or teletherapy treatment, when rendered in the same course of treatment.

Items 15500 to 15533 (inclusive) are for a planning episode for 2D conformal radiotherapy. Items 15550 to 15562 (excluding item 15555) are for a planning episode for 3D conformal radiotherapy. Items 15555 and 15565 are for a planning episode for intensity modulated radiotherapy (IMRT).

It is expected that the 2D simulation items (15500, 15503, and 15506) would be used in association with the 2D planning items (15518, 15521, and 15524) in a planning episode. However there may be instances where it may be appropriate to use the 3D Planning items (15556, 15559, and 15562) in association with the 2D simulation items (15500, 15503, and 15506) in a planning episode. The 3D simulation items (15550 and 15553) can only be billed in association with the 3D planning items (15556, 15559, and 15562) in a planning episode. However there may be instances where it may be appropriate to use the 3D Planning items (15556, 15559, and 15562) in association with the 2D simulation items (15500, 15503, and 15506) in a planning episode. The 3D simulation items (15550 and 15553) can only be billed in association with the 3D planning items (15556, 15559, and 15562) in a planning episode. The IMRT simulation item (15555) and IMRT dosimetry item (15565) can only be billed in association with each other and only for IMRT (i.e. neither IMRT simulation item 15555, nor IMRT dosimetry item 15565, can be billed in association with any of the 2D or 3D treatment items for an episode of care).

Item 15850 covers radiation source localisation for high dose brachytherapy treatment. Item 15850 applies to brachytherapy provided to any part of the body.

TN.2.4 Treatment Verification - (Items 15700 to 15705, 15710, 15715 and 15800)

In these items, 'treatment verification' means:

A quality assurance procedure designed to facilitate accurate and reproducible delivery of the radiotherapy/brachytherapy to the prescribed site(s) or region(s) of the body as defined in the treatment prescription and/or associated dose plan(s) and which utilises the capture and assessment of appropriate images using:

(a) x-rays (this includes portal imaging, either megavoltage or kilovoltage, using a linear accelerator)

(b) computed tomography; or

(c) ultrasound, where the ultrasound equipment is capable of producing images in at least three dimensions (unidimensional ultrasound is not covered); together with a record of the assessment(s) and any correction(s) of significant treatment delivery inaccuracies detected.

Item 15700 covers the acquisition of images in one plane and incorporates both single or double exposures. The item may be itemised once only per attendance for treatment, irrespective of the number of treatment sites verified at that attendance.

Item 15705 (multiple projections) applies where images in more that one plane are taken, for example orthogonal views to confirm the isocentre. It can be itemised only where verification is undertaken of treatments involving three or more fields. It can be itemised where single projections are acquired for multiple sites, eg multiple

metastases for palliative patients. Item 15705 can be itemized only once per attendance for treatment, irrespective of the number of treatment sites verified at that attendance.

15710 applies to volumetric verification imaging using acquisition by computed tomography. It can be itemised only where verification is undertaken of treatments involving three or more fields and only once per attendance for treatment, irrespective of the number of treatment sites verified at that attendance.

Items 15700, 15705, 15710 and 15715:

- may not claimed together for the same attendance at which treatment is rendered

- must only be itemised when the verification procedure has been prescribed in the treatment plan and the image has been reviewed by a radiation oncologist

Item 15800 - Benefits are payable once only per attendance at which treatment is verified.

TN.3.1 Therapeutic Dose of Yttrium 90 - (Item 16003)

This item cannot be claimed for selective internal radiation therapy (SIRT).

See items 35404, 35406 and 35408 for SIRT using SIR_Spheres (yttrium-90 microspheres).

TN.4.1 Antenatal Service Provided by a Nurse, Midwife or an Aboriginal and Torres Strait Islander health practitioner - (Item 16400)

Item 16400 can only be claimed by a medical practitioner (including a vocationally registered or non-vocationally registered GP, a specialist or a consultant physician) where an antenatal service is provided to a patient by a midwife, nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of the medical practitioner at, or from an eligible practice location in a regional, rural or remote area.

A regional, rural or remote area is classified as a RRMA 3-7 area under the Rural Remote Metropolitan Areas classification system.

Evidence based national or regional guidelines should be used in the delivery of this antenatal service.

An eligible practice location is the place associated with the medical practitioner's Medicare provider number from which the service has been provided. If you are unsure if the location is in an eligible area you can call the Department of Human Services on 132 150.

A midwife means a registered midwife who holds a current practising certificate as a midwife issued by a State or Territory regulatory authority and who is employed by, or whose services are otherwise retained by, the medical practitioner or their practice.

A nurse means a registered or enrolled nurse who holds a current practising certificate as a nurse issued by a State or Territory regulatory authority and who is employed by, or whose services are otherwise retained by, the medical practitioner or their practice. The nurse must have appropriate training and skills to provide an antenatal service.

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the Health Insurance Act 1973.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

The midwife, nurse or Aboriginal and Torres Strait Islander health practitioner must also comply with any relevant legislative or regulatory requirements regarding the provision of the antenatal service.

The medical practitioner under whose supervision the antenatal service is provided retains responsibility for the health, safety and clinical outcomes of the patient. The medical practitioner must be satisfied that the midwife, nurse or Aboriginal and Torres Strait Islander health practitioner is appropriately registered, qualified and trained, and covered by indemnity insurance to undertake antenatal services.

Supervision at a distance is recognised as an acceptable form of supervision. This means that the medical practitioner does not have to be physically present at the time the service is provided. However, the medical practitioner should be able to be contacted if required.

The medical practitioner is not required to see the patient or to be present while the antenatal service is being provided by the midwife, nurse or Aboriginal and Torres Strait Islander health practitioner. It is up to the medical practitioner to decide whether they need to see the patient. Where a consultation with the medical practitioner has taken place prior to or following the antenatal service, the medical practitioner is entitled to claim for their own professional service, but item 16400 cannot be claimed in these circumstances.

Item 16400 cannot be claimed in conjunction with another antenatal attendance item for the same patient, on the same day by the same practitioner.

A bulk billing incentive item (10990, 10991 or 10992) cannot be claimed in conjunction with item 16400. An incentive payment is incorporated into the schedule fee.

Item 16400 can only be claimed 10 times per pregnancy.

Item 16400 cannot be claimed for an admitted patient of a hospital.

TN.4.2 Items for Initial and Subsequent Obstetric Attendances (Items 16401 and 16404)

16401 and 16404 replace items 104 and 105 for any specialist obstetric attendance relating to pregnancy. This includes any initial and subsequent attendance with a specialist obstetrician for discussion of pregnancy or pregnancy related conditions or complications, or any postnatal care provided to the patient subsequent to the expiration of normal aftercare period. Item 16500 is still claimed for routine antenatal attendances. These items are subject to Extended Medicare Safety Net caps.

TN.4.3 Antenatal Care - (Item 16500)

In addition to routine antenatal attendances covered by Item 16500 the following services, where rendered during the antenatal period, attract benefits:-

(a) Items 16501, 16502, 16505, 16508, 16509 (but not normally before the 24th week of pregnancy), 16511, 16512, 16514, 16533, 16534 and 16600 to 16627.

(b) The initial consultation at which pregnancy is diagnosed.

(c) The first referred consultation by a specialist obstetrician when called in to advise on the pregnancy.

(d) All other services, excluding those in Category 1 and Group T4 of Category 3 not mentioned above.

(e) Treatment of an intercurrent condition not directly related to the pregnancy.

Item 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 birth.

TN.4.4 External Cephalic Version for Breech Presentation - (Item 16501)

Contraindications for this item are as follows:

- antepartum haemorrhage (APH)
- multiple pregnancy,
- fetal anomaly,
- fetal growth restriction,
- caesarean section scar,
- uterine anomalies,
- obvious cephalopelvic disproportion,
- isoimmunization,
- premature rupture of the membranes.

TN.4.5 Labour and Birth - (Items 16515, 16518, 16519, 16530 and 16531)

Benefits for management of labour and birth covered by Items 16515, 16518, 16519, 16530 and 16531 includes the following (where indicated):-

- surgical and/or intravenous infusion induction of labour;
- forceps or vacuum extraction;
- evacuation of products of conception by manual removal (not being an independent procedure);
- episiotomy or repair of tears.

Item 16519 covers birth 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 birth by Caesarean section, whether because of an emergency situation or otherwise, then Item 16520 would be the appropriate item.

In some instances the obstetrician may not be able to be present at all stages of confinement. In these circumstances, Medicare benefits are payable under Item 16519 provided that the doctor attends the patient as soon as possible during the confinement and assumes full responsibility for the mother and baby.

Two items in Group T9 provide benefits for assistance by a medical practitioner at a Caesarean section. Item 51306 relates to those instances where the Caesarean section is the only procedure performed, while Item 51309 applies when other operative procedures are performed at the same time.

Where, during labour, a medical practitioner hands the patient over to another medical practitioner, benefits are payable under Item 16518 for the referring practitioner's services. The second practitioner's services would attract benefits under Item 16515 (i.e., management of vaginal birth) or Item 16520 (Caesarean section). If another medical practitioner is called in for the management of the labour and birth, benefits for the referring practitioner's services should be assessed under Item 16500 for the routine antenatal attendances and on a consultation basis for the postnatal attendances, if performed.

At a high risk birth benefits will be payable for the attendance of any medical practitioner (called in by the doctor in charge of the birth) for the purposes of resuscitation and subsequent supervision of the neonate. Examples of high risk births include cases of difficult vaginal birth, Caesarean section or the birth of babies with Rh problems and babies of toxaemic mothers.

TN.4.6 Caesarean Section - (Item 16520)

Benefits under this item are attracted only where the patient has been specifically referred to another medical practitioner for the management of the birth 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.

TN.4.7 Complicated Confinement - (Item 16522)

A record of the clinical indication/s that constitute billing under item 16522 should be retained on the patient's medical record.

TN.4.8 Labour and Birth Where Care is Transferred by a Participating Midwife - (Items 16527 to 16528)

Where the intrapartum care of a patient is transferred to a medical practitioner by a participating midwife for the management of birth, item 16527 or 16528 would apply depending on the service provided.

Where care is transferred by a participating midwife prior to the commencement of labour, items 16519 or 16522 would apply.

TN.4.9 Items for Planning and Management of a Pregnancy (Item 16590 and 16591)

Item 16590 is intended to provide for the planning and management of pregnancy that has progressed beyond 28 weeks, where the medical practitioner is intending to undertake the birth for a privately admitted patient.

Item 16591 is for the planning and management of a pregnancy that has progressed beyond 28 weeks and the medical practitioner is providing shared antenatal care and is not intending to undertake the birth.

Items 16590 and 16591 are to include the provision of a mental health assessment of the patient. Both items are subject to Extended Medicare Safety Net caps and should only be claimed by a patient once per pregnancy.

TN.4.10 Post-Partum Care - (Items 16515 to 16520 and 16564 to 16573)

The Schedule fees and benefits payable for Items 16519 and 16520 cover all postnatal attendances on the mother and the baby, except in the following circumstances:-

(i) where the medical services rendered are outside those covered by a consultation, e.g., blood transfusion;

(ii) where the condition of the mother and/or baby is such as to require the services of another practitioner (e.g., paediatrician, gynaecologist, etc);

(iii) where the patient is transferred, at arms length, to another medical practitioner for routine post-partum, care (eg mother and/or baby returning from a larger centre to a country town or transferring between hospitals following confinement). In such cases routine postnatal attendances attract benefits on an attendance basis. The transfer of a patient within a group practice would not qualify for benefits under this arrangement except in the case of Items 16515 and 16518. These items cover those occasions when a patient is handed over <u>while in labour</u> from the practitioner who under normal circumstances would have delivered the baby, but because of compelling circumstances decides to transfer the patient to another practitioner for the birth;

(iv) where during the postnatal period a condition occurs which requires treatment outside the scope of normal postnatal care;

(v) in the management of premature babies (i.e. babies born prior to the end of the 37th week of pregnancy or where the birth weight of the baby is less than 2500 grams) during the period that close supervision is necessary.

Normal postnatal care by a medical practitioner would include:-

(i) uncomplicated care and check of

- lochia
- fundus
- perineum and vulva/episiotomy site
- temperature
- bladder/urination
- bowels

(ii) advice and support for establishment of breast feeding

(iii) psychological assessment and support

(iv) Rhesus status

(v) Rubella status and immunisation

(vi) contraception advice/management

Examinations of apparently normal newborn infants by consultant or specialist paediatricians do not attract benefits

Items 16564 to 16573 relate to postnatal complications and should not be itemised in respect of a normal birth. 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.

TN.4.11 Interventional Techniques - (Items 16600 to 16627, 35518 and 35674)

For Items 16600 to 16627, 35518 and 35674 there is no component in the Schedule fee for the associated ultrasound. Benefits are attracted for the ultrasound under the appropriate items in Group I1 of the Diagnostic Imaging Services Table. If diagnostic ultrasound is performed on a separate occasion to the procedure, benefits would be payable under the appropriate ultrasound item.

Item 51312 provides a benefit for assistance by a medical practitioner at interventional techniques covered by Items 16606, 16609, 16612, 16615, and 16627.

TN.4.12 Telehealth Specialist Services

These notes provide information on the telehealth MBS video consultation items by specialists, consultant physicians and psychiatrists. A video consultation involves a single specialist, consultant physician or psychiatrist attending a patient, with the possible support of another medical practitioner, a participating optometrist, a participating nurse practitioner, a participating midwife, practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker at the patient end of the video conference. The decision as to whether the patient requires clinical support at the patient end of the specialist service is based on whether the support is necessary for the provision of the specialist service. Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

MBS items numbers 99, 112, 149, 288, 389, 2820, 3015, 6016, 13210, 16399 and 17609 allow a range of existing MBS attendance items to be provided via video conferencing. These items have a derived fee which is equal to 50% of the schedule fee for the consultation item claimed (e.g. 50% of the schedule fee for item 104) when billed with one of the associated consultation items (such as 104). A patient rebate of 85% for the derived fee is payable.

Six MBS item numbers (113, 114, 384, 2799, 3003 and 6004) provide for an initial attendance via videoconferencing by a specialist, consultant physician, consultant occupational physician, pain medicine

specialist/consultant physician, palliative medicine specialist/consultant physician or neurosurgeon where the service is 10 minutes or less. The items are stand alone items and do not have a derived fee.

Where an attendance is more than 10 minutes, practitioners should use the existing item numbers consistent with the current arrangements. Normal restrictions which apply for initial consultations will also apply for these items. For example, if a patient has an initial consultation via telehealth, they cannot also claim an initial face-to-face consultation as part of the same course of treatment.

Clinical indications

The specialist, consultant physician or psychiatrist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the specialist, consultant physician or psychiatrist.

Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

Restrictions

The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes hospital in the home patients). Benefits are not payable for telephone or email consultations. In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Billing Requirements

All video consultations provided by specialists, consultant physicians or psychiatrists must be **separately billed**. That is, only the relevant telehealth MBS consultation item and the associated derived item are to be itemised on the account/bill/voucher. Any other service/item billed should be itemised on a separate account/bill/voucher. This will ensure the claim is accurately assessed as being a video consultation and paid accordingly.

Practitioners should not use the notation 'telehealth', 'verbal consent' or 'Patient unable to sign' to overcome administrative difficulties to obtaining a patient signature for bulk billed claims (for further information see mbsonline.gov.au/telehealth).

Eligible Geographical Areas

Geographic eligibility for telehealth services funded under Medicare are determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are areas that are outside a Major City (RA1) according to ASGC-RA (RA2-5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

This rule will not apply to specialist video consultation with patients who are a care recipient in a residential care service; or at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the *Health Insurance Act 197,* as these patients are able to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at www.mbsonline.gov.au/ telehealth eligible areas

Record Keeping

Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Extended Medicare Safety Net (EMSN)

All telehealth consultations (with the exceptions of the participating optometrist telehealth items) are subject to EMSN caps. The EMSN caps for ART and Obstetric telehealth items 13210 and 16399 were set in reference to the EMSN caps applying to the base ART and Obstetric consultation items.

The EMSN caps for all other telehealth consultation items are equal to 300% of the schedule fee (to a maximum of $500). The maximum EMSN benefit for a telehealth consultation is equal to the sum of the EMSN cap for the base item and the EMSN cap for the telehealth items.

Aftercare Rule

Video consultations are subject to the same aftercare rules as practitioners providing face-to-face consultations.

Multiple attendances on the same day

In some situations a patient may receive a telehealth consultation and a face to face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Referrals

The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Technical requirements

In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

TN.4.13 Mental Health Assessments for Obstetric Patients (Items 16590, 16591, 16407)

Items for the planning and management of pregnancy (16590 and 16591) and for a postnatal attendance between 4 and 8 weeks after birth (16407), include a mental health assessment of the patient, including screening for drug and alcohol use and domestic violence, to be performed by the clinician or another suitably qualified health professional on behalf of the clinician. A mental health assessment must be offered to each patient, however, if the patient chooses not to undertake the assessment, this does not preclude a rebate being payable for these items.

It is recommended that mental health assessments associated with items 16590, 16591, and 16407 be conducted in accordance with the National Health and Medical Research Council (NHMRC) endorsed guideline: *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline* – October 2017, Centre for Perinatal Excellence.

Results of the mental health assessment must be recorded in the patient’s medical record. A record of a patient’s decision not to undergo a mental health assessment must be recorded in the patient’s clinical notes.

TN.4.14 Extended Medicare Safety Net (EMSN) for Obstetric Services (Items 16531, 16533 and 16534)

The Extended Medicare Safety Net (EMSN) benefit is capped at 65% of the schedule fee for obstetric items 16531, 16533, and 16534. However, as these items are for in-hospital services only, the EMSN does not apply

TN.6.1 Pre-anaesthesia Consultations by an Anaesthetist - (Items 17610 to 17625)

Pre-anaesthesia consultations are covered by items in the range 17610 - 17625.

Pre-anaesthesia consultations comprise 4 time-based items utilising 15 minute increments up to and exceeding 45 minutes, in conjunction with content-based descriptors. A pre-anaesthesia consultation will attract benefits under the appropriate items based on **BOTH** the duration of the consultation **AND** the complexity of the consultation in accordance with the requirements outlined in the content-based item descriptions.

Whether or not the proposed procedure proceeds, the pre-anaesthetic attendance will attract benefits under the appropriate consultation item in the range 17610 - 17625, as determined by the duration and content of the consultation.

The following provides further guidance on utilisation of the appropriate items in common clinical situations:

(i) Item 17610 (15 mins or less) - a pre-anaesthesia consultation of a straightforward nature occurring prior to investigative procedures and other routine surgery. This item covers routine pre-anaesthesia consultation services including the taking of a brief history, a limited examination of the patient including the cardio-respiratory system and brief discussion of an anaesthesia plan with the patient.

(ii) Item 17615 (16-30 mins) - a pre-anaesthesia consultation of between 16 to 30 minutes duration AND of significantly greater complexity than that required under item 17610. To qualify for benefits patients will be undergoing advanced surgery or will have complex medical problems. The consultation will involve a more extensive examination of the patient, for example: the cardio-respiratory system, the upper airway, anatomy relevant to regional anaesthesia and invasive monitoring. An anaesthesia plan of management should be formulated, of which there should be a written record included in the patient notes.

(iii) Item 17620 (31-45 mins) - a pre-anaesthesia consultation of high complexity involving all of the requirements of item 17615 and of between 31 to 45 minutes duration. The pre-anaesthesia consultation will also involve evaluation of relevant patient investigations and the formulation of an anaesthesia plan of management of which there should be a written record in the patient notes.

(iv) Item 17625 (more than 45 mins) - a pre-anaesthesia consultation of high complexity involving all of the requirements of item 17615 and item 17620 and of more than 45 minutes duration. The pre-anaesthesia consultation will also involve evaluation of relevant patient investigations as well as discussion of the patient's medical condition and/or anaesthesia plan of management with other relevant healthcare professionals. An anaesthesia plan of management should be formulated, of which there should be a written record included in the patient notes.

Some examples of advanced surgery that may require a longer consultation under items 17615-17625 would include:

· Bowel resection

· Caesarean section

· Neonatal surgery

· Major laparotomies

· Radical cancer resection

· Major reconstructive surgery eg free flap transfers, breast reconstruction

· major joint arthroplasty

· joint reconstruction

· Thoracotomy

· Craniotomy

· Spinal surgery eg spinal fusion, discectomy

· Major vascular surgery eg aortic aneurysm repair, arterial bypass surgery, carotid artery endarterectomy

Some examples of complex medical problems in relation to items 17615-17625 would include:

· Major cardiac problems - e.g cardiomyopathy, unstable ischaemic heart disease, heart failure

· Major respiratory disease - e.g COPD, respiratory failure, acute lung conditions eg. infection and asthma,

· Major neurological conditions - CVA, intra/extra cerebral haemorrhage, cerebral palsy and/or major intellectual disability, degenerative conditions of the CNS

· Major metabolic conditions - e.g unstable diabetes, uncontrolled hyperthyroidism, renal failure, liver failure, immune deficiency

· Anaesthetic problems - eg past history of awareness, known or anticipated difficulty with securing the airway, malignant hyperpyrexia, drug allergy,

· Other conditions -

- patients with history of stroke/TIA's presenting for vascular surgery

- patients on anti-platelet agents presenting for major surgery requiring management of anticoagulant status

- patients with poor respiratory/cardiac function presenting for major surgery requiring management of perioperative medications, analgaesia and monitoring

NOTE I:

It is important to note that:

· patients undergoing the types of advanced surgery listed above but who are otherwise of reasonable health and who, therefore, do not require a longer pre-anaesthesia consultation as provided for under items 17615-17625, would qualify for benefits under item 17610; and

· not all patients with complex medical problems will qualify for a longer consultation under items 17615-17625. For example, patients who have reasonably stable diabetes may only require a short consultation, covered under item 17610. Similarly, patients with reasonably well controlled emphysema (COPD) undergoing minor surgery may only require a short pre-anaesthesia consultation (item 17610), whereas the same patient scheduled for an upper abdominal laparotomy and with recent onset angina with the possible need for ICU postoperatively may require a longer consultation.

NOTE II:

· Consultation services covered by pain specialists items in the range 2801-3000 cannot be claimed in conjunction with items 17610-17625

· The consultation time under items 17610 - 17625 only applies to the period of active attendance on the patient and does not include time spent in discussion with other health care practitioners.

· The requirement of a written patient management plan in items 17615-17625 or the discussion of the management plan with other health care professions, where this occurs, does not relate to and cannot be claimed in conjunction GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans or Case Conference items in Group A15 of the MBS.

TN.6.2 Referred Anaesthesia Consultations - (Items 17640 to 17655)

Referred anaesthesia consultations (other than pre-anaesthesia attendances) where the patient is referred will be covered by new items in the range 17640 - 17655. These new items replace the use of specialist referred items 104 and 105. Items 104 and 105 will no longer apply to referred anaesthesia consultations provided by specialist anaesthetists.

Referred anaesthesia consultations comprise 4 time-based items utilising 15 minute increments up to and exceeding 45 minutes, in conjunction with content-based descriptors. Services covered by these specialist referred items include consultations in association with the following:

(i) Acute pain management

· Postoperative, utilising specialised techniques eg Patient Controlled Analgesia System (PCAS)

· as an independent service eg pain control following fractured ribs requiring nerve blocks

· obstetric pain management

(ii) Perioperative management of patients

· postoperative management of cardiac, respiratory and fluid balance problems following major surgery

· vascular access procedures (other than intra-operative peripheral vascular access procedures)

Items 17645 - 17655 will involve the examination of multiple systems and the formulation of a written management plan. Items 17650 and 17655 would also entail the ordering and/or evaluation of relevant patient investigations.

NOTE :

· It should be noted that the consultation time under items 17640 - 17655 only applies to the period of active attendance on the patient and does not include time spent in discussion with other health care practitioners.

· Consultation services covered by pain medicine specialist items in the range 2801-3000 cannot be claimed in conjunction with items 17640 - 17655.

· The requirement of a written patient management plan in items 17645-17655 or the discussion of the management plan with other health care professions, where this occurs, does not relate to and cannot be claimed in conjunction GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans or Case Conference items in Group A15 of the MBS.

It would be expected that in the vast majority of cases, the insertion of a peripheral venous cannula (other than in association with anaesthesia) where the patient is referred, would attract benefit under item 17640. However, in exceptional clinical circumstances, where the procedure is considerably more difficult and exceeds 15 minutes, such as for patients with chronic disease undergoing long term intravenous therapy, paediatric patients or patients having chemotherapy, item 17645 would apply.

TN.6.3 Anaesthetist Consultations - Other - (Items 17680, 17690)

A consultation occurring immediately before the institution of major regional blockade for a patient in labour is covered by item 17680.

Item 17690 can only be claimed where all of the conditions set out in (a) to (d) of item 17690 have been met.

Item 17690 can only be claimed in conjunction with a service covered by items 17615, 17620, or 17625.

Item 17690 cannot be claimed where the pre-anaesthesia consultation covered by items 17615, 17620 or 17625 is provided on the same day as admission to hospital for the subsequent episode of care involving anaesthesia services.

NOTE: Consultation services covered by pain medicine specialist items in the range 2801-3000 cannot be claimed in conjunction with anaesthesia consultation items 17610 - 17690.

TN.6.4 Telehealth Specialist Services

These notes provide information on the telehealth MBS video consultation items by specialists, consultant physicians and psychiatrists. A video consultation involves a single specialist, consultant physician or psychiatrist attending a patient, with the possible support of another medical practitioner, a participating optometrist, a participating nurse practitioner, a participating midwife, practice nurse or Aboriginal health worker at the patient end of the video conference. The decision as to whether the patient requires clinical support at the patient end of the specialist service is based on whether the support is necessary for the provision of the specialist service. Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

MBS items numbers 99, 112, 149, 288, 389, 2820, 3015, 6016, 13210, 16399 and 17609 allow a range of existing MBS attendance items to be provided via video conferencing. These items have a derived fee which is equal to 50% of the schedule fee for the consultation item claimed (e.g. 50% of the schedule fee for item 104) when billed with one of the associated consultation items (such as 104). A patient rebate of 85% for the derived fee is payable.

Six MBS item numbers (113, 114, 384, 2799, 3003 and 6004) provide for an initial attendance via videoconferencing by a specialist, consultant physician, consultant occupational physician, pain medicine specialist/consultant physician, palliative medicine specialist/consultant physician or neurosurgeon where the service is 10 minutes or less. The items are stand-alone items and do not have a derived fee.

Where an attendance is more than 10 minutes, practitioners should use the existing item numbers consistent with the current arrangements. Normal restrictions which apply for initial consultations will also apply for these items. For example, if a patient has an initial consultation via telehealth, they cannot also claim an initial face-to-face consultation as part of the same course of treatment.

Clinical indications

The specialist, consultant physician or psychiatrist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the specialist, consultant physician or psychiatrist.

Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

Restrictions

The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes hospital in the home patients). Benefits are not payable for telephone or email consultations. In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Billing Requirements

All video consultations provided by specialists, consultant physicians or psychiatrists must be **separately billed**. That is, only the relevant telehealth MBS consultation item and the associated derived item are to be itemised on the account/bill/voucher. Any other service/item billed should be itemised on a separate account/bill/voucher. This will ensure the claim is accurately assessed as being a video consultation and paid accordingly.

Practitioners should not use the notation 'telehealth', 'verbal consent' or 'Patient unable to sign' to overcome administrative difficulties to obtaining a patient signature for bulk billed claims (for further information see mbsonline.gov.au/telehealth).

Eligible Geographical Areas

Geographic eligibility for telehealth services funded under Medicareare determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are areas that are outside a Major City (RA1) according to ASGC-RA (RA2-5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

This rule will not apply to specialist video consultation with patients who are a care recipient in a residential care service; or at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the *Health Insurance Act 1973* as these patients are able to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at www.mbsonline.gov.au/ telehealth eligible areas

Record Keeping

Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Extended Medicare Safety Net (EMSN)

All telehealth consultations (with the exceptions of the participating optometrist telehealth items) are subject to EMSN caps. The EMSN caps for ART and Obstetric telehealth items 13210 and 16399 were set in reference to the EMSN caps applying to the base ART and Obstetric consultation items.

The EMSN caps for all other telehealth consultation items are equal to 300% of the schedule fee (to a maximum of $500). The maximum EMSN benefit for a telehealth consultation is equal to the sum of the EMSN cap for the base item and the EMSN cap for the telehealth items.

Aftercare Rule

Video consultations are subject to the same aftercare rules as practitioners providing face-to-face consultations.

Multiple attendances on the same day

In some situations a patient may receive a telehealth consultation and a face to face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Referrals

The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Technical requirements

In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

TN.7.1 Regional or Field Nerve Blocks - General

A nerve block is interpreted as the anaesthetising of a substantial segment of the body innervated by a large nerve or an area supplied by a smaller nerve where the technique demands expert anatomical knowledge and a high degree of precision.

Where anaesthesia combines a regional nerve block with general anaesthesia for an operative procedure, benefit will be paid only under the relevant anaesthesia item as set out in Group T10.

Where a regional or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block attracts benefits under the Group T10 anaesthesia item and not the block item in Group T7.

Where a regional or field nerve block which is covered by an item in Group T7 is administered by a medical practitioner in the course of a surgical procedure undertaken by that practitioner, then such a block will attract benefit under the appropriate Group T7 item.

When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.

Digital ring analgesia, local infiltration into tissue surrounding a lesion or paracervical (uterine) analgesia are not eligible for the payment of Medicare benefits under items within Group T7. Where procedures are carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure.

TN.7.2 Maintenance of Regional or Field Nerve Block - (Items 18222 and 18225)

Medicare benefit is attracted under these items only when the service is performed other than by the operating surgeon. This does not preclude benefits for an obstetrician performing an epidural block during labour.

When the service is performed by the operating surgeon during the post-operative period of an operation it is considered to be part of the normal aftercare. In these circumstances a Medicare benefit is not attracted.

TN.7.3 Intrathecal or Epidural Injection - (Item 18232)

This items covers caudal infusion/injection.

TN.7.4 Intrathecal or Epidural Infusion - (Items 18226 and 18227)

Items 18226 and 18227 apply where intrathecal or epidural analgesia is required for obstetric patients in the after hours period. For these items, the after hours period is defined as the period from 8pm to 8am on any weekday, or any time on a Saturday, Sunday or a public holiday.

Medicare benefits are only payable under item 18227 where more than 50% of the service is provided in the after hours period, otherwise benefits would be payable under item 18219.

TN.7.5 Regional or Field Nerve Blocks - (Items 18234 to 18298)

Items in the range 18234 - 18298 are intended to cover the injection of anaesthetic into the nerve or nerve sheath and not for the treatment of carpal tunnel or similar compression syndromes.

Paravertebral nerve block items 18274 and 18276 cover the provision of regional anaesthesia for surgical and related procedures for the management acute pain or of chronic pain related to radiculopathy. Infiltration of the soft tissue of the paravertebral area for the treatment of other pain symptoms does not attract benefit under these items. Additionally, items 18274 and 18276 do not cover facet joint blocks/injections. This procedure is covered under item 39013.

Item 18292 may not be claimed for the injection of botulinum toxin, but may be claimed where a neurolytic agent (such as phenol) is used to treat the obturator nerve in patients receiving botulinum toxin injections under item 18354 for a dynamic foot deformity.

TN.8.1 Surgical Operations

Many items in Group T8 of the Schedule are qualified by one of the following phrases:

· "as an independent procedure";

· "not being a service associated with a service to which another item in this Group applies"; or

· "not being a service to which another item in this Group applies"

An explanation of each of these phrases is as follows.

As an Independent Procedure

The inclusion of this phrase in the description of an item precludes payment of benefits when:-

(i) a procedure so qualified is associated with another procedure that is performed through the same incision, e.g. nephrostomy (Item 36552) in the course of an open operation on the kidney for another purpose;

(ii) such procedure is combined with another in the same body area, e.g. direct examination of larynx (Item 41846) with another operation on the larynx or trachea;

(iii) the procedure is an integral part of the performance of another procedure, e.g. removal of foreign body (Item 30067/30068) in conjunction with debridement of deep or extensive contaminated wound of soft tissue, including suturing of that wound when performed under general anaesthetic (Item 30023).

Not Being a Service Associated with a Service to which another Item in this Group Applies

"Not being a service associated with a service to which another item in this Group applies" means that benefit is not payable for any other item in that Group when it is performed on the same occasion as this item. eg item 30106.

"Not being a service associated with a service to which Item ..... applies" means that when this item is performed on the same occasion as the reference item no benefit is payable. eg item 39330.

Not Being a Service to which another Item in this Group Applies

"Not being a service to which another item in this Group applies" means that this item may be itemised if there is no specific item relating to the service performed, e.g. Item 30387 (Laparotomy involving operation on abdominal viscera (including pelvic viscera), not being a service to which another item in this Group applies). Benefits may be attracted for an item with this qualification as well as benefits for another service during the course of the same operation.

TN.8.2 Multiple Operation Rule

The fees for two or more operations, listed in Group T8 (other than Subgroup 12 of that Group), performed on a patient on the one occasion (except as provided in paragraph T8.2.3) are calculated by the following rule:-

- 100% for the item with the greatest Schedule fee

plus 50% for the item with the next greatest Schedule fee

plus 25% for each other item.

Note:

(a) Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents.

(b) Where two or more operations performed on the one occasion have Schedule fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.

(c) The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

(d) For these purposes the term "operation" only refers to all items in Group T8 (other than Subgroup 12 of that Group).

This rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient if the medical practitioner who performed the operation did not also perform or assist at the other operation or any of the other operations, or administer the anaesthetic. In such cases the fees specified in the Schedule apply.

Where two medical practitioners operate independently and either performs more than one operation, the method of assessment outlined above would apply in respect of the services performed by each medical practitioner.

If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

There are a number of items in the Schedule where the description indicates that the item applies only when rendered in association with another procedure. The Schedule fees for such items have therefore been determined on the basis that they would always be subject to the "multiple operation rule".

Where the need arises for the patient to be returned to the operating theatre on the same day as the original procedure for further surgery due to post-operative complications, which would not be considered as normal aftercare - see paragraph T8.2, such procedures would generally not be subject to the "multiple operation rule". Accounts should be endorsed to the effect that they are separate procedures so that a separate benefit may be paid.

Extended Medicare Safety Net Cap

The Extended Medicare Safety Net (EMSN) benefit cap for items subject to the multiple operations rule, where all items in that claim are subject to a cap are calculated from the abated (reduced) schedule fee.

For example, if an item has a Schedule fee of $100 and an EMSN benefit cap equal to 80 per cent of the schedule fee, the calculated EMSN benefit cap would be $80. However, if the schedule fee for the item is reduced by 50 per cent in accordance with the multiple operations rule provisions, and all items in that claim carry a cap, the calculated EMSN benefit cap for the item is $40 (50% of $100*80%).

TN.8.3 Procedure Performed with Local Infiltration or Digital Block

It is to be noted that where a procedure is carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure and an additional benefit is therefore not payable.

TN.8.4 Aftercare (Post-operative Treatment)

Definition

Section 3(5) of the Health Insurance Act 1973 states that services included in the Schedule (other than attendances) include all professional attendances necessary for the purposes of post-operative treatment of the patient. For the purposes of this book, post-operative treatment is generally referred to as "aftercare".

Aftercare is deemed to include all post-operative treatment rendered by medical specialists and consultant physicians, and includes all attendances until recovery from the operation, the final check or examination, regardless of whether the attendances are at the hospital, private rooms, or the patient's home. Aftercare need not necessarily be limited to treatment given by the surgeon or to treatment given by any one medical practitioner.

If the initial procedure is performed by a general practitioner, normal aftercare rules apply to any post-operative service provided by the same practitioner.

The medical practitioner determines each individual aftercare period depending on the needs of the patient as the amount and duration of aftercare following an operation may vary between patients for the same operation, as well as between different operations.

Private Patients

Medicare will not normally pay for any consultations during an aftercare period as the Schedule fee for most operations, procedures, fractures and dislocations listed in the MBS item includes a component of aftercare.

There are some instances where the aftercare component has been excluded from the MBS item and this is clearly indicated in the item description.

There are also some minor operations that are merely stages in the treatment of a particular condition. As such, attendances subsequent to these services should not be regarded as aftercare but rather as a continuation of the treatment of the original condition and attract benefits. Likewise, there are a number of services which may be performed during the aftercare period for pain relief which would also attract benefits. This includes all items in Groups T6 and T7, and items 39013, 39100, 39115, 39118, 39121, 39127, 39130, 39133, 39136, 39324 and 39327.

Where there may be doubt as to whether an item actually does include the aftercare, the item description includes the words "including aftercare".

If a service is provided during the aftercare phase for a condition not related to the operation, then this can be claimed, provided the account identifies the service as 'Not normal aftercare', with a brief explanation of the reason for the additional services.

If a patient was admitted as a private patient in a public hospital, then unless the MBS item does not include aftercare, no Medicare benefits are payable for aftercare.

Medicare benefits are not payable for surgical procedures performed primarily for cosmetic reasons. However, benefits are payable for certain procedures when performed for specific medical reasons, such as breast reconstruction following mastectomy. Surgical procedures not listed on the MBS do not attract a Medicare benefit.

Where an initial or subsequent consultation relates to the assessment and discussion of options for treatment and, a cosmetic or other non-rebatable service are discussed, this would be considered a rebatable service under Medicare. Where a consultation relates entirely to a cosmetic or other non-Medicare rebatable service (either before or after that service has taken place), then that consultation is not rebatable under Medicare. Any aftercare associated with a cosmetic or non-Medicare rebatable service is also not rebatable under Medicare.

Public Patients

All care directly related to a public in-patient's care should be provided free of charge. Where a patient has received in-patient treatment in a hospital as a public patient (as defined in Section 3(1) of the Health Insurance Act 1973), routine and non-routine aftercare directly related to that episode of admitted care will be provided free of charge as part of the public hospital service, regardless of where it is provided, on behalf of the state or territory as required by the National Healthcare Agreement. In this case no Medicare benefit is payable.

Notwithstanding this, where a public patient independently chooses to consult a private medical practitioner for aftercare, then the clinically relevant service provided during this professional attendance will attract Medicare benefits.

Where a public patient independently chooses to consult a private medical practitioner for aftercare following treatment from a public hospital emergency department, then the clinically relevant service provided during this professional attendance will attract Medicare benefits.

Fractures

Where the aftercare for fractures is delegated to a doctor at a place other than where the initial reduction was carried out, then Medicare benefits may be apportioned on a 50:50 basis rather than on the 75:25 basis for surgical operations.

Where the reduction of a fracture is carried out by hospital staff in the out-patient or emergency department of a public hospital, and the patient is then referred to a private practitioner for aftercare, Medicare benefits are payable for the aftercare on an attendance basis.

The following table shows the period which has been adopted as reasonable for the after-care of fractures:-

Treatment of fracture of	After-care Period
Terminal phalanx of finger or thumb	6 weeks
Proximal phalanx of finger or thumb	6 weeks
Middle phalanx of finger	6 weeks
One or more metacarpals not involving base of first carpometacarpal joint	6 weeks
First metacarpal involving carpometacarpal joint (Bennett's fracture)	8 weeks
Carpus (excluding navicular)	6 weeks
Navicular or carpal scaphoid	3 months
Colles'/Smith/Barton's fracture of wrist	3 months
Distal end of radius or ulna, involving wrist	8 weeks
Radius	8 weeks
Ulna	8 weeks
Both shafts of forearm or humerus	3 months
Clavicle or sternum	4 weeks
Scapula	6 weeks
Pelvis (excluding symphysis pubis) or sacrum	4 months
Symphysis pubis	4 months
Femur	6 months
Fibula or tarsus (excepting os calcis or os talus)	8 weeks
Tibia or patella	4 months

Both shafts of leg, ankle (Potts fracture) with or without dislocation, os calcis (calcaneus) or os talus	4 months
Metatarsals - one or more	6 weeks
Phalanx of toe (other than great toe)	6 weeks
More than one phalanx of toe (other than great toe)	6 weeks
Distal phalanx of great toe	8 weeks
Proximal phalanx of great toe	8 weeks
Nasal bones, requiring reduction	4 weeks
Nasal bones, requiring reduction and involving osteotomies	4 weeks
Maxilla or mandible, unilateral or bilateral, not requiring splinting	6 weeks
Maxilla or mandible, requiring splinting or wiring of teeth	3 months
Maxilla or mandible, circumosseous fixation of	3 months
Maxilla or mandible, external skeletal fixation of	3 months
Zygoma	6 weeks
Spine (excluding sacrum), transverse process or bone other than vertebral body requiring immobilisation in plaster or traction by skull calipers	3 months
Spine (excluding sacrum), vertebral body, without involvement of cord, requiring immobilisation in plaster or traction by skull calipers	6 months
Spine (excluding sacrum), vertebral body, with involvement of cord	6 months

Note: This list is a guide only and each case should be judged on individual merits.

TN.8.5 Abandoned surgery - (Item 30001)

Item 30001 applies when a procedure has commenced, but is then discontinued for medical reasons, or for other reasons which are beyond the surgeon's control (eg equipment failure).

An operative procedure commences when:

a) The patient is in the procedure room or on the bed or operation table where the procedure is to be performed; and

b) The patient is anaesthetised or operative site is sufficiently anaesthetised for the procedure to commence; and

c) The patient is positioned or the operative site which is prepared with antiseptic or draping.

Where an abandoned procedure eligible for a benefit under item 30001 attracts an assistant under the provisions of the items listed in Group T9 (Assistance at Operations), the fee for the surgical assistant is calculated as 50% of the assistance fee that would have applied under the relevant item from Group T9.

Practitioners claiming an assistant fee for abandoned surgery should itemise their accounts with the relevant item from group T9. Such claims should include an account endorsement "assistance at abandoned surgery" or similar.

Under the Health Insurance Act 1973 the Chief Executive Medicare does not require claims for this item to be accompanied by details of the proposed surgery and the reasons why the operation was discontinued. However, practitioners must maintain a clinical record of this information, which may be subject to audit.

TN.8.6 Repair of Wound - (Items 30023 to 30049)

The repair of wound referred to in these items must be undertaken by suture, tissue adhesive resin (such as methyl methacrylate) or clips. These items do not cover repair of wound at time of surgery.

Item 30023 covers debridement of traumatic, "deep or extensively contaminated" wound. Benefits are not payable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures.

For the purpose of items 30026 to 30049 the term 'superficial' means affecting skin and subcutaneous tissue including fat and the term 'deeper tissue' means all tissues deep to but not including subcutaneous tissue such as fascia and muscle.

TN.8.7 Biopsy for Diagnostic Purposes - (Items 30071 to 30096)

Needle aspiration biopsy attracts benefits on an attendance basis and not under item 30078.

Item 30071 (diagnostic biopsy of the skin) or 30072 (diagnostic biopsy of mucous membrane) should be used when a biopsy (including shave) of a lesion is required to confirm a diagnosis and would facilitate the appropriate management of that lesion. If the shave biopsy results in a definitive excision of the lesion, only 30071 or 30072 can be claimed.

Items 30071-30096 require that the specimen be sent for pathological examination.

The aftercare period for item 30071 or 30072 is 2 days rather than the standard aftercare period for skin excision of 10 days.

TN.8.8 Lipectomy - (Items 30165 to 30179)

Lipectomy is not intended as a primary bariatric procedure to correct obesity. MBS benefits are not available for surgery performed for cosmetic purposes.

For the purpose of informing patient eligibility for lipectomy items (30165-30172, 30177, 30179) that are for the management of significant weight loss (SWL), SWL is defined as a weight loss equivalent of at least five BMI units. Weight must be stable for at least six months following significant weight loss prior to lipectomy. For significant weight loss that has occurred following pregnancy, the products of conception must not be included in the calculation of baseline weight to measure weight loss against.

Multiple lipectomies of redundant non-abdominal skin and fat as a direct consequence of mass weight loss (for example on both buttocks and both thighs), attracts a Medicare benefit only once against the relevant item (30171 or 30172). The schedule fee for multiple lipectomies for excision of redundant non-abdominal skin and fat following massive weight loss is the same regardless of the number of excisions.

The lipectomy items cannot be claimed in association with items 45564, 45565 or 45530. Where the abdomen requires surgical closure with reconstruction of the umbilicus following free tissue transfer (45564, 45565) or breast reconstruction (45530), item 45569 is to be claimed.

TN.8.9 Treatment of Keratoses, Warts etc (Items 30187, 30189, 30192 and 36815)

Treatment of seborrheic keratoses by any means, attracts benefits on an attendance basis only.

Treatment of fewer than 10 solar keratoses by ablative techniques such as cryotherapy attracts benefits on an attendance basis only. Where 10 or more solar keratoses are treated by ablative techniques, benefits are payable under item 30192.

Warts and molluscum contagiosum where treated by any means attract benefits on an attendance basis except where:

(a) admission for treatment in an operating theatre of an accredited day surgery facility or hospital is required. In this circumstance, benefits are paid under item 30189 where a definitive removal of the wart or molluscum contagiosum is to be undertaken.

(b) benefits have been paid under item 30189, and recurrence occurs.

(c) palmar and plantar warts are treated by laser and require treatment in an operating theatre of an accredited day surgery facility or hospital. In this circumstance, benefits are paid under item 30187.

TN.8.10 Cryotherapy and Serial Curettage Excision - (Items 30196 and 30202)

In item 30196, serial curettage excision, as opposed to simple curettage, refers to the technique where the margin having been defined, the lesion is carefully excised by a skin curette using a series of dissections and cauterisations so that all extensions and infiltrations of the lesion are removed.

For the purposes of items 30196 and 30202, the requirement for histopathological proof of malignancy is satisfied where multiple lesions are to be removed from the one anatomical region if a single lesion from that region is histologically tested and proven for malignancy.

For the purposes of items 30196 and 30202, an anatomical region is defined as: hand, forearm, upper arm, shoulder, upper trunk or chest (anterior and posterior), lower trunk (anterior or posterior) or abdomen (anterior lower trunk), buttock, genital area/perineum, upper leg, lower leg and foot, neck, face (six sections: left/right lower, left/right mid and left/right upper third) and scalp.

For Medicare benefits to be payable for item 30196, the provider performing the service must also retain documented evidence that malignancy has been proven by histopathology.

For Medicare benefits to be payable for item 30202, the provider performing the service must also retain documented evidence that malignancy has either been proven by histopathology or confirmed by opinion of a specialist in the specialty of dermatology.

The Department of Human Services (DHS) has developed a Health Practitioner Guideline to substantiate proof of malignancy where required for MBS items which is located on the DHS website.

TN.8.12 Sentinel Node Biopsy for Breast Cancer - (Items 30299 to 30303)

The Medical Services Advisory Committee (MSAC) evaluated the available evidence and found that sentinel lymph node biopsy is safe and effective in identifying sentinel lymph nodes, but that the long term outcomes of sentinel lymph node biopsy compared to lymph node clearance are uncertain. As a result, interim Medicare funding is available for these items pending the outcome of clinical trials and further consideration by the MSAC.

For items 30299 and 30300, both lymphoscintigraphy and lymphotropic dye injection must be used, unless the patient has an allergy to the lymphotropic dye.

For the purposes of these items, the axillary lymph node levels referred to are as follows:

- **Level I** - axillary lymph nodes up to the inferior border of pectoralis minor.
- **Level II** -axillary lymph nodes up to the superior border of pectoralis minor.
- **Level III** - axillary lymph nodes extending above the superior border of pectoralis minor.

TN.8.13 Dissection of Axillary Lymph Nodes - (Items 30335 and 30336)

For the purposes of Items 30335 and 30336, the definitions of lymph node levels referred to are set out below.

Anatomically, the dissection extends from below upwards as follows:

- **Level I** - dissection of axillary lymph nodes up to the inferior border of pectoralis minor.
- **Level II** - dissection of axillary lymph nodes up to the superior border of pectoralis minor.
- **Level III** - dissection of axillary lymph nodes extending above the superior border of pectoralis minor.

TN.8.14 Laparotomy and Other Procedures on the Abdominal Viscera - (Items 30375 and 30622)

Procedures on the abdominal viscera may be performed by laparotomy or laparoscopically. Both items 30375 and 30622 cover several operations on abdominal viscera. Where more than one of the procedures referrec to in these items are performed during the one operation, each procedure may be itemised according to the multiple operation formula.

TN.8.15 Diagnostic Laparoscopy - (Items 30390 and 30627)

If a diagnostic laparoscopy procedure is performed at a different time on the same day to another laparoscopic service, the procedures are considered to be un-associated services. The claim for benefits should be annotated to indicate that the two services were performed on separate occasions, otherwise the claims will be considered to be a single service.

TN.8.16 Major Abdominal Incision - (Item 30396)

A major abdominal incision is one that gives access through an open wound to all compartments of the abdominal cavity. Item 30396 is intended for open surgical incisions only and not those performed laparoscopically.

TN.8.17 Gastrointestinal Endoscopic Procedures - (Items 30473 to 30481, 30484, 30485, 30490 to 30494, 30680 to 32023, 32084 to 32095, 32103, 32104, 32106 and 32222 to 32229)

The following are guidelines for appropriate minimum standards for the performance of GI endoscopy in relation to (a) cleaning, disinfection and sterilisation procedures, and (b) anaesthetic and resuscitation equipment.

These guidelines are based on the advice of the Gastroenterological Society of Australia, the Sections of HPB and Upper GI and of Colon and Rectal Surgery of the Royal Australasian College of Surgeons, and the Colorectal Surgical Society of Australia.

Cleaning, disinfection and sterilisation procedures

Endoscopic procedures should be performed in facilities where endoscope and accessory reprocessing protocols follow procedures outlined in:

- Infection Control in Endoscopy, Gastroenterological Society of Australia and Gastroenterological Nurses College of Australia , 2011;
- Australian Guidelines for the Prevention and Control of Infection in Healthcare (NHMRC, 2010);
- Australian Standard AS 4187-2014 (and Amendments), Standards Association of Australia.

Anaesthetic and resuscitation equipment

Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post-operative and resuscitation facilities should conform to the standards outlined in 'Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures' (PS09), Australian & New Zealand College of Anaesthetists, Gastroenterological Society of Australia and Royal Australasian College of Surgeons.

Conjoint Committee

For the purposes of Item 32023, the procedure is to be performed by a colorectal surgeon or gastroenterologist with endoscopic training who is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy.

TN.8.18 Gastrectomy, Sub-total Radical - (Item 30523)

The item differs from total radical Gastrectomy (Item 30524) in that a small part of the stomach is left behind. It involves resection of the greater omentum and posterior abdominal wall lymph nodes with or without splenectomy.

TN.8.19 Anti reflux Operations - (Items 30527 to 30533, 31464 and 31466)

These items cover various operations for reflux oesophagitis. Where the only procedure performed is the simple closure of a diaphragmatic hiatus benefit would be attracted under Item 30387 (Laparotomy involving operation on abdominal viscera, including pelvic viscera, not being a service to which another item in this Group applies).

TN.8.20 Radiofrequency ablation of mucosal metaplasia for the treatment of Barrett's Oesophagus (Item 30687)

The diagnosis of high grade dysplasia is recommended to be confirmed by two expert pathologists with experience in upper gastrointestinal pathology.

A multidisciplinary team should review treatment options for patients with high grade dysplasia and would typically include upper gastrointestinal surgeons and/or interventional gastroenterologists.

TN.8.21 Endoscopic or Endobronchial Ultrasound +/- Fine Needle Aspiration - (Items 30688 - 30710)

For the purposes of these items the following definitions apply:

Biopsy means the removal of solid tissue by core sampling or forceps

FNA means aspiration of cellular material from solid tissue via a small gauge needle.

The provider should make a record of the findings of the ultrasound imaging in the patient's notes for any service claimed against items 30688 to 30710.

Endoscopic ultrasound is an appropriate investigation for patients in whom there is a strong clinical suspicion of pancreatic neoplasia with negative imaging (such as CT scanning). Scenarios include, but are not restricted to:

- A middle aged or elderly patient with a first attack of otherwise unexplained (eg negative abdominal CT) first episode of acute pancreatitis; or

- A patient with biochemical evidence of a neuroendocrine tumour.

The procedure is not claimable for periodic surveillance of patients at increased risk of pancreatic cancer, such as chronic pancreatitis. However, EUS would be appropriate for a patient with chronic pancreatitis in whom there was a clinical suspicion of pancreatic cancer (eg: a pancreatic mass occurring on a background of chronic pancreatitis).

TN.8.22 Removal of Skin Lesions - (Items 31356 to 31376)

The excision of warts and seborrheic keratoses attracts benefits on an attendance basis with the exceptions outlined in TN.8.9 of the explanatory notes to this category. Excision of pre-malignant lesions including solar keratoses where clinically indicated are covered by items 31357, 31360, 31362, 31364, 31366, 31368 and 31370.

The excision of suspicious pigmented lesions for diagnostic purposes attract benefits under items 31357, 31360, 31362, 31364, 31366, 31368 and 31370.

Malignant tumours are covered by items 31356, 31358, 31359, 31361, 31363, 31365, 31367, 31369 and 31371 to 31376.

Items 31357, 31360, 31362, 31364, 31366, 31368, 31370 *require* that the specimen be sent for histological examination. Items 31356, 31358, 31359, 31361, 31363, 31365, 31367, 31369, 31371-31376 also *require* that a specimen has been sent for histological confirmation of malignancy, and any subsequent specimens are sent for

histological examination. Confirmation of malignancy *must* be received before itemisation of accounts for Medicare benefits purposes.

Where histological results are available at the time of issuing accounts, the histological diagnosis will decide the appropriate itemisation. If the histological report shows the lesion to be benign, items 31357, 31360, 31362, 31364, 31366, 31368 or 31370 should be used.

It will be necessary for practitioners to retain copies of histological reports.

TN.8.23 Removal of Skin Lesion From Face - (Items 31245, 31361 to 31364, 31372 and 31373)

For the purposes of these items, the face is defined as that portion of the head anterior to the hairline and above the jawline.

TN.8.24 Dissection of Lymph Nodes of Neck - (Items 30618, 31423 to 31438)

For the purposes of these items, the lymph node levels referred to are as follows:

Level I	Submandibular and submental lymph nodes
Level II	Lymph nodes of the upper aspect of the neck including the jugulodigastric node, upper jugular chain nodes and upper spinal accessory nodes
Level III	Lymph nodes deep to the middle third of the sternomastoid muscle consisting of mid jugular chain nodes, the lower most of which is the jugulo-omohyoid node, lying at the level where the omohyoid muscle crosses the internal jugular vein
Level IV	Lower jugular chain nodes, including those nodes overlying the scalenus anterior muscle
Level V	Posterior triangle nodes, which are usually distributed along the spinal accessory nerve in the posterior triangle

Comprehensive dissection involves all 5 neck levels while ***selective*** dissection involves the removal of only certain lymph node groups, for example:-

Item 31426 (removal of 3 lymph node levels) - e.g. supraomohyoid neck dissection (levels I-III) or lateral neck dissection (levels II-IV).

Item 31429 (removal of 4 lymph node levels) - e.g. posterolateral neck dissection (levels II-V) or anterolateral neck dissection (levels I-IV)

Other combinations of node levels may be removed according to clinical circumstances.

TN.8.25 Excision of Breast Lesions, Abnormalities or Tumours - Malignant or Benign - (Items 31500 to 31515)

Therapeutic biopsy or excision of breast lesions, abnormalities or tumours under Items: 31500, 31503, 31506, 31509, 31512, 31515 either singularly or in combination should not be claimed when using the Advanced Breast Biopsy Instrumentation (ABBI) procedure, or any other large core breast biopsy device.

TN.8.26 Fine Needle Aspiration of Breast Lesion - (Item 31533)

An impalpable lesion includes those lesions that clinically require definition by ultrasound or mammography for accurate or safe sampling, eg. lesions in association with breast prostheses or in areas of breast thickening.

TN.8.27 Diagnostic Biopsy of Breast using Advanced Breast Biopsy Instrumentation - (Items 31539 and 31545)

For the purposes of Items 31539 and 31545, surgeons performing this procedure should have evidence of appropriate training via a course approved by the Breast Section of the Royal Australasian College of Surgeons,

have experience in the procedure, and the Department of Human Services notified of their eligibility to perform this procedure.

The ABBI procedure is contraindicated and should not be performed on the following subset of patients:

- Patients with mass, asymmetry or clustered microcalcifications that cannot be targeted using digital imaging equipment;
- Patients unable to lie prone and still for 30 to 60 minutes;
- Breasts less than 20mm in thickness when compressed;
- Women on anticoagulants;
- Lesions that are too close to the chest wall to allow cannula access;
- Patients weighing more than 135kg;
- Women with prosthetic breast implants.

TN.8.28 Preoperative Localisation of Breast Lesion Prior to the Use of Advanced Breast Biopsy Instrumentation - (Item 31542)

For the purposes of item 31542, radiologists eligible to perform the procedure must have been identified by the Royal Australian and New Zealand College of Radiologists as having sufficient training and experience in this procedure, and the Department of Human Services notified of their eligibility to perform this procedure.

TN.8.29 Bariatric Procedures - (Items 31569 to 31581, anaesthesia item 20791)

Items 31569 to 31581 and item 20791 provide for surgical treatment of clinically severe obesity and the accompanying anaesthesia service (or similar). The term clinically severe obesity generally refers to a patient with a Body Mass Index (BMI) of 40kg/m^2 or more, or a patient with a BMI of 35kg/m^2 or more with other major medical co-morbidities (such as diabetes, cardiovascular disease, cancer). The BMI values in different population groups may vary due, in part, to different body proportions which affect the percentage of body fat and body fat distribution. Consequently, different ethnic groups may experience major health risks at a BMI that is below the 35-40 kg/m^2 provided for in the definition. The decision to undertake obesity surgery remains a matter for the clinical judgment of the surgeon.

If crural repair taking 45 minutes or less is performed in association with the bariatric procedure, additional hernia repair items cannot be claimed for the same service.

TN.8.30 Reversal of a Bariatric Procedure (item 31584)

If a revisional procedure requires the reversal of the existing bariatric procedure, item 31584 can be claimed with items 31569 to 31581 for the new procedure for the same patient on the same occasion. For example, item 31584 could be claimed for the reversal of a gastric band, and 31572 for conversion to gastric bypass or 31575 for conversion to sleeve gastrectomy.

TN.8.31 Per Anal Excision of Rectal Tumour using Rectoscopy - (Items 32103, 32104 and 32106)

Surgeons performing these procedures should be colorectal surgeons and have undergone appropriate training which is recognised by the Colorectal Surgical Society of Australasia.

Items 32103, 32104 and 32106 cannot be claimed in conjunction with each other or with anterior resection items 32024 or 32025 for the same patient, on the same day, by any practitioner.

TN.8.32 Varicose veins - (Items 32500 to 32517)

In relation to endovenous laser therapy (ELT) and/or radiofrequency diathermy/ablation, Rule 2.44.14 of the *Health Insurance (General Medical Services Table) Regulations* (GMST) means the following:

- ELT and/or radiofrequency diathermy/ablation are not payable if they are billed under any varicose vein items (32500 to 32517) or vascular item 35321.
- If ELT and/or radiofrequency diathermy/ablation are provided on the same occasion as these MBS items, the ELT and radiofrequency diathermy/ablation services must be itemised separately on the invoice, showing the full fees for each service separately to the fees billed against the MBS items.
- We strongly recommend that a practitioner who intends to bill ELT and/or radiofrequency diathermy/ablation on the same occasion as providing MBS services contact Department of Human Services' provider information line on 132 150 to confirm the Department of Human Services' requirements for correct itemisation of MBS and non-MBS services on a single invoice.
- The Department of Human Services monitors billing practices associated with MBS items and any billing which stands out as being out of line with most practitioners may warrant the attention of the Department of Human Services.
- In light of the policy clarification of GMST Rule 2.44.14, with effect from 1 May 2009, the Department of Human Services will be able to track any apparent cost-shifting (of ELT and/or radiofrequency diathermy/ablation) to the MBS items detailed in GMST Rule 2.44.14 or to other MBS items.

TN.8.33 Cyanoacrylate Embolisation (Items 32528 and 32529), Endovenous Laser Therapy (Items 32520 and 32522) and Radiofrequency Ablation (Items 32523 and 32526)

It is recommended that the medical practitioner performing cyanoacrylate embolisation (CAE), endovenous laser therapy (ELT) or radiofrequency ablation (RFA) has successfully completed a substantial course of study and training in the management of venous disease, which has been endorsed by their relevant professional organisation.

Medicare-funded CAE, ELT and RFA can only be performed in cases where it is documented by duplex ultrasound that the great or small saphenous vein (and major tributaries of saphenous veins as necessary) demonstrates reflux of 0.5 seconds or longer.

TN.8.34 Uterine Artery Embolisation - (Item 35410)

This item was introduced on an interim basis in November 2006 following a recommendation of the Medical Services Advisory Committee (MSAC), pending the outcome of clinical trials and further consideration by the MSAC. The requirement for specialist referral by a gynaecologist for uterine artery embolisation was a MSAC recommendation. Providers should retain the instrument of specialist referral for each patient from the date of the procedure, as this may be subject to audit by the Department of Human Services.

TN.8.35 Endovascular Coiling of Intracranial Aneurysms - (Item 35412)

This service includes balloon angioplasty and insertion of stents (assisted coiling) associated with intracranial aneurysm coiling. The use of liquid embolics alone is not covered by this item. Digital Subtraction Angiography (DSA) done to diagnose the aneurysm (items 60009 and either 60072, 60075 or 60078) is claimable, however this must be clearly noted on the claim and in the clinical notes as separate from the intra-operative DSA done with the coiling procedure.

TN.8.36 Arterial and Venous Patches - (Items 33545 to 33551and 34815)

Vascular surgery items have been constructed on the basis that arteriotomy and venotomy wounds are closed by simple suture without the use of a patch.

Where a patch angioplasty is used to enlarge a narrowed vein, artery or arteriovenous fistula, the correct item would be 34815 or 34518. If the vein is harvested for the patch through a separate incision, Item 33551 would also apply, in accordance with the multiple operation rule.

If a patch graft is involved in conjunction with an operative procedure included in Items 33500 - 33542, 33803, 33806, 33815, 33833 or 34142, the patch graft would attract benefits under Item 33545 or 33548 in addition to the item for the primary operation (under the multiple operation rule). Where vein is harvested for the patch through a separate incision Item 33551 would also apply.

TN.8.37 Carotid Disease - (Item 32700, 32703, 32760, 33500, 33545, 33548, 33551, 33554, 35303, 35307)

Interventional procedures for the management of carotid disease should be performed in accordance with the NHMRC endorsed *Clinical Guidelines for Stroke Management 2010*.

Carotid Percutaneous Transluminal Angioplasty with Stenting (CPTAS), under item 35307 is only funded under the MBS for patients who meet the criteria for carotid endarterectomy but are unfit for open surgery.

TN.8.38 Peripheral Arterial or Venous Catheterisation - (Item 35317)

Item 35317 is restricted to the regional delivery of thrombolytic, vasoactive or chemotherapeutic oncologic agents in association with a radiological service. This item in not intended for infusions with systemic affect.

TN.8.39 Peripheral Arterial or Venous Embolisation - (Item 35321)

As set out in Rule 2.44.14 in the *Health Insurance (General Medical Services Table) Regulations*, item 35321 does not apply to the service described in that item if the service is provided at the same time as, or in connection with, endovenous laser treatment for varicose veins.

TN.8.40 Selective Internal Radiation Therapy (SIRT) using SIR-Spheres - (Items 35404, 35406 and 35408)

These items were introduced into the Schedule on an interim basis in May 2006 following a recommendation of the Medical Services Advisory Committee (MSAC) pending the outcome of clinical trials and further consideration by the MSAC. SIRT should not be performed in an outpatient or day patient setting to ensure patient and radiation safety requirements are met.

TN.8.41 Percutaneous Transluminal Coronary Angioplasty - (Items 38309, 38312, 38315 and 38318)

A coronary artery lesion is considered to be complex when the lesion is a chronic total occlusion, located at an ostial site, angulated, tortuous or greater than 1cm in length. Percutaneous transluminal coronary rotational atherectomy is suitable for revascularisation of complex and heavily calcified coronary artery stenoses in patients for whom coronary artery bypass graft surgery is contraindicated.

Each of the items 38309, 38312, 38315 and 38318 describes an episode of service. As such, only one item in this range can be claimed in a single episode.

TN.8.42 Colposcopic Examination - (Item 35614)

It should be noted that colposcopic examination (screening) of a person during the course of a consultation does not attract Medicare benefits under Item 35614 except in the following circumstances:

(a) where the patient has had an abnormal cervical screen result;

(b) where there is a history of ingestion of oestrogen by the patient's mother during their pregnancy; or

(c) where the patient has been referred by another medical practitioner because of suspicious signs of genital cancer.

TN.8.43 Hysteroscopy - (Item 35626)

Hysteroscopy undertaken in the office/consulting rooms can be claimed under this item where the conditions set out in the description of the item are met.

TN.8.44 Curettage of Uterus under GA or Major Nerve Block - (Items 35639 and 35640)

Uterine scraping or biopsy using small curettes (e.g. Sharman's or Zeppelin's) and requiring minimal dilatation of the cervix, not necessitating a general anaesthesia, does not attract benefits under these items but would be paid under Item 35620 where malignancy is suspected, or otherwise on an attendance basis.

TN.8.45 Neoplastic Changes of the Cervix - (Items 35644-35648)

The term "previously confirmed intraepithelial neoplastic changes of the cervix" in these items refers to diagnosis made by either cytologic, colposcopic or histologic methods. This may also include persistent human papilloma virus (HPV) changes of the cervix.

TN.8.46 Sterilisation of Minors - Legal Requirements - (Items 35657, 35687, 35688, 35691, 37622 and 37623)

(i) It is unlawful throughout Australia to conduct a sterilisation procedure on a minor which is not a by-product of surgery appropriately carried out to treat malfunction or disease (eg malignancies of the reproductive tract) unless legal authorisation has been obtained.

(ii) Practitioners are liable to be subject to criminal and civil action if such a sterilisation procedure is performed on a minor (a person under 18 years of age) which is not authorised by the Family Court of Australia or another court or tribunal with jurisdiction to give such authorisation.

(iii) Parents/guardians have no legal authority to consent on behalf of minors to such sterilisation procedures. Medicare Benefits are only payable for sterilisation procedures that are clinically relevant professional services as defined in Section 3 (1) of the *Health Insurance Act 1973.*

TN.8.47 Debulking of Uterus - (Item 35658)

Benefits are payable under Item 35658, using the multiple operation rule, in addition to vaginal hysterectomy.

TN.8.48 Nephrectomy - (Items 36526 and 36527)

Items 36526 and 36527 are only claimable where the practitioner has a high index of suspicion of malignancy which cannot be confirmed by biopsy prior to surgery being performed, due to the biopsy being either clinically inappropriate, or the specimen provided showing an inconclusive diagnosis.

TN.8.50 Sacral Nerve Stimulation (items 36663-36668)

A two-stage process of testing and treatment is required to ensure suitability for Sacral Nerve Stimulation for detrusor overactivity or non obstructive urinary retention where urethral obstruction has been urodynamically excluded. The testing phase involves acute and sub-chronic testing. The first stage includes peripheral nerve evaluation and patients who achieve greater than 50% improvement in urinary incontinence or retention episodes during testing will be eligible to receive permanent SNS treatment.

TN.8.51 Ureteroscopy - (Item 36803)

Item 36803 refers to ureteroscopy of one ureter when performed for the purpose of inspection alone. It may not be used when one of the other ureteroscopy numbers (Items 36806 or 36809) or pyeloscopy numbers (Items 36652, 36654 or 36656) is used for a ureteroscopic procedure performed in the same ureter or collecting system. It may be used when inspection alone is carried out in one ureter independently from a ureteroscopic or pyeloscopic procedure in another ureter or collecting system. If Item number 36803 is used with one of the other above 5 numbers, it must be specified that item number 36803 refers to ureteroscopy performed in another ureter eg 36654 (Right side) and 36803 (Left side). 36803 may also be used in this way if there is a partial or complete duplex collecting system eg 36809 (Lower pole moiety ureter, Left side) and 36803 (Upper pole moiety ureter, Left side).

Item numbers 36806 and 36809 may only be used together when 2 independent ureteroscopic procedures are performed in separate ureters. These separate ureters may be components of a complete or partial duplex system. If

both these numbers are used together, the Regulations require qualification of these item numbers by the site, as is necessary with 36803 eg 36806 (Right side) and 36809 (Left side).

TN.8.52 Selective Coronary Angiography - (Items 38215 to 38246)

Each item in the range 38215-38240 describes an episode of service. As such, only one item in this range can be claimed in a single episode.

Item 38243 may be billed once only immediately prior to any coronary interventional procedure, including situations where a second operator performs any coronary interventional procedure after diagnostic angiography by the first operator.

Item 38246 may be billed when the same operator performs diagnostic coronary angiography and then proceeds directly with any coronary interventional procedure during the same occasion of service. Consequently, it may not be billed in conjunction with items 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38243. In the event that the same operator performed any coronary interventional procedure immediately after the diagnostic procedure described by item 38231, 38237 or 38240, that item may be billed as an alternative to item 38246.

Items in the range 38215 - 38246 cannot be claimed for any intravascular ultrasound (IVUS) procedure therefore Medicare Benefits are not payable for IVUS.

TN.8.53 Transurethral Needle Ablation (TUNA) of the Prostate - (Items 37201 and 37202)

Moderate to severe lower urinary tract symptoms are defined using the American Urological Association (AUA) Symptom Score or the International Prostate Symptom Score (IPSS).

Patients not medically fit for transurethral resection of the prostate (TURP) can be defined as:

(i) Those patients who have a high risk of developing a serious complication from the surgery. Retrograde ejaculation is **not** considered to be a serious complication of TURP.

(ii) Those patients with a co-morbidity which may substantially increase the risk of TURP or the risk of the anaesthetic necessary for TURP.

TN.8.54 Gold Fiducial Markers into the Prostate - (item 37217)

Item 37217 is for the insertion of gold fiducial markers into the prostate or prostate surgical bed as markers for radiotherapy. The service can not be claimed under item 37218 or any other surgical item.

This item is introduced into the Schedule on an interim basis pending the outcome of an evaluation being undertaken by the Medical Services Advisory Committee (MSAC).

Further information on the review of this service is available from the MSAC Secretariat.

TN.8.55 Brachytherapy of the Prostate - (Item 37220)

One of the requirements of item 37220 is that patients have a Gleason score of less than or equal to 7. However, where the patient has a score of 7, comprising a primary score of 4 and a secondary score of 3 (ie. 4+3=7), it is recommended that low dose rate brachytherapy form part of a combined modality treatment.

Low dose rate brachytherapy of the prostate should be performed in patients, with favourable anatomy allowing adequate access to the prostate without pubic arch interference, and who have a life expectancy of greater than 10 years.

An 'approved site' for the purposes of this item is one at which radiation oncology services may be performed lawfully under the law of the State or Territory in which the site is located.

TN.8.56 High Dose Rate Brachytherapy - (Item 37227)

Item 37227 covers the service undertaken by an urologist or radiation oncologist as part of the High Dose Rate Brachytherapy procedure, in association with a radiation oncologist. If the service is undertaken by an urologist, a radiation oncologist must be present in person at the time of the service. The removal of the catheters following completion of the Brachytherapy is also covered under this item.

TN.8.57 Radical or Debulking Operation for Ovarian Tumour - (Item 35720)

This item refers to the operation for carcinoma of the ovary where the bulk of the tumour and the omentum are removed. Where this procedure is undertaken in association with hysterectomy benefits are payable under both item numbers with the application of the multiple operation formula.

TN.8.58 Transcutaneous Sperm Retrieval - (Item 37605)

Item 37605 covers transcutaneous sperm retrieval for the purposes of intracytoplasmic sperm injection (item 13251) for male factor infertility, in association with assisted reproductive technologies.

Item 37605 provides for the procedure to be performed unilaterally. Where it is clinically necessary to perform the service bilaterally, the multiple operation rule would apply, in accordance with point T8.5 of these Explanatory Notes.

Where the procedure is carried out under local infiltration as the means of anaesthesia, additional benefit is not payable for the anaesthesia component as this is considered to be part of the procedure.

TN.8.59 Surgical Sperm Retrieval, by Open Approach - (Item 37606)

Item 37606 covers open sperm retrieval for the purposes of intracytoplasmic sperm injection (item 13251) for male factor infertility, in association with assisted reproductive technologies. Item 37606 provides for the procedure to be performed unilaterally. Where it is clinically necessary to perform the service bilaterally, the multiple operation rule would apply.

Benefits for item 37606 may be claimed in conjunction with a service or services provided under item 37605, where an open approach is clinically necessary following an unsuccessful percutaneous approach. Likewise, such services would be subject to the multiple operation rule.

Benefit is not payable for item 37606 in conjunction with item 37604.

TN.8.60 Cardiac Pacemaker Insertion - (Items 38209, 38212, 38350, 38353 and 38356)

The fees for the insertion of a pacemaker (Items 38350, 38353 and 38356) cover the testing of cardiac conduction or conduction threshold, etc related to the pacemaker and pacemaker function.

Accordingly, additional benefits are not payable for such routine testing under Item 38209 or 38212 (Cardiac electrophysiological studies).

TN.8.61 Implantable ECG Loop Recorder - (Item 38285)

The fee for implantation of the loop recorder (item 38285) covers the initial programming and testing of the device for satisfactory rhythm capture. Benefits are payable only once per day.

The term "recurrent" refers to more than one episode of syncope, where events occur at intervals of 1 week or longer. The term "other available cardiac investigations" includes the following:

- a complete history and physical examination that excludes a primary neurological cause of syncope and does not exclude a cardiac cause;

- *electrocardiography (ECG) (items 1170-11702);*

- *echocardiography (items 55113-55115);*

- *continuous ECG recording or ambulatory ECG monitoring (items 11708-11711);*

- *up-right tilt table test (item 11724); and*

- cardiac electrophysiological study, unless there is reasonable medical reason to waive this requirement (item 38209).

TN.8.62 Transluminal Insertion of Stent or Stents - (Item 38306)

Item 38306 should only be billed once per occlusional site. It is not appropriate to bill item 38306 multiple times for the insertion of more than one stent at the same occlusional site in the same artery. However, it would be appropriate to claim this item multiple times for insertion of stents into the same artery at different occlusional sites or into another artery or occlusional site. It is expected that the practitioner will note the details of the artery or site into which the stents were placed, in order for the Department of Human Services to process the claims.

TN.8.63 Permanent Cardiac Synchronisation Device (Items 38365, 38368 and 38654)

Items 38365, 38368 and 38654 apply only to patients who meet the criteria listed in the item descriptor, and to patients who do not meet the criteria listed in the descriptor but have previously had a CRT device and transvenous left ventricular electrode inserted and who prior to its insertion met the criteria and now need the device replaced.

TN.8.64 Intravascular Extraction of Permanent Pacing Leads - (Item 38358)

For the purposes of Item 38358 specialists or consultant physicians claiming this item must have training recognised by the Lead Extraction Advisory Committee of the Cardiac Society of Australia and New Zealand, and the Department of Human Services notified of that recognition. The procedure should only be undertaken in a hospital capable of providing cardiac surgery.

TN.8.65 Cardiac Resynchronisation Therapy - (Item 38371)

Item 38371 applies only to patients who meet the criteria listed in the item descriptor, and to patients who do not meet the criteria listed in the descriptor but have previously had an CRT device capable of defibrillation inserted and who prior to its insertion met the criteria and now need the device replaced.

TN.8.66 Implantable Cardioverter Defibrillator - (Items 38384 and 38387)

Items 38384 and 38387 apply only to patients who meet the criteria listed in the item descriptor, and to patients who do not meet the criteria listed in the descriptor but have previously had an ICD device inserted and who prior to its insertion met the criteria and now need the device replaced.

TN.8.67 Cardiac and Thoracic Surgical Items - (Items 38470 to 38766)

Items 38470 to 38766 must be performed using open exposure or minimally invasive surgery which excludes percutaneous and transcatheter techniques unless otherwise stated in the item.

TN.8.68 Coronary Artery Bypass - (Items 38497 to 38504)

The fees for Items 38497 and 38498 include the harvesting of vein graft material. Harvesting of internal mammary artery and/or vein graft material is covered in the fees for Items 38500, 38501, 38503 and 38504. Where harvesting of an artery other than the internal mammary artery is undertaken, benefits are payable under Item 38496 on the multiple operation basis. The procedure of coronary artery bypass grafting using arterial graft is covered by Item 38500, 38501, 38503 or 38504 irrespective of the origin of the arterial graft.

Items 38498, 38501 and 38504 require that either a clinical or medical perfusionist are present in the operating theatre throughout the procedure in case it is necessary to convert to an on-pump procedure and cardiopulmonary bypass is required.

If it is necessary to provide cardiopulmonary bypass items 38498, 38501 and 38504 cannot be claimed. The procedure should be claimed under items 38497, 38500 or 38503 as appropriate in conjunction with the relevant cardiopulmonary bypass procedures.

TN.8.69 Re-operation via Median Sternotomy - (Item 38640)

Medicare benefits are payable for Item 38640 plus the item/s covering the major surgical procedure/s performed at the time of the re-operation, using the multiple operation formula. Benefits are not payable for Item 38640 in association with Item 38656, 38643 or 38647.

TN.8.70 Skull Base Surgery - (Items 39640 to 39662)

The surgical management of lesions involving the skull base (base of anterior, middle and posterior fossae) often requires the skills of several surgeons or a number of surgeons from different surgical specialties working together or in tandem during the operative session. These operations are usually not staged because of the need for definitive closure of the dura, subcutaneous tissues, and skin to avoid serious infections such as osteomyelitis and/or meningitis.

Items 39640 to 39662 cover the removal of the tumour, which would normally be performed by a neurosurgeon. Other items are available to cover procedures performed as a part of skull base surgery by practitioners in other specialities, such as ENT and plastic and reconstructive surgery.

TN.8.71 Intradiscal Injection of Chymopapain - (Item 40336)

The fee for this item includes routine post-operative care. Associated radiological services attract benefits under the appropriate item in Group I3.

TN.8.72 Removal of Ventilating Tube from Ear - (Item 41500)

Benefits are not payable under Item 41500 for removal of ventilating tube. This service attracts benefits on an attendance basis.

TN.8.73 Meatoplasty - (Item 41515)

When this procedure is associated with Item 41530, 41548, 41557, 41560 or 41563 the multiple operation rule applies.

TN.8.74 Reconstruction of Auditory Canal - (Item 41524)

When associated with Item 41557, 41560 or 41563 the multiple operation rule applies.

TN.8.75 Removal of Nasal Polyp or Polypi - (Items 41662 and 41668)

Where such polyps are removed in association with another intranasal procedure, Medicare benefit is paid under Item 41662. However where the associated procedure is of lesser value than Item 41668, benefit for removal of polypi would be paid under Item 41668.

Services performed under item 41668 require admission to hospital.

TN.8.76 Larynx, Direct Examination - (Item 41501)

Benefit is not attracted under this item when an anaesthetist examines the larynx during the course of administration of a general anaesthetic.

TN.8.77 Microlaryngoscopy - (Item 41858)

This item covers the removal of "juvenile papillomata" by mechanical means, e.g. cup forceps. Item 41861 refers to the removal by laser surgery.

TN.8.78 Imbedded Foreign Body - (Item 42644)

For the purpose of item 42644, an imbedded foreign body is one that is sub-epithelial or intra-epithelial and is completely removed using a hypodermic needle, foreign body gouge or similar surgical instrument with magnification provided by a slit lamp biomicroscope, loupe or similar device.

Item 42644 also provides for the removal of rust rings from the cornea, which requires the use of a dental burr, foreign body gouge or similar instrument with magnification by a slit lamp biomicroscope.

Where the imbedded foreign body is not completely removed, benefits are payable under the relevant attendance item.

TN.8.79 Corneal Incisions - (Item 42672)

The description of this item refers to two sets of calculations, one performed some time prior to the operation, the other during the course of the operation. Both of these measurements are included in the Schedule fee and benefit for Item 42672.

TN.8.80 Cataract surgery (Items 42698 and 42701)

Items 42698 and 42701 provide for intraocular lens extraction and replacement as a separate procedure to be used in instances when lens removal and replacements are contraindicated at the same operation, such as in patients presenting with proliferative diabetic retinopathy or recurrent uveitis.

TN.8.81 Posterior Juxtascleral Depot injection - (Item 42741)

For the purpose of item 42741, the therapeutic substance must be registered with the Therapeutic Goods Administration (or listed on the Pharmaceutical Benefits Schedule, if so listed) as being suitable for injection for the treatment of predominantly (greater than or equal to 50%) classic, subfoveal choroidal neovascularisation due to age-related macular degeneration, as diagnosed by fluorescein angiography, in a patient with a baseline visual acuity equal to or better than 6/60.

TN.8.82 Cyclodestructive Procedures - (Items 42770)

Item 42770 is restricted to a maximum of 2 treatments in a 2 year period.

TN.8.83 Insertion of drainage device for glaucoma (Item 42752)

Item 42752 provides for the insertion of a drainage device for the treatment of glaucoma patients who are at high risk of failure of trabeculectomy (such as patients who have aggressive neovascular glaucoma or extensive conjunctival scarring); have iridocorneal endothelial syndrome; inflammatory (uveitic) glaucoma; or aphakic glaucoma.

TN.8.84 Laser Trabeculoplasty - (Item 42782)

Item 42782 is restricted to a maximum of 4 treatments in a 2 year period.

TN.8.85 Laser Iridotomy - (Item 42785)
Item 42785 is restricted to a maximum of 3 treatments in a 2 year period.

TN.8.86 Laser Capsulotomy - (Items 42788)
Item 42788 is restricted to a maximum of 2 treatments in a 2 year period.

TN.8.87 Laser Vitreolysis or Corticolysis of Lens Material or Fibrinolysis - (Item 42791)
Item 42791 is restricted to a maximum of 3 treatments in a 2 year period.

TN.8.88 Division of Suture by Laser - (Item 42794)
Benefits under this item are restricted to a maximum of 2 treatments in a 2 year period. There is no provision for additional treatments in that period.

TN.8.89 Ophthalmic Sutures - (Item 42845)
This item refers to the occasion when readjustment has to be made to the sutures to vary the angle of deviation of the eye. It does not cover the mere tightening of the loosely tied sutures without repositioning, or adjustment performed prior to the patient leaving the operating theatre.

TN.8.91 Abrasive Therapy/Resurfacing - (Items 45021 to 45026)
For the purposes of the above items, one aesthetic area is any of the following of the whole face (considered to be divided into six segments):- forehead; right cheek; left cheek; nose; upper lip; and chin.

Items 45021 and 45024 cover abrasive therapy only. For the purposes of these items, abrasive therapy requires the removal of the epidermis and into the deeper papillary dermis. Services performed using a laser are not eligible for benefits under these items.

Items 45025 and 45026 do not cover the use of fractional (Fraxel®) laser therapy.

TN.8.92 Escharotomy - (Item 45054)
Benefits are payable once only under Item 45054 for each limb (or chest) regardless of the number of incisions to each of these areas.

TN.8.93 Local Skin Flap - Definition
Medicare benefits for flaps are only payable when clinically appropriate. Clinically appropriate in this instance means that the flap or graft is required to close the defect because the defect cannot be closed directly, or because the flap is required to adapt scar position optimally with regard to skin creases or landmarks,maintain contour on the face or neck, or prevent distortion of adjacent structures or apertures.

A local skin flap is an area of skin and subcutaneous tissue designed to be elevated from the skin adjoining a defect requiring closure. The flap remains partially attached by its pedicle and is moved into the defect by rotation, advancement or transposition, or a combination of these manoeuvres. A benefit is only payable when the flap is required for adequate wound closure. A secondary defect will be created which may be closed by direct suture, skin grafting or sometimes a further local skin flap. This later procedure will also attract benefit if closed by graft or flap repair but not when closed by direct suture.

By definition, direct wound closure (e.g. by suture) does not constitute skin flap repair. Similarly, angled, curved or trapdoor incisions which are used for exposure and which are sutured back in the same position relative to the adjacent tissues are not skin flap repairs. Undermining of the edges of a wound prior to suturing is considered a normal part of wound closure and is not considered a skin flap repair.

A "Z" plasty is a particular type of transposition flap repair. Although 2 flaps are created, benefit will be paid on the basis of Item 45201, claimable once per defect. Additional flaps are to be claimed under Item 45202, if clinically indicated.

Note: refer to T8.128 for MBS item 45202 for circumstances where other services might involve flap repair.

TN.8.94 Free Grafting to Burns - (Items 45406 to 45418)

Items 45406 to 45418 cover split skin grafting using autografts, homografts or xenografts.

TN.8.95 Revision of Scar - (Items 45506 to 45518)

For the purposes of items 45506 to 45518, revision of scar refers to modification of existing scars (traumatic, surgical or pathological) that is designed to decrease scar width, adapt scar position with regard to skin creases and landmarks, release scars from adhering to underlying structures, improve scar contour in keeping with undamaged skin or restore the shape of facial aperture.

Items 45506 to 45518 are only claimable when performed by a specialist in the practice of his or her specialty or where undertaken in the operating theatre of a hospital.

Only items 45506 and 45512, for the face and neck, can be claimed in association with items providing for graft or flap services.

For excision of scar services which do not meet the requirements of the revision of scar items as defined, the appropriate item in the range 31206 to 31225 should be claimed.

TN.8.96 Augmentation Mammaplasty - (Items 45524, 45527 and 45528)

A Medicare benefit is generally not attracted under item 45524 unless the asymmetry in breast size is greater than 10%. Augmentation of a second breast sometime after an initial augmentation of one side would not attract benefits. Benefits are not payable for augmentation mammaplasty services performed using fat transfer to the breast.

Item 45528 applies where bilateral mammaplasty is indicated because of malformation of breast tissue, disease or trauma of the breast, (but not as a result of previous cosmetic surgery) other than covered under item 45524 or 45527.

Volumetric measurement of the breasts should be performed using a technique which has been reported in a published study.

TN.8.97 Breast Reconstruction, Myocutaneous Flap - (Item 45530)

When a prosthesis is inserted in conjunction with this operation, benefit would be attracted under Item 45527, the multiple operation rule applying. Benefits would also be payable for nipple reconstruction (Item 45545) when performed.

When claiming item 45530 for a rectus abdominis flap; item 45569 should be claimed for closure of the abdomen and reconstruction of the umbilicus, and item 45570 may be claimed if repair of the musculoaponeurotic layer is required. When claiming item 45530 for a latissimus dorsi flap, no item for the closure of the musculoaponeurotic layer should be claimed as it is expected that repair will be by direct suture. In the small number of cases, when a latissimus dorsi flap is used, and repair by means other than direct suture is required, use of item 45203 would be appropriate.

Items 30165-30179 (lipectomy items) should not be claimed in association with item 45530 as stated in the Health Insurance (General Medical Services Table) Regulations.

TN.8.98 Breast Prosthesis, Removal and Replacement of - (Items 45553 and 45554)

It is generally expected that the replacement prosthesis will be the same size as the prosthesis that is removed. Medicare benefits are not payable for services under items 45553-45554 where the procedure is performed solely to increase breast size.

Where the original implant was not inserted in the context of breast cancer or developmental abnormality, intra-operative photographs need to demonstrate significant evidence of substantial skin laxity to justify replacement of the prosthesis.

In the context of eligibility for item 45553 and 45554, an unacceptable deformity would not include asymmetry caused as a result of implant removal.

Where a rupture has been established through imaging and reported, items 45553 and 45554 will still apply even if intra-operatively the implant is found to be structurally intact.

Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic imaging evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.99 Breast Ptosis - (Items 45556 and 45558)

For the purposes of item 45556, Medicare benefit is only payable for the correction of breast ptosis when performed unilaterally, in the context of breast cancer or developmental breast abnormality to match the position of the contralateral breast. This item is payable only once per patient. Additional benefit is not payable if this procedure is also performed on the contralateral breast.

Item 45558 applies where correction of breast ptosis is indicated because at least two-thirds of the breast tissue, including the nipple, lies inferior to the infra-mammary fold where the nipple is located at the most dependent, inferior part of the breast contour.

Full clinical details must be documented in patient notes, including pre-operative photographic evidence (including anterior, left lateral and right lateral views) as specified in the item descriptor which demonstrates the clinical need for the service, as this may be subject to audit.

TN.8.100 Nipple and/or Areola Reconstruction - (Items 45545 and 45546)

Item 45545 involves the taking of tissue from, for example, the other breast, the ear lobe and the inside of the upper thigh with or without local flap.

Item 45546 covers the non-surgical creation of nipple or areola by intradermal colouration.

TN.8.101 Liposuction - (Items 45584 and 45585)

Medicare benefits for liposuction are generally attracted under item 45584, that is for the treatment of post-traumatic pseudolipoma. Such trauma must be significant and result in large haematoma and localised swelling. Only on very rare occasions would benefits be payable for bilateral liposuction.

Where liposuction is indicated for the treatment of Barraquer-Simons Syndrome, lymphoedema or macrodystrophia lipomatosa, or the reduction of buffalo hump, item 45585 applies. One regional area is defined as one limb or trunk. If liposuction is required on more than one limb, item 45585 can be claimed once per limb.

Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic imaging evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.102 Meloplasty for Correction of Facial Asymmetry - (Items 45587 and 45588)

Benefits are payable under items 45587 and 45588 for face lift operations performed in hospital to correct soft tissue abnormalities of the face due to causes other than the ageing process, including trauma, a congenital condition or disease.

Where bilateral meloplasty is indicated because of congenital malformation for conditions such as drooling from the angles of the mouth and deep pitting of the skin resulting from severe acne scarring, disease or trauma (but not as a result of previous cosmetic surgery), item 45588 applies.

Full clinical details must be documented in patient notes, including pre-operative photographic and/or diagnostic imaging evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.103 Reduction of Eyelids - (Items 45617 and 45620)

Where a reduction is performed for a medical condition of one eyelid, it may be necessary to undertake a similar compensating procedure on the other eyelid to restore symmetry. The latter operation would also attract benefits.

Medicare benefits are not payable for non-therapeutic cosmetic services. Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.104 Rhinoplasty - (Items 45632 to 45644, and 45650)

Benefits are payable for septoplasty (item 41671) where performed in conjunction with rhinoplasty.

A Medicare benefit for items 45632 – 45644 and 45650 is payable where the indication for surgery is for:

(i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or

(ii) significant acquired, congenital or developmental deformity.

The NOSE Scale refers to the Nasal Obstruction Symptom Evaluation Scale, developed by Stewart et al, as published in the Otolaryngology-Head and Neck Surgery, 130: 2.

The NOSE Scale can be accessed here: https://www.entnet.org//content/facial-plasticsrhinology-outcome-tool-nose-scale

Full clinical details must be documented in patient notes, including pre-operative photographic and / or NOSE Scale evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.105 Contour Restoration - (Item 45647)

For the purpose of item 45647, a region in relation to the face is defined as either being upper left or right, mid left or right or lower left or right. Accounts should be annotated with region/s to which the service applies.

TN.8.106 Vermilionectomy - (Item 45669)

Item 45669 covers treatment of the entire lip.

TN.8.107 Osteotomy of Jaw - (Items 45720 to 45752)

The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site. Bone grafts taken from a separate site, eg iliac crest, would attract additional benefit under Item 47726 or 47729 for the harvesting, plus Item 48239 or 48242 for the grafting.

For the purposes of these items, a reference to maxilla includes the zygoma.

Item 75621 for the provision of fitting of surgical templates may be claimed in association with the appropriate orthognathic surgical items in the range of 45720 to 45754 for prescribed dental patients registered under the Cleft Lip and Cleft Palate Scheme.

TN.8.108 Genioplasty - (Item 45761)
Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

TN.8.109 Tumour, Cyst, Ulcer or Scar - (Items 45801 to 45813)
It is recognised that odontogenic keratocysts, although not neoplastic, often require the same surgical management as benign tumours.

TN.8.110 Fracture of Mandible or Maxilla - (Items 45975 to 45996)
There are two maxillae in the skull and for the purpose of these items the mandible is regarded as comprising two bones.

TN.8.111 Reduction of Dislocation or Fracture
Closed reduction means treatment of a dislocation or fracture by non-operative reduction, and includes the use of percutaneous fixation or external splintage by cast or splints.

Open reduction means treatment of a dislocation or fracture by either operative exposure including the use of any internal or external fixation; or non-operative (closed reduction) where intra-medullary or external fixation is used.

Where the treatment of a fracture requires reduction on more than one occasion to achieve an adequate alignment, benefits are payable for each separate occasion at which reduction is performed under the appropriate item covering the fracture being treated.

The treatment of fractures/dislocations not specifically covered by an item in Subgroup 15 (Orthopaedic) attracts benefits on an attendance basis.

TN.8.112 Removal of Multiple Exostoses (Items 47933 and 47936)
Items 47933 and 47936 provide for removal of multiple exostoses when undertaken via the same incision.

TN.8.116 Wrist Surgery - (Items 49200 to 49227)
For the purposes of these items, the wrist includes both the radiocarpal joint and the midcarpal joint.

TN.8.117 Diagnostic Arthroscopy and Arthroscopic Surgery of the Knee (Items 49557 and 49563)
The Medical Services Advisory Committee (MSAC) evaluated the available evidence and did not support public funding for matrix-induced autologous chondrocyte implantation (MACI) or autologous chondrocyte implantation (ACI) for the treatment of chondral defects in the knee and other joints, due to the increased cost compared to existing procedures and the lack of evidence showing short term or long-term improvements in clinical outcomes. Medicare benefits are not payable in association with this technology.

TN.8.118 Paediatric Patients - (Items 50450 to 50658)
For the purpose of Medicare benefits a paediatric patient is considered to be a patient under the age of eighteen years, except in those instances where an item provides further specifications (i.e. fracture items for paediatric patients which state "with open growth plates").

TN.8.119 Treatment of Fractures in Paediatric Patients - (Items 50500 to 50588)
Items 50552 and 50560 apply to fractures that may arise during delivery and at an age when anaesthesia poses a significant risk and thus reduction is usually performed in the neonatal unit or nursery.

Item 50576 provides for closed reduction in the skeletally immature patient and will require application of a hip spica cast and related aftercare.

Medicare benefits are payable for services that specify reduction with or without internal fixation by open or percutaneous means, where reduction is carried out on the growth plate or joint surface or both.

TN.8.120 Unresectable primary malignant tumour of the liver destruction of by open or laparoscopic radiofrequency ablation or microwave tissue ablation- (Item 50952)

A multi-disciplinary team for the purposes of item 50952 would include a hepatobilliary surgeon, interventional radiologist and a gastroenterologist or oncologist.

TN.8.121 Paracentesis of anterior chamber or vitreous cavity and/or intravitreal injection - (Items 42738 to 42740)

Items 42738 and 42739 provide for paracentesis for the injection of therapeutic substances and/or the removal of aqueous or vitreous, when undertaken as an independent procedure. That is, not in conjunction with other intraocular surgery.

Item 42739 should be claimed for patients requiring anaesthetic services for the procedure. Advice from the Royal Australian and New Zealand College of Ophthalmologists is that independent injections require only topical anaesthesia, with or without subconjunctival anaesthesia, except in specific circumstances as outlined below where additional anaesthetic services may be indicated:

- nystagmus or eye movement disorder;
- cognitive impairment precluding safe intravitreal injection without sedation;
- a patient under the age of 18 years;
- a patient unable to tolerate intravitreal injection under local anaesthetic without sedation; or
- endophthalmitis or other inflammation requiring more extensive anaesthesia (eg peribulbar).

Practitioners billing item 42739 must keep clinical notes outlining the basis for the use of anaesthetic.

Item 42740 provides for intravitreal injection of therapeutic substances and/or the removal of vitreous for diagnostic purposes when performed in conjunction with other intraocular surgery including with a service to which Item 42809 (retinal photocoagulation) applies.

TN.8.122 Bone Graft (Items 48200-48242 and 48642-48651)

Bone graft substitute materials can be used for the purpose of bone graft for items 48200-48242 and 48642-48651.

TN.8.123 Vulvoplasty and Labioplasty - (Items 35533 and 35534)

Item 35533 is intended to cover the surgical repair of female genital mutilation or a major congenital anomaly of the uro-gynaecological tract which is not covered by existing MBS items. For example, this item would apply where a patient who has previously received treatment for cloacal extrophy, bladder exstrophy or congenital adrenal hyperplasia requires additional or follow-up treatment.

Item 35534 is intended to cover services for a structural abnormality causing significant functional impairment and is restricted to patients aged 18 years and over.

A detailed clinical history outlining the structural abnormality and the medical need for surgery of the vulva and/or labia must be included in patient notes, as this may be subject to audit.

Medicare benefits are not payable for non-therapeutic cosmetic services.

TN.8.124 Treatment of Wrist and Finger Fractures - (Items 47301 to 47319, and 47361 to 47373)

- For the purposes of these items, fixation includes internal and external.
- Regarding item 47362, major regional anaesthesia includes bier block.

TN.8.125 Removal of Skin Lesions - Necessary Excision Diameter - (Items 31356 to 31376)

The necessary excision diameter (or defect size) refers to the lesion size plus a clinically appropriate margin of healthy tissue required with the intent of complete surgical excision. Measurements should be taken prior to excision. Margin size should be determined in line with NHMRC guidelines:

Clinical practice guide - Basal cell carcinoma, squamous cell carcinoma(and related lesions)-a guide to clinical management in Australia. November 2008. Cancer Council Australia and; *Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand (2008).*

For the purpose of Items 31356 to 31376 the defect size is calculated by the average of the width and the length of the skin lesion and an appropriate margin. The necessary excision diameter is calculated as shown in the Factsheet at this link: Determining lesion size for MBS item selection.

Practitioners must retain copies of histological reports and any other supporting evidence (patient notes, photographs etc). Photographs should include scale.

An episode of care includes both the excision and closure for the same defect, even when excision and closure occur at separate attendances.

Definitive surgical excision for items 31371 to 31376 means surgical removal with adequate margins as part of the curative management of the malignancies specified in these items.

An incomplete surgical excision of a malignant skin lesion with curative intent should be billed as a malignant skin lesion excision item even when further surgery is needed. Wide excision of the primary tumour bed following local excision of a primary melanoma, appendageal carcinoma, malignant connective tissue or merkel cell carcinoma of the skin may be claimed using item 31371, 31372, 31373, 31374, 31375 or 31376, depending on the location of the malignancy and the size of the excision diameter.

For Items 31356 to 31370, a malignant skin lesion is defined as a basal cell carcinoma; a squamous cell carcinoma (including keratoacanthoma); a cutaneous deposit of lymphoma; or a cutaneous metastasis from an internal malignancy.

TN.8.126 Flap Repair - (Item 45202)

Practitioners must only perform a muscle or skin flap repair where clinical need can be clearly evidenced (i.e. where a patient hassevere pre-existing scarring, severe skin atrophy, sclerodermoid changes or where the defect is contiguous witha free margin).

Clinical evidence may be supported by patient notes, photographs of the affected area and pathology reports.

TN.8.127 Interpretation of femoroacetabular impingement (FAI) restriction (items 48424, 49303,49366)

Patients presenting with hip dysplasia, Perthes Disease and Slipped Upper Femoral Epiphysis (SUFE) are eligible for treatment under items 49366, 49303 and 48424.

TN.8.132 Transcatheter occlusion of left atrial appendage for stroke prevention (item 38276)

Explanatory Note

A contraindication to lifelong anticoagulation is defined as:

i) a previous major bleeding complication experienced whilst undergoing treatment with oral anticoagulation therapy,

ii) a blood dyscrasia, or

iii) a vascular abnormality predisposing to potentially life threatening haemorrhage

The procedure is performed as a hospital service.

TN.8.133 Endoscopic upper gastrointestinal strictures (item 30475)

Endoscopic upper GI stricture services 41819 and 41820 have been consolidated under item 30475. This consolidated item will allow any endoscopic technique to be performed for oesophageal through to gastroduodenal procedures and will include imaging intensification if done. The fee is the same as item 41819 which higher than item 30475 but lower than 41820.

TN.8.134 Application of items 32084, 32087, 32090 and 32093

If a service to which item 32084, 32087, 32090 or 32093 applies is provided by a practitioner to a patient on more than one occasion on a day, the second service is taken to be a separate service for the purposes of the item if the second service is provided under a second episode of anaesthesia or other sedation.

TN.8.135 Transcatheter Aortic Valve Implantation (Item 38495)

Item 38495 applies only to a service for Transcatheter Aortic Valve Implantation (TAVI) for the treatment of symptomatic severe aortic stenosis, that is to be provided in a TAVI Hospital by a TAVI Practitioner on a TAVI patient.

TAVI Hospital

For item 38495 a TAVI Hospital means a hospital, as defined by subsection 121-5(5) of the Private Health Insurance Act 2007, that is clinically accepted as being a suitable hospital in which the service described in Item 38495 may be performed.

The Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners developed by Cardiac Accreditation Services Limited provides guidance on what are considered by the sector as minimum requirements that must be met in order to be a clinically acceptable facility that is suitable for TAVI procedures to be performed at.

Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners can be accessed via www.tavi.org.au.

TAVI Practitioner

For item 38495 a TAVI Practitioner is either a cardiothoracic surgeon or interventional cardiologist who is accredited by Cardiac Accreditation Services Limited.

Accreditation by Cardiac Accreditation Services Limited must be valid prior to the service being undertaken in order for benefits to be payable under item 38495.

The process for accreditation and re-accreditation is outlined in the *Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners,* issued by Cardiac Accreditation Services Limited, and is available on the Cardiac Accreditation Services Limited website, *www.tavi.org.au.*

Cardiac Accreditation Services Limited is a national body comprising representatives from the Australian & New Zealand Society of Cardiac & Thoracic Surgeons (ANZSCTS) and the Cardiac Society of Australia and New Zealand (CSANZ).

TAVI Patient

A TAVI Patient means a patient who, as a result of a TAVI Case Conference, has been assessed as having an unacceptably high risk for surgical aortic valve replacement and is recommended as being suitable to receive the service described in item 38495.

A TAVI Case Conference is a process by which:

(a) there is a team of 3 or more participants, where:

(i) the first participant is a cardiothoracic surgeon; and

(ii) the second participant is an interventional cardiologist; and

(iii) the third participant is a specialist or consultant physician who does not perform a service described in Item 38495 for the patient being assessed; and

(iv) either the first or the second participant is also a TAVI Practitioner; and

(b) the team assesses a patient's risk and technical suitability to receive the service described in Item 38495, taking into account matters such as:

(i) the patient's risk and technical suitability for a surgical aortic valve replacement; and

(ii) the patient's cognitive function and frailty; and

(c) the result of the assessment is that the team makes a recommendation about whether or not the patient is suitable to receive the service described in Item 38495; and

(d) the particulars of the assessment and recommendation are recorded in writing.

While benefits are payable for an eligible TAVI Case Conference under Items 6080 and 6081, a claim for these services does not have to be made in order for a benefit to be paid under Item 38495. Item 38495 is only payable once per patient in a five year period.

TN.8.136 Corneal Collagen Cross Linking (Item 42652)

Evidence of progression in patients over the age of twenty five is determined by the patient history including an objective change in tomography or refraction over time. Evidence of progression in patients aged twenty five years or younger is determined by patient history including an objective change in tomography or refraction over time and/or posterior elevation data and objective documented progression at a subclinical level.

TN.8.137 Thyroidectomy and hemithyroidectomy procedures (items 30296, 30306, and 30310)

Total thyroidectomy or total hemithyroidectomy are the most appropriate procedures in the majority of circumstances when a thyroidectomy is required. The preferred procedure for thyrotoxicosis is total thyroidectomy (item 30296). Item 30310 is to be used only in uncommon circumstances where a subtotal or partial thyroidectomy is indicated and includes a subtotal lobectomy, nodulectomy, or isthmusectomy or equivalent partial thyroidectomy.

TN.8.138 Re-exploratory thyroid surgery (item 30297)

Item 30297 is for re-exploratory thyroid surgery where prior thyroid surgery and associated scar tissue increases the complexity of surgery. For completion hemithyroidectomy on the contralateral side to a previous hemithyroidectomy for thyroid cancer, item 30306 is the appropriate item.

TN.8.139 Personal performance of a Synacthen Stimulation Test (item 30097)

A 0900h serum cortisol (0830-0930) less than 100 nmol/L indicates adrenal deficiency and a Synacthen Test is not required.

A 0900h serum cortisol (0830-0930) greater than 400 nmol/L indicates adrenal sufficiency and a Synacthen Test is not required. An exception to this is when testing women on oral contraception where cortisol levels may be higher due to increases in cortisol-binding globulin and this threshold may not exclude women with adrenal insufficiency.

TN.8.140 Excision of graft material - Items 35581 and 35582

For items 35581 and 35582 the size of the excised graft material must be histologically tested and confirmed.

TN.8.141 Application of items 51011 to 51171 (Sub-group 17)

Spinal surgery items 51011 to 51171 cannot be performed in conjunction with any other item (outside of subgroup 17) in Group T8 of the MBS (surgical operation items 30001 to 50952), when that surgical item is related to spinal surgery. Items 50600 to 50644 - spine surgery for scoliosis and kyphosis in paediatric patients - are excepted from this rule when claimed in conjunction with items 51113 and 51114.

Meaning of Motion Segment

Motion segment is defined as including all anatomical structures (including traversing and exiting nerve roots) between and including the top of the pedicle above to the bottom of the pedicle below.

Combined Anterior and Posterior Surgery

Combined anterior/ posterior surgery items 51061, 51062, 51063, 51064, 51065 and 51066 cannot be claimed with any item between 51020 and 51045 (i.e. items for spinal instrumentation, posterior bone graft and/or anterior column fusion).

Interpretation of Spinal Fusion

Lumbar spinal fusion may not be claimed for chronic low back pain for which a diagnosis has not been made.

TN.8.142 Spinal Decompression - Items 51011 to 51015

Items 51011 to 51015 are for services which include discectomy, decompression of central spinal canal by laminectomy or partial corpectomy (vertebral spurs and osteophytes; less than 50% of the vertebral body), and decompression of the subfacetal recess, the exit foramen and far lateral (intertransverse) space.

For decompression procedures, only one item is selected from 51011 to 51015.

For posterolateral spinal fusion without instrumentation, if a decompression procedure is combined with the fusion, two items numbers can be selected: one from 51011 to 51015 and one from 51031 to 51036.

For posterolateral spinal fusion with instrumentation, two item numbers can be selected: one from 51020 to 51026 and one from 51031 to 51036. If decompression is also performed, three items can be selected: one from 51011 to 51015, one from 51020 to 51026 and one from 51031 to 51036.

For instrumented spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers can be selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

If more than 50% of a vertebral body is resected (piecemeal vertebrectomy) an item from 51051 to 51059 can be selected in addition to an item from 51011 to 51015.

Items 51011 to 51015 can be used when the purpose of the laminectomy is exposure or posterior spinal release.

TN.8.143 Spinal Instrumentation (cervical, thoracic and lumbar) - Items 51020 to 51026

Items 51020 to 51026 are intended for spinal instrumentation at any level. The appropriate item is determined by the number of motion segments instrumented, barring item 51020 which applies to one vertebra.

For posterolateral spinal fusion with instrumentation, two item numbers are selected: one from 51020 to 51026 and one from 51031 to 51036. If decompression is also performed, three items are selected: one from 51011 to 51015, one from 51020 to 51026 and one from 51031 to 51036.

For instrumented spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers are selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

TN.8.144 Posterior and/or Posterolateral (intertransverse or facet joint) bone graft (cervical, thoracic and lumbar) - Items 51031 to 51036

Items 51031 to 51036 are for services which include local morcellized, artificial or harvested bone graft with or without bone morphogenic protein (BMP).

For posterolateral spinal fusion without instrumentation, if a decompression is combined with the fusion, two items numbers are selected: one from 51011 to 51015 and one from 51031 to 51036.

For posterolateral spinal fusion with instrumentation, two item numbers are selected: one from 51020 to 51026 and one from 51031 to 51036. If decompression is also performed, three items are selected: one from 51011 to 51015, one from 51020 to 51026 and one from 51031 to 51036.

For instrumental spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers are selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

TN.8.145 Anterior column fusion, with or without implant, or limited vertebrectomy (less than 50%) and anterior fusion (cervical, thoracic and lumbar) - Items 51041 to 51045

Items 51041 to 51045 are for services which include placement of local morcellized, artificial, harvested bone graft, bone morphogenic protein (BMP) and prosthetic devices into the invertebral space. Artificial bone grafting materials must be used in accordance with the manufacturer's instructions.

Items 51041 to 51045 are to be selected irrespective of surgical approach (anterior, direct lateral or posterior via open or minimally invasive techniques).

For instrumented spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers are selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

For and instrumented anterior cervical decompression and fusion, (with or without cage) three items are selected: one from 51011 to 51015, one from 51020 to 51026, and one from 51041 to 51045.

Items 51041 to 51045 cannot be claimed with any item between 51051 and 51059 if performed at the same motion segment.

If an assisting surgeon is used at any time during the procedure, then 51160 or 51165 should be used in isolation by the assisting surgeon. If the assisting surgeon needs to perform complex non-spinal surgery, they may use a more appropriate item from outside the spinal surgery schedule.

TN.8.146 Spinal Osteotomy and/or vertebrectomy - Items 51051 to 51059

Items 51051 to 51059 are intended for spinal osteotomy and/or vertebrectomy at any level.

For the purpose of items 51054, 51055 and 51056, the definition of piecemeal or subtotal excision is the removal of at least 50% of the vertebral body.

Items 51051 to 51059 cannot be claimed with any item between 51041 and 51045 if performed at the same motion segment.

TN.8.147 Anterior and Posterior (combined) Spinal fusion under one anaesthetic via separate incisions - Items 51061 to 51066

Only one of these items should be billed for any appropriate combined anterior and posterior surgeries which are completed under one anaesthetic. The appropriate item is determined by the number of motion segments to which grafting and fusion occur.

These items cannot be claimed with any item between 51020 to 51026, 51031 to 51036 and 51041 to 51045.

If a laminectomy is included, an item from 51011 to 51015 can also be used appropriate to the level of decompression.

If spinal osteotomy or vertebrectomy (>50%) is performed as part of the combined anterior/posterior approach, it is appropriate to claim one item between 51051 to 51056 in addition to an item between 51061 to 51066.

TN.8.148 Odontoid Screw fixation – Item 51103

This item is not for use when another item is claimed for the management of the odontoid fracture.

TN.8.149 Application of items 51160 and 51166

If the spine surgeon performs their own exposure to the thoracic or lumbar spine then 51160 or 51165 can be added to the claim for the overall surgery. If an assisting surgeon is used at any time during the procedure, then 51160 or 51165 should be used in isolation by the assisting surgeon. If the assisting surgeon needs to perform complex non-spinal surgery, they may use a more appropriate item but not in combination with 51160 or 51165. If an exposure surgeon claims a number from any section of the MBS schedule, the spinal surgeon cannot claim 51160 or 51165.

TN.8.150 Correction of Developmental Breast Abnormality - (Items 45060 to 45062)

Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic imaging evidence as specified in the item descriptor which demonstrates the clinical need for the service, as this may be subject to audit.

Volumetric measurement of the breasts should be performed using a technique which has been reported in a published study.

TN.8.151 Mohs surgery service caseload

Services under items 31000, 31001 and 31002 should make up at least 90% of a Mohs surgeon's caseload of items 31000-31005 annually.

TN.8.152 Colonoscopy Items (items 32222-32229)

Colonoscopy items (items 32222-32229)

It is expected that clinicians using the MBS items for colonoscopy also refer to national guidelines such as the National Health and Medical Research Council (NHMRC) Clinical Practice Guidelines for Surveillance Colonoscopy (NHMRC guidelines). For more information on clinical practice guidelines for surveillance colonoscopy see the colorectal cancer pages on the Cancer Council Australia website.

Surveillance colonoscopy should be planned based on high-quality endoscopy in a well-prepared colon using most recent and previous procedure information when histology is known. Clinicians should use their best clinical judgement to determine the interval between testing and the item that best suits the condition of the patient.

The NHMRC guidelines do not support the use of colonoscopy for patients at average or slightly above average risk of colorectal cancer who do not have symptoms or a positive faecal occult blood test (FOBT).

Items 32222-32228 specify that there is endoscopic examination to the caecum. The 'to the caecum' requirements for colonoscopy examinations do not apply to patients who have no caecum following right hemi colectomy. For these patients the examination should be to the anastomosis. Item 32084 should be billed if preparation is inadequate to allow visualisation to the caecum.

General practitioners should ensure colonoscopy referral practices align with applicable national guidelines, including the Royal Australian College of General Practitioners' guidelines for preventive activities in general practice (the red book). In addition, general practitioners are urged to recommend biennial FOBT screening to age-appropriate patients.

Colonoscopy where a polyp/polyps are removed
Items 32222-32226 and 32228 provide for diagnostic colonoscopy when claimed alone. Where a polyp or polyps are removed during the colonoscopy, item 32229 should also be claimed in association with the appropriate colonoscopy item.

Definition of previous history (items 32222-32225)
For items 32223-32225 the most appropriate item to be billed is determined by the previous history of the patient. The previous history for the purpose of these items is defined by number, size and type of adenomas removed during any previous colonoscopy.

Although with a patient with a previous history of 1-2 low risk adenomas (<10mm with no high-risk histological features) is eligible for a colonoscopy every five years under item 32223, clinical guidlines indicate that colonoscopy every 10 years is sufficient.

Definition of moderate risk of colorectal cancer due to family history (item 32223)
For item 32223 a patient is considered at moderate risk of colorectal cancer if there is moderate risk family history of colorectal cancer – defined as:
- 1 first degree relative less than 55 years of age at diagnosis; OR
- 2 first degree relatives with a history of colorectal cancer; OR
- 1 first degree relative and 2 second degree relatives with a history of colorectal cancer.

The national clinical practice guidelines support the use of FOBT as a first line test for patients with a low risk family history of colorectal cancer.

Exception item (item 32228)
Timing of colonoscopy following polypectomy should conform to the recommended surveillance intervals set out in clinical guidelines, taking into account individualised risk assessment. In the absence of reliable clinical history, clinicians should use their best clinical judgement to determine the interval between testing and the item that best suits the condition of the patient. Where the clinician is unable to access sufficient patient information to enable a colonoscopy to be performed under items 32222-32226, but in their opinion there is a clinical need for a colonoscopy, then item 32228 should be used. This item is available once per patient per lifetime.

Time intervals
Items 32223, 32224, 32225 and 32226 have time intervals for repeat colonoscopy which are consistent with guidelines. These services are payable under Medicare only when provided in accordance with the approved intervals.

Patients may fit several categories and the most appropriate fit is a matter for clinician judgement with the highest risk indicating what subsequent colonoscopy intervals are appropriate. The examples provided below show that the result of the histopathology will not lengthen the surveillance intervals (in the case of patient with familial adenomatous polyposis (FAP) or Lynch syndrome) and may actually shorten the surveillance intervals.

Example 1
A patient at high risk of colorectal cancer with FAP or Lynch syndrome has a number of polyps removed at a surveillance colonoscopy. Item 32226 and 32229 are the appropriate items to bill. If the histology result returns 1-2

adenomas for patients at low to moderate risk then the next surveillance colonoscopy is recommended in 5 years. However, the patient's familial condition means that a shorter interval (12 months) is recommended and payable.

Example 2
A patient at moderate risk of colorectal cancer because of family history has a number of polyps removed at a surveillance colonoscopy. Item 32223 and 32229 are the appropriate items to bill based on the patient's family history. If the histology testing returns showing an adenoma with high-risk histological features then the next surveillance colonoscopy is recommended in 3 years instead of 5 years.

How to use the items with new patients who have undergone previous colonoscopy

Patients whose care continues within one practice should have the relevant history readily available to guide decision making. For new patients, practitioners should make reasonable efforts to establish a patient's previous colonoscopy history. This includes seeking information from My Health Record, the records department of the hospital where the previous procedure occurred, the GP or the patient. The patients' MBS claims history for colonoscopy services will also assist with this.

For audit purposes it is important to record the most appropriate item. In accordance with good practice, clinicians are required to maintain records that include pathology results which must be made available to the patient or other practitioners as required.

The Australian Commission on Safety and Quality in Health Care's Colonoscopy Clinical Care Standard states all facilities and clinicians delivering colonoscopy services must provide a timely copy of the colonoscopy report and histology result to the patient and their GPs. Compliance with the Colonoscopy Clinical Care Standard is mandatory under the Australian Health Service Safety and Quality Accreditation Scheme.

Patient eligibility for colonoscopy services
The Department of Human Services (DHS) will be able to confirm whether a colonoscopy service has been claimed by an individual patient and the date of service. It will also be able to confirm any restriction on the frequency of the item claimed which would prevent a rebate from being paid if the service was provided again within the restricted period. Patients can seek clarification from the DHS by calling 132 011.

Patients can also access their own claiming history with a My Health Record or by establishing a Medicare online account through myGov or the Express Plus Medicare mobile app.

Further information about these services can be found on the Department of Human Services website.

Practitioners providing colonoscopy services can call Medicare on **132 150** to check the patient's claiming history. The patient's Medicare card number will be required together with the range of item numbers to be checked. For example, the new item numbers for colonoscopy services are in the range 32222-32229. The operator will interrogate the patient's claiming history and provide advice on any claims paid for a colonoscopy service within the range of items specified and the date of the service.

All patients who require a colonoscopy will be eligible for a service. However, MBS rebates will not be payable for services which do not meet the clinical indications and the item requirements for a colonoscopy or a repeat colonoscopy where the interval is specified in the item. Practitioners should ensure that their practice conforms to the approved clinical guidelines.

TN.9.1 Assistance at Operations - (Items 51300 to 51318)

Items covering operations which are eligible for benefits for surgical assistance have been identified by the inclusion of the word "Assist." in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

The assistance must be rendered by a medical practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.

Where more than one practitioner provides assistance to a surgeon no additional benefits are payable. The assistance benefit payable is the same irrespective of the number of practitioners providing surgical assistance.

NOTE: The Benefit in respect of assistance at an operation is not payable unless the assistance is rendered by a medical practitioner other than the anaesthetist or assistant anaesthetist. The amount specified is the amount payable whether the assistance is rendered by one or more medical practitioners.

Assistance at Multiple Operations

Where surgical assistance is provided at two or more operations performed on a patient on the one occasion the multiple operation formula is applied to all the operations to determine the surgeon's fee for Medicare benefits purposes. The multiple-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for surgical assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Item 51300 or 51303).

Multiple Operation Rule - Surgeon	Multiple Operation Rule - Assistant
Item A - $300@100%	Item A (Assist.) - $300@100%
Item B - $250@50%	Item B (No Assist.)
Item C - $200@25%	Item C (Assist.) - $200@50%
Item D - $150@25%	Item D (Assist.) - $150@25%

The derived fee applicable to Item 51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery which attracts an assistance rebate.

Surgeons Operating Independently

Where two surgeons operate independently (ie neither assists the other or administers the anaesthetic) the procedures they perform are considered as two separate operations, and therefore, where a surgical assistant is engaged by each, or one of the surgeons, benefits for surgical assistance are payable in the same manner as if the surgeons were operating separately.

TN.9.2 Benefits Payable under Item 51300

Medicare benefits are payable under item 51300 for assistance rendered at any operation identified by the word "Assist." for which the fee does not exceed the fee threshold specified in the item descriptor, or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee threshold specified in the item descriptor has not been exceeded.

TN.9.3 Benefits Payable Under Item 51303

Medicare benefits are payable under item 51303 for assistance rendered at any operation identified by the word "Assist." for which the fee exceeds the fee threshold specified in the item descriptor or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee exceeds the threshold specified in the item descriptor.

TN.9.4 Benefits Payable Under Item 51309

Medicare benefits are payable under item 51309 for assistance rendered at any operation identified by the word "Assist." or a series or combination of operations identified by the word "Assist." and assistance at a birth involving Caesarean section.

Where assistance is provided at a Caesarean section birth and at a procedure or procedures which have not been identified by the word "Assist.", benefits are payable under item 51306.

TN.9.5 Assistance at Cataract and Intraocular Lens Surgery - (Item 51318)

The reference to "previous significant surgical complication" covers vitreous loss, rupture of posterior capsule, loss of nuclear material into the vitreous, intraocular haemorrhage, intraocular infection (endophthalmitis), cystoid macular oedema, corneal decompensation or retinal detachment.

TN.10.1 Relative Value Guide For Anaesthetics - (Group T10)

Overview of the RVG

The RVG groups anaesthesia services within anatomical regions. These items are listed in the MBS under Group T10, Subgroups 1-16 Anaesthesia for radiological and other therapeutic and diagnostic services are grouped separately under Subgroup 17. Also included in the RVG format are certain additional monitoring and therapeutic services, such as blood pressure monitoring (item 22012) and central vein catheterisation (item 22020) when performed in association with the administration of anaesthesia. These services are listed at subgroup 19. The RVG also provides for assistance at anaesthesia under certain circumstances. These items are listed at subgroup 26.

Details of the billing requirements for the RVG are available from the Department of Human Services website.

The RVG is based on an anaesthesia unit system reflecting the complexity of the service and the total time taken for the service. Each unit has been assigned a dollar value.

Under the RVG, the MBS fee for anaesthesia in connection with a procedure is comprised of up to three components:

1. The basic units allocated to each anaesthetic procedure, reflecting the complexity of the procedure (an item in the range 20100-21997);

2. The time unit allocation reflecting the total time of the anaesthesia (an item in the range 23010-24136); and

3. Where appropriate, modifying units recognising certain added complexities in anaesthesia (an item/s in the range 25000-25020).

Assistance at anaesthesia

To establish the fee for the assistant service items 25200 and 25205, both services have 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 determine the MBS fee.

Whole body perfusion

Where whole body perfusion is performed, the MBS fee is determined by adding together the following:

1. The base units allocated to the service (item 22060);

2. The time unit allocation reflecting the total time of the perfusion (an item in the range 23010 - 24136); and

3. Where appropriate, modifying units recognising certain added complexities in perfusion (an item/s in the range 25000 – 25020).

TN.10.2 Eligible Services

Generally, a Medicare benefit is only payable for anaesthesia which is performed in connection with an "eligible" service. An "eligible" service is defined as a clinically relevant professional service which is listed in the Schedule and which has been identified as attracting an anaesthetic fee**.**

TN.10.3 RVG Unit Values

Basic Units

The RVG basic unit allocation represents the complexity of the anaesthetic procedure relative to the anatomical site and physiological impact of the surgery.

Time Units

The number of time units is calculated from the total time of the anaesthesia service, the assistant at anaesthesia service or the whole body perfusion service:

i. *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;

h. *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

ii. *for perfusion*, perfusion time begins with the commencement of anaesthesia and finishes with the closure of the chest.

For up to and including the first - 2 hours of time, each 15 minutes (or part thereof) constitutes 1 time unit. For time beyond 2 hours, each time unit equates to 10 minutes (or part thereof).

Modifying Units (25000 - 25050)

Modifying units have been included in the RVG to recognise added complexities in anaesthesia or perfusion, associated with the patient's age, physical status or the requirement for emergency surgery. These cover the following clinical situations:

ASA physical status indicator 3 - A patient with severe systemic disease that significantly limits activity (item 25000). This would include: severely limiting heart disease; severe diabetes with vascular complications or moderate to severe degrees of pulmonary insufficiency.

Some examples of clinical situations to which ASA 3 would apply are:

ii. a patient with ischaemic heart disease such that they encounter angina frequently on exertion thus significantly limiting activities;

g. a patient with chronic airflow limitation who gets short of breath such that the patient cannot complete one flight of stairs without pausing;

ii. a patient who has suffered a stroke and is left with a residual neurological deficit to the extent that is significantly limits normal activity, such as hemiparesis; or

ii. a patient who has renal failure requiring regular dialysis.

ASA physical status indicator 4 - A patient with severe systemic disease which is a constant threat to life (item 25005). This covers patients with severe systemic disorders that are already life-threatening, not always correctable by an operation. This would include: patients with heart disease showing marked signs of cardiac failure; persistent angina or advanced degrees of pulmonary, hepatic, renal or endocrine insufficiency.

ASA physical status indicator 4 would be characterised by the following clinical examples:

c. a person with coronary disease such that they get angina daily on minimum exertion thus severely curtailing their normal activities;

j. a person with end stage emphysema who is breathless on minimum exertion such as brushing their hair or walking less than 20 metres; or

e. a person with severe diabetes which affects multiple organ systems where they may have one or more of the following examples:

iii. severe visual impairment or significant peripheral vascular disease such that they may get intermittent claudication on walking less than 20 metres; or

iii. severe coronary artery disease such that they suffer from cardiac failure and/or angina whereby they are limited to minimal activity.

ASA physical status indicator 5 - a moribund patient who is not expected to survive for 24 hours with or without the operation (item 25010). This would include: a burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure or massive pulmonary embolus.

The following are some examples that would equate to ASA physical status indicator 5

iii. a burst abdominal aneurysm with profound shock;

g. major cerebral trauma with increasing intracranial pressure; or

f. massive pulmonary embolus.

NOTE: It should be noted that the Medicare Benefits Schedule does NOT include modifying units for patients assessed as ASA physical status indicator 2. Some examples of ASA 2 would include:

i. A patient with controlled hypertension which has no affect on the patient's normal lifestyle;

c. A patient with coronary artery disease that results in angina occurring on substantial exertion but not limiting normal activity; or

c. A patient with insulin dependant diabetes which is well controlled and has minimal effect on normal lifestyle.

c. Where the patient is less than 4 years of age or 75 years or greater (item 25015).

c. For anaesthesia, assistance at anaesthesia or a perfusion service in association with an *emergency procedure (item 25020).

h. For anaesthesia or assistance at anaesthesia in association with an *after hours emergency procedure (items 25025 and 25030).

i. For a perfusion service in association with *after hours emergency surgery (item 25050).

*** NOTE:** It should be noted that the emergency modifier and the after hours emergency modifiers cannot both be claimed in the one anaesthesia assistance at anaesthesia or perfusion episode.

It should also be noted that modifiers are not stand alone services and can only be claimed in association with anaesthesia, assistance at anaesthesia or with a perfusion service covered by item 22060.

Definition of Emergency

For the purposes of both the emergency modifier and the after hours emergency modifiers, emergency is defined as existing where the patient requires immediate treatment without which there would be significant threat to life or body part.

Definition of After Hours

For the purposes of the after hours emergency modifier items, the after hours period is defined as being the period from 8pm to 8am on any weekday or at any time on a Saturday, a Sunday or a public holiday. Benefit for the After Hours Emergency Modifiers is only payable where more than 50% of the time for the emergency anaesthesia, the assistance at emergency anaesthesia or the perfusion service is provided in the after hours period. In situations where less than the 50% of the time for the service falls in the after hours period, the emergency modifier rather than the after hours emergency modifier applies. For information about deriving the fee for the service where the after hours emergency modifier applies.

TN.10.4 Deriving the Schedule Fee under the RVG

The Schedule fee for each component of anaesthesia (base items, time items and modifier items) in the RVG Schedule is derived by applying the unit value to the total number of anaesthesia units for each component. For example:

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE (Units x $20.10)
20840	Anaesthesia for resection of perforated bowel	6	$120.60
23200	Time - 4 hours 40 minutes	24	$482.40
25000	Modifier - Physical status	1	$20.10
22012	Central Venous Pressure Monitoring	3	$60.30
	TOTAL	**34**	**$683.40**

After Hours Emergency Services

When deriving the fee for the after hours emergency modifier for anaesthesia or assistance at anaesthesia, the 50% loading applies to the anaesthesia or assistance service from Group T10 and to any additional clinically relevant therapeutic or diagnostic service from Group T10, Subgroup 18, provided during the anaesthesia episode. For example:

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE (Units x $20.10)
20840	Anaesthesia for resection of perforated bowel	6	$120.60
23200	Time - 4 hours 40 minutes	24	$482.40
25000	Modifier - Physical status	1	$20.10
22012	Central Venous Pressure Monitoring	3	$60.30
	TOTAL	**34**	**Schedule fee = $683.40**
25025	Anaesthesia After Hours Emergency Modifier		Schedule Fee $683.40 x **50%** = $341.70

Definition of Radical Surgery for the RVG

Where the term radical appears in an item description, it refers to an extensive surgical procedure, performed for the treatment of malignancy. It usually denotes extensive block dissection not only of the malignant tissue, but also of the surrounding tissue, particularly fat and lymphatic drainage systems. See notes T10.18 and T10.22 which clarify the definitions of the words "extensive" and "radical" used in items 20192 and 20474.

Multiple Anaesthesia Services

Where anaesthesia is provided for services covered by multiple items in the RVG, Medicare benefit is only payable for the RVG item with the highest basic unit value. However, the time component should include the total anaesthesia time taken for all services. For example:

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE
20790	Anaesthesia for open Cholecystectomy	8	$160.80
20752	Incisional Hernia	6	(lower value than 20790 = 20752 schedule fee not payable) $120.60
23111	Time - 2hrs 30mins	11	$221.10
25015	Physical Status - Over 75	1	$20.10
	TOTAL	**20**	**$402.00**

Prolonged Anaesthesia

Under the RVG, the previous rules that related to prolonged anaesthesia no longer apply. Where anaesthesia is prolonged beyond that which an anaesthetist would normally encounter for a particular service, the RVG provides for the anaesthetist to claim the total anaesthesia time for the procedure/s.

TN.10.5 Minimum Requirements for Claiming Benefits under Items in the RVG (including sedation)

Medicare benefits for RVG services (including sedation) are only payable where both the staffing and the facility in which the service was rendered meets the following minimum guidelines. These guidelines are based on protocols established by the Australian and New Zealand College of Anaesthetists.

Staffing

- Techniques intended to produce loss of consciousness must not be used unless an anaesthetist is present to care exclusively for the patient;
- Where the patient is a young child, is elderly or has any serious medical condition (such as significant cardio-respiratory disease or danger of airway compromise), an anaesthetist should be present to administer sedation and monitor the patient;
- In all other cases, an appropriately trained medical practitioner, other than the proceduralist, is required to be in exclusive attendance on the patient during the procedure, to administer sedation and to monitor the patient; and
- There must be sufficient equipment (including oxygen, suction and appropriate medication), to enable resuscitation should it become necessary.

Facilities

The procedure must be performed in a location which is adequate in size and staffed and equipped to deal with a cardiopulmonary emergency. This must include:

- An operating table, trolley or chair which can be readily tilted;
- Adequate uncluttered floor space to perform resuscitation, should this become necessary;
- Adequate suction and room lighting;
- A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient;
- A self inflating bag suitable for artificial ventilation together with a range of equipment for advance airway management;
- Appropriate drugs for cardiopulmonary resuscitation;
- A pulse oximeter; and
- Ready access to a defibrillator.

These requirements apply equally to dental anaesthesia or sedation services provided under items in Group T10, Subgroup 20 of the RVG.

TN.10.6 Account Requirements

Before a benefit will be paid for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of details additional to those set out in the General Explanatory Notes of the Medicare Benefits Schedule are required on the anaesthetist's account:

- **the anaesthetist's account** must show the name/s of the medical practitioner/s who performed the associated operation/s. In addition, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and total time of the anaesthetic.
- **the assistant anaesthetist's account** must show the names/s of the medical practitioners who performed the associated operation/s, as well as the name of the principal anaesthetist. In addition, where the after hours emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthetic.
- **the perfusionist's account** must record the start time, end time and total time of the perfusion service where the after hours emergency modifier is claimed.

TN.10.7 General Information

The Health Insurance Act provides that where anaesthesia is administered to a patient, the premedication of the patient in preparation for anaesthesia is deemed to form part of the administration of anaesthesia. The administration of anaesthesia also includes the pre-anaesthesia consultation with the patient in preparation for that administration, except where such consultation entails a separate attendance carried out at a place other than an operating theatre or an anaesthesia induction room. The pre-anaesthesia consultation for a patient should be performed in association with a clinically relevant service.

Except in special circumstances, benefit is not payable for the administration of anaesthesia listed in Subgroups 1-18, unless the anaesthesia is administered by a medical practitioner other than the medical practitioner who renders the medical service in connection with which anaesthesia is administered.

Fees and benefits for anaesthesia services under the RVG cover all essential components in the administration of the anaesthesia service. Separate benefit may be attracted, however, for complementary services such as central venous pressure and direct arterial pressure monitoring (see note T10.8).

It should be noted that additional benefit is not payable for intravenous infusion or electrocardiographic monitoring, provision for which has been made in the value determined for the anaesthetic units.

The Medicare benefit derived under the RVG for the administration of anaesthesia is the benefit payable for that service irrespective of whether one or more than one medical practitioner administers it. However, benefit is provided under Subgroup 26 for the services of one assistant anaesthetist (who must not be either the surgeon or assistant surgeon (see Note 10.9)

Where a regional nerve block or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block is assessed as an anaesthesia item according to the advice in paragraph TN.7.1. When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.

When a regional nerve block or field nerve block covered by an item in Group T7 of the Schedule is administered by a medical practitioner in the course of a surgical procedure undertaken by the same medical practitioner, then such a block will attract benefit under the appropriate item in Group T7.

It should be noted that where a procedure is carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure and an additional benefit is therefore not payable.

It may happen that the professional service for which the anaesthesia is administered does not itself attract a benefit because it is part of the after-care of an operation. This does not, however, affect the benefit payable for the

anaesthesia service. Benefit is payable for anaesthesia administered in connection with such a professional service (or combination of services) even though no benefit is payable for the associated professional service.

The administration of epidural anaesthesia during labour is covered by items 18216 or 18219 (18226 and 18227 for afer hours) 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.

For the purposes of items 18216 and 18226, one attendance means that the medical practitioner cannot claim either of these items if the additional attendance is to optimise the initial treatment. Optimise means extension or improvement in analgesic quality of an existing block, without the insertion of a new block as a separate procedure.

TN.10.8 Additional Services Performed in Connection with Anaesthesia - Subgroup 19

Included in the RVG format are a number of additional or complimentary services which may be provided in connection with anaesthesia such as blood pressure monitoring (item 22012) and intra-arterial cannulation (item 22025).

These items (with the exception of peri-operative nerve blocks (22031-22042)) and perfusion services (22055-22075) have also been retained in the MBS in the non-RVG format, for use by practitioners who provide these services other than in association with anaesthesia.

Where an anaesthetist provides an additional (clinically relevant) service during anaesthesia that is not one listed in Subgroup 19 (excluding intravenous infusion or electrocardiographic monitoring) the relevant non-RVG item should be claimed.

Items 22012 and 22014

Benefits are payable under items 22012 and 22014 only once for each type of pressure, up to a maximum of 4 pressures per patient per calendar day, and irrespective of the number of practitioners involved in monitoring the pressures.

Items 22012, 22014 and 22025

A patient who is categorised as having a high risk of complications is one where clinical indications allow for the following items to be claimed (in conjunction with items 22012, 22014 and 22025) with item 25000, item 25005 or item 25010 modifiers, and/or item 25015, and/or items 25020, 25025 and/or when the basic surgical item value is 10 or more units, and/or is conjunction with items in group T10 Subgroup 13 (Shoulder and Axilla), or with items 23170 – 24136 (for procedures of greater than four hours duration) noting this is not an exhaustive list.

Item 22042

This item can be co-claimed with item 20142 (anaesthesia for lens surgery), when anaesthesia or sedation was also provided by the same anaesthetist.

Item 22042 cannot be co-claimed with item 20142, 20144, 20145 and 20147 when a general anaesthetic is the primary anaesthetic approach.

TN.10.9 Assistance in the Administration of Anaesthesia

The RVG provides for a separate benefit to be paid for the services of an assistant anaesthetist in connection with an operation or series of operations in specified circumstances, as outlined below. This benefit is payable only in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

Therapeutic and Diagnostic services covered by Subgroup 19 items (such as blood transfusion, pressure monitoring, insertion of CVC, etc) are payable only once per patient per anaesthetic episode. Where these services are provided by the assistant anaesthetist these services are eligible for Medicare benefits only where the same service is not also claimed by the primary anaesthetist.

Assistance at anaesthesia in connection with emergency treatment (Item 25200)

Item 25200 provides for assistance at anaesthesia where the patient is in imminent danger of death. Situations where imminent danger of death requiring an assistant anaesthetist might arise include: complex airway problems, anaphylaxis or allergic reactions, malignant hyperpyrexia, neonatal and complicated paediatric anaesthesia, massive blood loss and subsequent resuscitation, intra-operative cardiac arrest, critically ill patients from intensive care units or inability to wean critically ill patients from pulmonary bypass.

Assistance in the administration of elective anaesthesia (Item 25205)

A separate benefit is payable under Item 25205 for the services of an assistant anaesthetist in connection with elective anaesthesia in the circumstances outlined in the item descriptor. This benefit is only payable in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

For the purposes of Item 25205, a 'complex paediatric case' involves one or more of the following:

c. the need for invasive monitoring (intravascular or transoesophageal); or
d. organ transplantation; or
e. craniofacial surgery; or
f. major tumour resection; or
g. separation of conjoint twins.

TN.10.10 Perfusion Services - (Items 22055 to 22075)

Perfusion services covered by items 22055-22075 have been included in the RVG format.

As with anaesthesia, where whole body perfusion is performed, the Schedule fee is determined on the base units allocated to the service (item 22060), the total time for the perfusion, and modifying units, as appropriate, i.e.

(a) the basic units allocated to whole body perfusion under item 22060:

22060	**WHOLE BODY PERFUSION, CARDIAC BYPASS**, where the heart-lung machine or equivalent is continuously operated by a medical perfusionist, other than a service associated with anaesthesia to which an item in Subgroup 21 applies. (20 basic units) *(See para TN.10.10 of explanatory notes to this Category)*

(b) plus, the time unit allocation reflecting the total time of the perfusion (an item in the range 23010 - 24136), for example:

23170	4:01 HOURS TO 4:10 HOURS (21 basic units)

plus, where appropriate

(c) modifying units recognising certain added complexities in perfusion (an item/s in the range 25000 - 25020), for example:

25015	Anaesthesia, perfusion or assistance in the management of anaesthesia, for a patient less than 4 years or 75 years or older (1 basic unit)

The time component for item 22060 is defined as beginning with the commencement of anaesthesia and finishing with the closure of the chest.

Item 22065 may only be used in association with item 22060.

Medicare benefits are not payable for perfusion unless the perfusion is performed by a medical practitioner other than the medical practitioner who renders the associated service in Group T8 or the medical practitioner who administers the anaesthesia listed in the RVG in Group T10.

The medical practitioner providing the service must comply with the training requirements in the Australian and New Zealand College of Anaesthetists *Guidelines for Major Extracorporeal Perfusion* (PS27).

Benefits are not payable if another person primarily and/or continuously operates the Heart Lung Machine.

TN.10.12 Discontinued Procedure - (Item 21990)

Item 21990 applies when a patient has been anaesthetised but the proposed procedure has been abandoned prior to surgery commencing.

Claims should include notation of the surgery or procedure which had been proposed.

Under the Health Insurance Act 1973 the Chief Executive Medicare does not require claims for this item to be accompanied by details of the proposed surgery and the reasons why the operation was discontinued. However, practitioners must maintain a clinical record of this information, which may be subject to audit.

TN.10.13 Anaesthesia in Connection with a Procedure not Identified as Attracting a Medicare Benefit for Anaesthesia - (Item 21997)

Payment of benefit for Item 21997 is not restricted to the service being performed in connection with a surgical service in Group T8. Item 21997 may be performed with any item in the Medicare Benefits Schedule that has not been identified as attracting a Medicare benefit for anaesthesia (including attendances) in circumstances where anaesthesia is considered clinically necessary.

TN.10.14 Anaesthesia in Connection with a Dental Service - (Items 22900 and 22905)

Items 22900 and 22905 cover the administration of anaesthesia in connection with a dental service that is not a service covered by an item in the Medicare Benefits Schedule i.e removal of teeth and restorative dental work. Therefore, the requirement that anaesthesia be performed in association with an 'eligible' service (as defined in point T10.2) does not apply to dental anaesthesia items 22900 and 22905.

TN.10.15 Anaesthesia in Connection with Cleft Lip and Cleft Palate Repair - (Items 20102 and 20172)

Anaesthesia associated with cleft lip and cleft palate repair is covered in Subgroup 1 of the RVG Schedule, under items 20102 and 20172.

TN.10.16 Anaesthesia in Connection with an Oral and Maxillofacial Service - (Category 4 of the Medicare Benefits Schedule)

Benefit for anaesthesia provided by a medical practitioner in association with an Oral and Maxillofacial service (Category 4 of the Medicare Benefits Schedule) is derived using the RVG. Benefit for anaesthesia for oral and maxillofacial services should be claimed under the appropriate RVG item from Subgroup 1 or 2.

TN.10.17 Nerve or Plexus Blocks for Post Operative Pain - (Items 22031 to 22041)

Items 22031 to 22041

Benefits are only payable for intra-operative nerve or plexus blocks performed for the management of post-operative pain that are specifically catered for under items 22031 to 22041.

Items 22031 and 22036
For items 22031 and 22036, postoperative pain management means that the injected therapeutic substance is expected to prolong the analgesic effect of the epidural or intrathecal technique.

Item 22031 (initial intrathecal or epidural injection)
Benefits are payable under item 22031 for the initial intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, for the control of post-operative pain. Benefit is not payable for subsequent intra-operative intrathecal and epidural injection (item 22036) in the same anaesthetic episode. Where subsequent infusion is provided post operatively, to maintain analgesia, benefit would be payable under items 18222 or 18225.

Item 22036 (subsequent intrathecal or epidural injection)
Benefits are payable under item 22036 for subsequent intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, performed intra-operatively, for postoperative pain management, where the catheter is already in-situ. Benefits are not payable under this item where the initial injection was performed intra-operatively, under item 22031, in the same anaesthetic episode.

Item 22041 (plexus or nerve block)
Benefits are payable under item 22041 in addition to the general anaesthesia for the related procedure.

TN.10.18 Anaesthesia in Connection with Extensive Surgery on Facial Bones - (Item 20192)
The term 'extensive' in relation to this item is defined as major facial bone surgery or reconstruction including major resection or osteotomies or osteectomies of mandibles and/or maxillae, surgery for prognathism or surgery for Le Fort II or III fractures.

TN.10.22 Anaesthesia for Radical Procedures on the Chest Wall - (Item 20474)
Radical procedures on the chest wall referred to in item 20474 would include procedures such as pectus excavatum.

TN.10.23 Anaesthesia for Extensive Spine or Spinal Cord Procedures - (Item 20670)
This item covers major spinal surgery involving multiple levels of the spinal cord and spinal fusion where performed. Procedures covered under this item would include the Harrington Rod technique. Surgery on individual spinal levels would be covered under items 20600, 20620 and 20630.

TN.10.24 Anaesthesia for Femoral Artery Embolectomy - (Item 21274)
Item 21274 covers anaesthesia for femoral artery embolectomy. Grafts involving intra-abdominal vessels would be covered under item 20880.

TN.10.25 Anaesthesia for Cardiac Catheterisation - (Item 21941)
Item 21941 does not include either central vein catheterisation or insertion of right heart balloon catheter. Anaesthesia for these procedures is covered under item 21943.

TN.10.26 Anaesthesia for 2 Dimensional Real Time Transoesophageal Echocardiography - (Item 21936)
Benefits are payable for anaesthesia in connection with 2 dimensional real time transoesophageal echocardiography, (including intra-operative echocardiography) which includes doppler techniques, real time colour flow mapping and recording onto video tape or digital medium.

TN.10.27 Anaesthesia for Services on the Upper and Lower Abdomen - (Subgroups 6 and 7)
Establishing whether an RVG anaesthetic item pertains to the upper or lower abdomen, depends on whether the majority of the associated surgery was performed in the region above or below the umbilicus.

Some examples of upper abdomen would be:

c. laparoscopy on upper abdominal viscera;
d. laparoscopy with operative focus superior to the umbilical port;
e. surgery to the liver, gallbladder and ducts, stomach, pancreas, small bowel to DJ flexure;
f. the kidneys in their normal location (as opposed to pelvic kidney); or
g. spleen or bowel (where it involves a diaphragmatic hernia or adhesions to gallbladder bed).

Some examples of lower abdomen would be:

x. abdominal wall below the umbilicus;
xi. laparoscopy on lower abdominal viscera;
xii. laparoscopy with operative focus inferior to the umbilical port;
xiii. surgery on the jejunum, ileum, or colon;
xiv. surgery on the appendix; or
xv. surgery associated with the female reproductive system.

TN.10.28 Anaesthesia for Microvascular Free Tissue Flap Surgery - (Items 20230, 20355, 20475, 20704, 20804, 20905, 21155, 21275, 21455, 21535, 21685, 21785 and 21865)

Benefits are only payable where complete free tissue flap surgery is undertaken involving microsurgical arterial and venous anastomoses. Benefits do not apply for microsurgical rotation flaps or for re-implementation of digits or either the hand or the foot.

TN.10.29 Anaesthesia for Endoscopic Ureteric Surgery - Including Laser Procedure - (Item 20911)

Benefits are not payable under item 20911 for diagnostic ureteroscopy.

TN.10.30 Credentialing for peri-operative cardiac ultrasound services (22051)

Item 22051 should be performed by a provider who is appropriately credentialed to provide the particular service, by a recognised body for the credentialing of peri-operative cardiac ultrasound services. Credentialing must be based on criteria consistent with those recommended by the Australian and New Zealand College of Anaesthetists in the current version of their Professional Document PS46 "Guidelines on Training and Practice of Perioperative Cardiac Ultrasound in Adults.

TN.11.1 Botulinum Toxin - (Items 18350 to 18379)

The Therapeutic Goods Administration (TGA) assesses each indication for the therapeutic use of botulinum toxin on an individual basis. There are currently three botulinum toxin agents with TGA registration (Botox®, Dysport® and Xeomin®). Each has undergone a separate evaluation of its safety and efficacy by the TGA as they are neither bioequivalent, nor dose equivalent. When claiming under an item for the injection of botulinum toxin, only the botulinum toxin agent specified in the item can be used. Benefits are not payable where an agent other than that specified in the item is used.

The TGA assesses each indication for the therapeutic use of botulinum toxin by assessment of clinical evidence for its use in paediatric or adult patients. Where an indication has been assessed for adult use, data has generally been assessed using patients over 12 years of age. Paediatric indications have been assessed using data from patients under 18 years of age. Botulinum toxin should only be administered to patients under the age of 18 where an item is for a paediatric indication, and patients over 12 years of age where the item is for an adult indication, unless otherwise specified.

Items for the administration of botulinum toxin can only be claimed by a medical practitioner who is recognised as an eligible medical practitioner for the relevant indication under the arrangements under Section 100 of the *National Health Act 1953* (the Act) relating to the use and supply of botulinum toxin. The specialist qualifications required to administer botulinum toxin vary across the indications for which the medicine is listed on the PBS, and are detailed within the relevant PBS restrictions available at: www.pbs.gov.au/browse/section100-mf

Item 18354 for the treatment of equinus, equinovarus or equinovalgus is limited to a maximum of 4 injections per patient on any day (2 per limb). Accounts should be annotated with the limb which has been treated. Item 18292 may not be claimed for the injection of botulinum toxin, but may be claimed where a neurolytic agent (such as phenol) is used, in addition to botulinum toxin injection(s), to treat the obturator nerve in patients with a dynamic foot deformity.

Treatment under item 18375 or 18379 can only continue if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline from the start of week 6 through to the end of week 12 after the first treatment. The term 'continue' means the patient can be retreated under item 18375 or 18379 at some point after the 12 week period (for example; 6 to 12 months after the first treatment). This requirement is in line with the PBS listing for the supply of the medicine for this indication under Section 100 of the *Act*.

Item 18362 for the treatment of severe primary axillary hyperhidrosis allows for a maximum number of 3 treatments per patient in a 12 month period, with no less than 4 months to elapse between treatments.

Botulinum toxin which is not supplied and administered in accordance with the arrangements under Section 100 of the *Act* is not required to be provided free of charge to patients. Where a charge is made for the botulinum toxin administered, it must be separately listed on the account and not billed to Medicare. Since 1 September 2015, PBS patient co-payments have applied to botulinum toxin supplied and administered in accordance with the arrangements under Section 100 of the Act.

The Department of Human Services (DHS) has developed a Health Practitioner Guideline to substantiate that a patient had a pre-existing condition at the time of the service which is located on the DHS website.

TR.8.1 Mechanical thrombectomy - (Item 35414)

For the purposes of this item, ***eligible stroke centre*** means a facility that:

(a) has a designated stroke unit;

(b) is equipped and has staff available or on call so that it is capable of providing the following to a patient on a 24-hour basis:

> (i) the services of a specialist or consultant physician who has the training required under paragraph (b) of item 35414;
>
> (ii) diagnostic imaging services using advanced imaging techniques, which must include computed tomography, computed tomography angiography, digital subtraction angiography, magnetic resonance imaging, and magnetic resonance angiography; and
>
> (iii) care from a team of health practitioners which includes a stroke physician, a neurologist, a neurosurgeon, a radiologist, an anaesthetist, an intensive care unit specialist, a medical imaging technologist, and a nurse;

(c) has dedicated endovascular angiography facilities; and

(d) has written procedures for assessing and treating patients who have, or may have, experienced a stroke.

Note: A health practitioner may fulfil the role of more than one of the types of health practitioner specified in paragraph (b)(iii). For example, a neurologist may also be a stroke physician.

Conjoint Committee for Recognition of Training in Interventional Neuroradiology (CCINR)

CCINR comprises representatives from the Australian and New Zealand Society of Neuroradiology (ANZSNR), the Neurosurgical Society of Australasia (NSA) and the Australian and New Zealand Association of Neurologists (ANZAN). For the purposes of this item, specialists or consultant physicians performing this procedure must have training recognised by CCINR, and the Department of Human Services notified of that recognition.

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	1. HYPERBARIC OXYGEN THERAPY
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 1. Hyperbaric Oxygen Therapy
13015	HYPERBARIC, OXYGEN THERAPY, for treatment of localised non-neurological soft tissue radiation injuries excluding radiation-induced soft tissue lymphoedema of the arm after treatment for breast cancer, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance. (See para TN.1.1 of explanatory notes to this Category) **Fee:** $258.85 **Benefit:** 75% = $194.15 85% = $220.05
13020	HYPERBARIC OXYGEN THERAPY, for treatment of decompression illness, gas gangrene, air or gas embolism; diabetic wounds including diabetic gangrene and diabetic foot ulcers; necrotising soft tissue infections including necrotising fasciitis or Fournier's gangrene; or for the prevention and treatment of osteoradionecrosis, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance (See para TN.1.1 of explanatory notes to this Category) **Fee:** $263.00 **Benefit:** 75% = $197.25 85% = $223.55
13025	HYPERBARIC OXYGEN THERAPY for treatment of decompression illness, air or gas embolism, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber greater than 3 hours, including any associated attendance - per hour (or part of an hour) (See para TN.1.1 of explanatory notes to this Category) **Fee:** $117.55 **Benefit:** 75% = $88.20 85% = $99.95
13030	HYPERBARIC OXYGEN THERAPY performed in a comprehensive hyperbaric medicine facility where the medical practitioner is pressurised in the hyperbaric chamber for the purpose of providing continuous life saving emergency treatment, including any associated attendance - per hour (or part of an hour) (See para TN.1.1 of explanatory notes to this Category) **Fee:** $166.05 **Benefit:** 75% = $124.55 85% = $141.15

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	2. DIALYSIS
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 2. Dialysis
13100	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in 1 day (See para TN.1.2 of explanatory notes to this Category) **Fee:** $138.85 **Benefit:** 75% = $104.15 85% = $118.05
13103	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance

	time on the patient by the supervising medical specialist does not exceed 45 minutes in 1 day (See para TN.1.2 of explanatory notes to this Category) **Fee:** $72.35 **Benefit:** 75% = $54.30 85% = $61.50
13104	Planning and management of home dialysis (either haemodialysis or peritoneal dialysis), by a consultant physician in the practice of his or her specialty of renal medicine, for a patient with end-stage renal disease, and supervision of that patient on self-administered dialysis, to a maximum of 12 claims per year (See para TN.1.3, TN.1.23 of explanatory notes to this Category) **Fee:** $150.30 **Benefit:** 85% = $127.80
13105	Haemodialysis for a patient with end-stage renal disease if: (a) the service is provided by a registered nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner; and (b) the service is supervised by the medical practitioner (either in person or remotely); and (c) the patient's care is managed by a nephrologist; and (d) the patient is treated or reviewed by the nephrologist every 3 to 6 months (either in person or remotely); and (e) the patient is not an admitted patient of a hospital; and (f) the service is provided in a Modified Monash 7 area **Fee:** $601.45 **Benefit:** 100% = $601.45
13106	DECLOTTING OF AN ARTERIOVENOUS SHUNT **Fee:** $123.30 **Benefit:** 75% = $92.50 85% = $104.85
13109	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS INSERTION AND FIXATION OF (Anaes.) **Fee:** $231.40 **Benefit:** 75% = $173.55 85% = $196.70
13110	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS , removal of (including catheter cuffs) (Anaes.) **Fee:** $232.15 **Benefit:** 75% = $174.15 85% = $197.35

	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 3. Assisted Reproductive Services
13200	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE PROCEEDING TO OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13201, 13202, 13203, 13206, 13218 applies - being services rendered during 1 treatment cycle - INITIAL cycle in a single

	calendar year (See para TN.1.4 of explanatory notes to this Category) **Fee:** $3,160.50 **Benefit:** 75% = $2370.40 85% = $3075.80 **Extended Medicare Safety Net Cap:** $1,675.50
13201	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE PROCEEDING TO OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13200, 13202, 13203, 13206, 13218 applies - being services rendered during 1 treatment cycle - each cycle SUBSEQUENT to the first in a single calendar year (See para TN.1.4 of explanatory notes to this Category) **Fee:** $2,956.30 **Benefit:** 75% = $2217.25 85% = $2871.60 **Extended Medicare Safety Net Cap:** $2,432.15
13202	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE THAT IS CANCELLED BEFORE OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation and including quantitative estimation of hormones, semen preparation, ultrasound examinations, but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which Item 13200, 13201, 13203, 13206, 13218, applies being services rendered during 1 treatment cycle (See para TN.1.4 of explanatory notes to this Category) **Fee:** $473.00 **Benefit:** 75% = $354.75 85% = $402.05 **Extended Medicare Safety Net Cap:** $64.95
13203	OVULATION MONITORING SERVICES, for artificial insemination - including quantitative estimation of hormones and ultrasound examinations, being services rendered during 1 treatment cycle but excluding a service to which Item 13200, 13201, 13202, 13206, 13212, 13215, 13218, applies (See para TN.1.4 of explanatory notes to this Category) **Fee:** $494.55 **Benefit:** 75% = $370.95 85% = $420.40 **Extended Medicare Safety Net Cap:** $108.15
13206	ASSISTED REPRODUCTIVE TECHNOLOGIES TREATMENT CYCLE using either the natural cycle or oral medication only to induce oocyte growth and development, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, frozen embryo transfer or donated embryos or ova or treatment involving the use of injectable drugs to induce superovulation being services rendered during 1 treatment cycle but only if rendered in conjunction with a service to which item 13212 applies (See para TN.1.4 of explanatory notes to this Category) **Fee:** $473.00 **Benefit:** 75% = $354.75 85% = $402.05 **Extended Medicare Safety Net Cap:** $64.95
13209	PLANNING and MANAGEMENT of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies or for artificial insemination payable once only during 1 treatment cycle (See para TN.1.4 of explanatory notes to this Category) **Fee:** $86.05 **Benefit:** 75% = $64.55 85% = $73.15 **Extended Medicare Safety Net Cap:** $10.90
13210	Professional attendance on a patient by a specialist practising in his or her specialty if:

	(a) the attendance is by video conference; and (b) item 13209 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies (See para TN.1.21 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 13209. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** $5.30
13212	Oocyte retrieval for the purpose of assisted reproductive technologies-only if rendered in connection with a service to which item 13200, 13201 or 13206 applies (Anaes.) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $360.10 **Benefit:** 75% = $270.10 85% = $306.10 **Extended Medicare Safety Net Cap:** $70.35
13215	Transfer of embryos or both ova and sperm to the uterus or fallopian tubes, excluding artificial insemination-only if rendered in connection with a service to which item 13200, 13201, 13206 or 13218 applies, being services rendered in one treatment cycle (Anaes.) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $112.90 **Benefit:** 75% = $84.70 85% = $96.00 **Extended Medicare Safety Net Cap:** $48.70
13218	PREPARATION of frozen or donated embryos or donated oocytes for transfer to the uterus or fallopian tubes, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in 1 treatment cycle and excluding a service to which item 13200, 13201, 13202, 13203, 13206, 13212 applies (Anaes.) (See para TN.1.4, TN.1.5 of explanatory notes to this Category) **Fee:** $806.25 **Benefit:** 75% = $604.70 85% = $721.55 **Extended Medicare Safety Net Cap:** $702.65
13221	Preparation of semen for the purpose of artificial insemination-only if rendered in connection with a service to which item 13203 applies (See para TN.1.4 of explanatory notes to this Category) **Fee:** $51.60 **Benefit:** 75% = $38.70 85% = $43.90 **Extended Medicare Safety Net Cap:** $21.70

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	3. ASSISTED REPRODUCTIVE SERVICES
13251	INTRACYTOPLASMIC SPERM INJECTION for the purposes of assisted reproductive technologies, for male factor infertility, excluding a service to which Item 13203 or 13218 applies (See para TN.1.5 of explanatory notes to this Category) **Fee:** $424.65 **Benefit:** 75% = $318.50 85% = $361.00 **Extended Medicare Safety Net Cap:** $108.15
13260	Processing and cryopreservation of semen for fertility preservation treatment before or after completion of gonadotoxic treatment for malignant or non-malignant conditions, in a post-pubertal male in Tanner stages II-V, up to 60 years old, if the patient is referred by a specialist or consultant physician, initial cryopreservation of semen (not including storage) - one of a maximum of two semen collection cycles per patient in a lifetime. (See para TN.1.22 of explanatory notes to this Category) **Fee:** $421.65 **Benefit:** 75% = $316.25 85% = $358.45 **Extended Medicare Safety Net Cap:** $274.10
13290	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required **Fee:** $207.50 **Benefit:** 75% = $155.65 85% = $176.40
13292	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required, under general anaesthetic, in a hospital (Anaes.) **Fee:** $415.25 **Benefit:** 75% = $311.45 85% = $353.00

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	4. PAEDIATRIC & NEONATAL
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 4. Paediatric & Neonatal
13300	UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate **Fee:** $57.85 **Benefit:** 75% = $43.40 85% = $49.20
13303	UMBILICAL ARTERY CATHETERISATION with or without infusion **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
13306	BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor **Fee:** $339.45 **Benefit:** 75% = $254.60 85% = $288.55
13309	BLOOD TRANSFUSION with venesection and complete replacement of blood, using blood already collected **Fee:** $289.40 **Benefit:** 75% = $217.05 85% = $246.00
13312	BLOOD for pathology test, collection of, BY FEMORAL OR EXTERNAL JUGULAR VEIN PUNCTURE IN INFANTS

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	4. PAEDIATRIC & NEONATAL
	Fee: $28.90 **Benefit:** 75% = $21.70 85% = $24.60
13318	CENTRAL VEIN CATHETERISATION - by open exposure in a person under 12 years of age (Anaes.) (See para TN.1.6 of explanatory notes to this Category) **Fee:** $231.10 **Benefit:** 75% = $173.35 85% = $196.45
13319	CENTRAL VEIN CATHETERISATION in a neonate via peripheral vein (Anaes.) **Fee:** $231.10 **Benefit:** 75% = $173.35 85% = $196.45

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	5. CARDIOVASCULAR
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 5. Cardiovascular
13400	RESTORATION OF CARDIAC RHYTHM by electrical stimulation (cardioversion), other than in the course of cardiac surgery (Anaes.) **Fee:** $98.35 **Benefit:** 75% = $73.80 85% = $83.60

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	6. GASTROENTEROLOGY
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 6. Gastroenterology
13506	GASTRO-OESOPHAGEAL balloon intubation, for control of bleeding from gastric oesophageal varices **Fee:** $187.45 **Benefit:** 75% = $140.60 85% = $159.35

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	8. HAEMATOLOGY
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 8. Haematology
13700	HARVESTING OF HOMOLOGOUS (including allogeneic) or AUTOLOGOUS bone marrow for the purpose of transplantation (Anaes.) **Fee:** $338.60 **Benefit:** 75% = $253.95 85% = $287.85
13703	TRANSFUSION OF BLOOD, including collection from donor **Fee:** $121.40 **Benefit:** 75% = $91.05 85% = $103.20
13706	TRANSFUSION OF BLOOD or bone marrow already collected (See para TN.1.7 of explanatory notes to this Category) **Fee:** $84.70 **Benefit:** 75% = $63.55 85% = $72.00
13709	COLLECTION OF BLOOD for autologous transfusion or when homologous blood is required for immediate transfusion in emergency situation (See para TN.1.8 of explanatory notes to this Category)

	Fee: $49.25 **Benefit:** 75% = $36.95 85% = $41.90
13750	THERAPEUTIC HAEMAPHERESIS for the removal of plasma or cellular (or both) elements of blood, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies, if performed; continuous monitoring of vital signs, fluid balance, blood volume and other parameters with continuous registered nurse attendance under the supervision of a consultant physician, not being a service associated with a service to which item 13755 applies -payable once per day **Fee:** $138.85 **Benefit:** 75% = $104.15 85% = $118.05
13755	DONOR HAEMAPHERESIS for the collection of blood products for transfusion, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies; continuous monitoring of vital signs, fluid balance, blood volume and other parameters; with continuous registered nurse attendance under the supervision of a consultant physician; not being a service associated with a service to which item 13750 applies - payable once per day **Fee:** $138.85 **Benefit:** 75% = $104.15 85% = $118.05
13757	THERAPEUTIC VENESECTION for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda **Fee:** $74.10 **Benefit:** 75% = $55.60 85% = $63.00
13760	IN VITRO PROCESSING (and cryopreservation) of bone marrow or peripheral blood for autologous stem cell transplantation as an adjunct to high dose chemotherapy for: . chemosensitive intermediate or high grade non-Hodgkin's lymphoma at high risk of relapse following first line chemotherapy; or . Hodgkin's disease which has relapsed following, or is refractory to, chemotherapy; or . acute myelogenous leukaemia in first remission, where suitable genotypically matched sibling donor is not available for allogeneic bone marrow transplant; or . multiple myeloma in remission (complete or partial) following standard dose chemotherapy; or . small round cell sarcomas; or . primitive neuroectodermal tumour; or . germ cell tumours which have relapsed following, or are refractory to, chemotherapy; . germ cell tumours which have had an incomplete response to first line therapy. - performed under the supervision of a consultant physician - each day. **Fee:** $774.80 **Benefit:** 75% = $581.10 85% = $690.10

	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 9. Procedures Associated With Intensive Care And Cardiopulmonary Support
13815	CENTRAL VEIN CATHETERISATION by percutaneous or open exposure not being a service to

	which item 13318 applies (Anaes.) (See para TN.1.6 of explanatory notes to this Category) **Fee:** $86.60 **Benefit:** 75% = $64.95 85% = $73.65
13818	RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and cardiac output measurement (Anaes.) (See para TN.1.10 of explanatory notes to this Category) **Fee:** $115.50 **Benefit:** 75% = $86.65 85% = $98.20
13830	INTRACRANIAL PRESSURE, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician - each day **Fee:** $76.55 **Benefit:** 75% = $57.45 85% = $65.10
13839	ARTERIAL PUNCTURE and collection of blood for diagnostic purposes **Fee:** $23.40 **Benefit:** 75% = $17.55 85% = $19.90
13842	INTRAARTERIAL CANNULATION for the purpose of taking multiple arterial blood samples for blood gas analysis (See para TN.1.10 of explanatory notes to this Category) **Fee:** $70.40 **Benefit:** 75% = $52.80 85% = $59.85
13847	COUNTERPULSATION BY INTRAAORTIC BALLOON management on the first day including initial and subsequent consultations and monitoring of parameters (Anaes.) (See para TN.1.10 of explanatory notes to this Category) **Fee:** $158.60 **Benefit:** 75% = $118.95 85% = $134.85
13848	COUNTERPULSATION BY INTRAAORTIC BALLOON management on each day subsequent to the first, including associated consultations and monitoring of parameters (See para TN.1.10 of explanatory notes to this Category) **Fee:** $133.15 **Benefit:** 75% = $99.90 85% = $113.20
13851	CIRCULATORY SUPPORT DEVICE, management of, on first day **Fee:** $501.55 **Benefit:** 75% = $376.20 85% = $426.35
13854	CIRCULATORY SUPPORT DEVICE, management of, on each day subsequent to the first **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
13857	AIRWAY ACCESS, ESTABLISHMENT OF AND INITIATION OF MECHANICAL VENTILATION (other than in the context of an anaesthetic for surgery), outside an Intensive Care Unit, for the purpose of subsequent ventilatory support in an Intensive Care Unit (See para TN.1.10 of explanatory notes to this Category) **Fee:** $148.75 **Benefit:** 75% = $111.60 85% = $126.45

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES — 10. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT

	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 10. Management And Procedures Undertaken In An Intensive Care Unit

	(Note: See para T1.8 of Explanatory Notes to this Category for definition of an Intensive Care Unit)
13870	MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on the first day (H) (See para TN.1.9, TN.1.11, TN.1.10 of explanatory notes to this Category) **Fee:** $367.90 **Benefit:** 75% = $275.95
13873	MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including all attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on each day subsequent to the first day (H) (See para TN.1.9, TN.1.11 of explanatory notes to this Category) **Fee:** $272.90 **Benefit:** 75% = $204.70
13876	CENTRAL VENOUS PRESSURE, pulmonary arterial pressure, systemic arterial pressure or cardiac intracavity pressure, continuous monitoring by indwelling catheter in an intensive care unit and managed by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - once only for each type of pressure on any calendar day (up to a maximum of 4 pressures) (H) (See para TN.1.9, TN.1.11, TN.1.10 of explanatory notes to this Category) **Fee:** $78.15 **Benefit:** 75% = $58.65
13881	AIRWAY ACCESS, ESTABLISHMENT OF AND INITIATION OF MECHANICAL VENTILATION, in an Intensive Care Unit, not in association with any anaesthetic service, by a specialist or consultant physician for the purpose of subsequent ventilatory support (H) (See para TN.1.9, TN.1.11 of explanatory notes to this Category) **Fee:** $148.75 **Benefit:** 75% = $111.60
13882	VENTILATORY SUPPORT in an Intensive Care Unit, management of, by invasive means, or by non-invasive means where the only alternative to non-invasive ventilatory support would be invasive ventilatory support, by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care, each day (H) (See para TN.1.9, TN.1.11 of explanatory notes to this Category) **Fee:** $117.10 **Benefit:** 75% = $87.85
13885	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, in an intensive care unit, management by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - on the first day (H) (See para TN.1.9, TN.1.11 of explanatory notes to this Category) **Fee:** $156.10 **Benefit:** 75% = $117.10
13888	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, in an intensive care unit, management by a specialist or consultant physician who is immediately available and

	exclusively rostered for intensive care - on each day subsequent to the first day (H) (See para TN.1.9, TN.1.11 of explanatory notes to this Category) **Fee:** $78.15 **Benefit:** 75% = $58.65

	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 11. Chemotherapeutic Procedures
13915	CYTOTOXIC CHEMOTHERAPY, administration of, either by intravenous push technique (directly into a vein, or a butterfly needle, or the side-arm of an infusion) or by intravenous infusion of not more than 1 hours duration - payable once only on the same day, not being a service associated with photodynamic therapy with verteporfin or for the administration of drugs used immediately prior to, or with microwave (UHF radiowave) cancer therapy alone (See para TN.1.12 of explanatory notes to this Category) **Fee:** $66.10 **Benefit:** 75% = $49.60 85% = $56.20
13918	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day **Fee:** $99.50 **Benefit:** 75% = $74.65 85% = $84.60
13921	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - for the first day of treatment **Fee:** $112.55 **Benefit:** 75% = $84.45 85% = $95.70
13924	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode **Fee:** $66.30 **Benefit:** 75% = $49.75 85% = $56.40
13927	CYTOTOXIC CHEMOTHERAPY, administration of, either by intra-arterial push technique (directly into an artery, a butterfly needle or the side-arm of an infusion) or by intra-arterial infusion of not more than 1 hours duration - payable once only on the same day **Fee:** $85.75 **Benefit:** 75% = $64.35 85% = $72.90
13930	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day **Fee:** $119.70 **Benefit:** 75% = $89.80 85% = $101.75
13933	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - for the first day of treatment **Fee:** $132.80 **Benefit:** 75% = $99.60 85% = $112.90
13936	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode **Fee:** $86.50 **Benefit:** 75% = $64.90 85% = $73.55
13939	IMPLANTED PUMP OR RESERVOIR, loading of, with a cytotoxic agent or agents, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or

	13945 applies (See para TN.1.13 of explanatory notes to this Category) **Fee:** $99.50 **Benefit:** 75% = $74.65 85% = $84.60
13942	AMBULATORY DRUG DELIVERY DEVICE, loading of, with a cytotoxic agent or agents for the infusion of the agent or agents via the intravenous, intra-arterial or spinal routes, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies (See para TN.1.13 of explanatory notes to this Category) **Fee:** $66.30 **Benefit:** 75% = $49.75 85% = $56.40
13945	LONG-TERM IMPLANTED DRUG DELIVERY DEVICE FOR CYTOTOXIC CHEMOTHERAPY, accessing of **Fee:** $53.35 **Benefit:** 75% = $40.05 85% = $45.35
13948	CYTOTOXIC AGENT, instillation of, into a body cavity **Fee:** $66.30 **Benefit:** 75% = $49.75 85% = $56.40

	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 12. Dermatology
14050	UVA or UVB phototherapy administered in a whole body cabinet or hand and foot cabinet including associated consultations other than the initial consultation, if treatment is initiated and supervised by a specialist in the specialty of dermatology Applicable not more than 150 times in a 12 month period (See para TN.1.14 of explanatory notes to this Category) **Fee:** $53.60 **Benefit:** 75% = $40.20 85% = $45.60
14100	Laser photocoagulation using laser radiation in the treatment of vascular abnormalities of the head or neck, including any associated consultation, if: (a) the abnormality is visible from 3 metres; and (b) photographic evidence demonstrating the need for this service is documented in the patient notes; to a maximum of 4 sessions (including any sessions to which this item or any of items 14106 to 14118 apply) in any 12 month period (Anaes.) (See para TN.1.15 of explanatory notes to this Category) **Fee:** $154.95 **Benefit:** 75% = $116.25 85% = $131.75 **Extended Medicare Safety Net Cap:** $124.00
14106	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), if the abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12 month period—area of treatment less than 150 cm^2 (Anaes.)

	(See para TN.1.15 of explanatory notes to this Category) **Fee:** $162.70 **Benefit:** 75% = $122.05 85% = $138.30
14115	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café 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 this item or any of items 14100 to 14118 apply) in any 12 month period—area of treatment 150 cm^2 to 300 cm^2 (Anaes.) (See para TN.1.15 of explanatory notes to this Category) **Fee:** $260.60 **Benefit:** 75% = $195.45 85% = $221.55
14118	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café 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 this item or any of items 14100 to 14115 apply) in any 12 month period—area of treatment more than 300 cm^2 (Anaes.) (See para TN.1.15 of explanatory notes to this Category) **Fee:** $330.95 **Benefit:** 75% = $248.25 85% = $281.35
14124	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, if: (a) a seventh or subsequent session (including any sessions to which this item or any of items 14100 to 14118 apply) is indicated in a 12 month period commencing on the day of the first session; and (b) photographic evidence demonstrating the need for this service is documented in the patient notes (Anaes.) (See para TN.1.15 of explanatory notes to this Category) **Fee:** $154.95 **Benefit:** 75% = $116.25 85% = $131.75

	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 13. Other Therapeutic Procedures
14200	GASTRIC LAVAGE in the treatment of ingested poison **Fee:** $60.75 **Benefit:** 75% = $45.60 85% = $51.65
14201	POLY-L-LACTIC ACID, one or more injections of, for the initial session only, for the treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the National Health Act 1953 - once per patient (See para TN.1.16 of explanatory notes to this Category) **Fee:** $240.65 **Benefit:** 75% = $180.50 85% = $204.60 **Extended Medicare Safety Net Cap:** $36.10
14202	POLY-L-LACTIC ACID, one or more injections of (subsequent sessions), for the continuation of treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the National Health Act 1953

	(See para TN.1.16 of explanatory notes to this Category) **Fee:** $121.80 **Benefit:** 75% = $91.35 85% = $103.55 **Extended Medicare Safety Net Cap:** $18.30
14203	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes.) (See para TN.1.4, TN.1.17 of explanatory notes to this Category) **Fee:** $51.95 **Benefit:** 75% = $39.00 85% = $44.20
14206	HORMONE OR LIVING TISSUE IMPLANTATION by cannula (See para TN.1.4, TN.1.17 of explanatory notes to this Category) **Fee:** $36.15 **Benefit:** 75% = $27.15 85% = $30.75
14209	INTRAARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent **Fee:** $90.10 **Benefit:** 75% = $67.60 85% = $76.60
14212	INTUSSUSCEPTION, management of fluid or gas reduction for (Anaes.) **Fee:** $188.25 **Benefit:** 75% = $141.20 85% = $160.05
14218	IMPLANTED INFUSION PUMP REFILLING OF reservoir, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of chronic intractable pain **Fee:** $99.50 **Benefit:** 75% = $74.65 85% = $84.60
14221	LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessing of, not being a service associated with a service to which item 13945 applies **Fee:** $53.35 **Benefit:** 75% = $40.05 85% = $45.35
14224	ELECTROCONVULSIVE THERAPY, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.) **Fee:** $71.50 **Benefit:** 75% = $53.65 85% = $60.80
14227	IMPLANTED INFUSION PUMP, REFILLING of reservoir, with baclofen, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of severe chronic spasticity (See para TN.1.18 of explanatory notes to this Category) **Fee:** $99.50 **Benefit:** 75% = $74.65 85% = $84.60
14230	Intrathecal or epidural SPINAL CATHETER insertion or replacement of, for connection to a subcutaneous implanted infusion pump, for the management of severe chronic spasticity with baclofen (Anaes.) (Assist.) (See para TN.1.18 of explanatory notes to this Category) **Fee:** $302.80 **Benefit:** 75% = $227.10
14233	INFUSION PUMP, subcutaneous implantation or replacement of, and connection to intrathecal or epidural catheter, and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.) (Assist.) (See para TN.1.18 of explanatory notes to this Category) **Fee:** $367.70 **Benefit:** 75% = $275.80
14236	INFUSION PUMP, subcutaneous implantation of, AND intrathecal or epidural SPINAL CATHETER

	insertion, and connection of pump to catheter and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.) (Assist.) (See para TN.1.18 of explanatory notes to this Category) **Fee:** $670.50 **Benefit:** 75% = $502.90
14239	Removal of subcutaneously IMPLANTED INFUSION PUMP, OR removal or repositioning of intrathecal or epidural SPINAL CATHETER, for the management of severe chronic spasticity (Anaes.) (See para TN.1.18 of explanatory notes to this Category) **Fee:** $161.95 **Benefit:** 75% = $121.50
14242	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management of severe chronic spasticity (Anaes.) (See para TN.1.18 of explanatory notes to this Category) **Fee:** $481.25 **Benefit:** 75% = $360.95
14245	IMMUNOMODULATING AGENT, administration of, by intravenous infusion for at least 2 hours duration - payable once only on the same day and where the agent is provided under section 100 of the Pharmaceutical Benefits Scheme (See para TN.1.19 of explanatory notes to this Category) **Fee:** $99.50 **Benefit:** 75% = $74.65 85% = $84.60

T2. RADIATION ONCOLOGY — 1. SUPERFICIAL

	Group T2. Radiation Oncology
	Subgroup 1. Superficial
15000	*(Benefits for administration of general anaesthetic for radiotherapy are payable under Group T10)* RADIOTHERAPY, SUPERFICIAL (including treatment with xrays, radium rays or other radioactive substances), not being a service to which another item in this Group applies each attendance at which fractionated treatment is given - 1 field **Fee:** $43.25 **Benefit:** 75% = $32.45 85% = $36.80
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:** The fee for item 15000 plus for each field in excess of 1, an amount of $17.35
15006	RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technique is applied - 1 field **Fee:** $95.85 **Benefit:** 75% = $71.90 85% = $81.50

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:** The fee for item 15006 plus for each field in excess of 1, an amount of $18.85
15012	RADIOTHERAPY, SUPERFICIAL each attendance at which treatment is given to an eye **Fee:** $54.30 **Benefit:** 75% = $40.75 85% = $46.20

T2. RADIATION ONCOLOGY — 2. ORTHOVOLTAGE

	Group T2. Radiation Oncology
	Subgroup 2. Orthovoltage
15100	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 3 or more treatments per week - 1 field (See para TN.2.1 of explanatory notes to this Category) **Fee:** $48.45 **Benefit:** 75% = $36.35 85% = $41.20
15103	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) (See para TN.2.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 15100 plus for each field in excess of 1, an amount of $19.10
15106	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 2 treatments per week or less frequently - 1 field **Fee:** $57.20 **Benefit:** 75% = $42.90 85% = $48.65
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:** The fee for item 15106 plus for each field in excess of 1, an amount of $23.05
15112	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field **Fee:** $122.15 **Benefit:** 75% = $91.65 85% = $103.85
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:** The fee for item 15112 plus for each field in excess of 1, an amount of $48.05

	Group T2. Radiation Oncology
	Subgroup 3. Megavoltage
15211	RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy unit each attendance at which treatment is given - 1 field **Fee:** $55.60 **Benefit:** 75% = $41.70 85% = $47.30
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:** The fee for item 15211 plus for each field in excess of 1, an amount of $32.40
15215	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (lung) **Fee:** $60.60 **Benefit:** 75% = $45.45 85% = $51.55
15218	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (prostate) **Fee:** $60.60 **Benefit:** 75% = $45.45 85% = $51.55
15221	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (breast) **Fee:** $60.60 **Benefit:** 75% = $45.45 85% = $51.55
15224	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15215, 15218 and 15221 **Fee:** $60.60 **Benefit:** 75% = $45.45 85% = $51.55
15227	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to secondary site **Fee:** $60.60 **Benefit:** 75% = $45.45 85% = $51.55
15230	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (lung) **Derived Fee:** The fee for item 15215 plus for each field in excess of 1, an amount of $38.55
15233	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site

	(prostate) **Derived Fee:** The fee for item 15218 plus for each field in excess of 1, an amount of $38.55
15236	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast) **Derived Fee:** The fee for item 15221 plus for each field in excess of 1, an amount of $38.55
15239	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15230, 15233 or 15236 **Derived Fee:** The fee for item 15224 plus for each field in excess of 1, an amount of $38.55
15242	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to secondary site **Derived Fee:** The fee for item 15227 plus for each field in excess of 1, an amount of $38.55
15245	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (lung) **Fee:** $60.60 **Benefit:** 75% = $45.45 85% = $51.55
15248	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (prostate) **Fee:** $60.60 **Benefit:** 75% = $45.45 85% = $51.55
15251	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (breast) **Fee:** $60.60 **Benefit:** 75% = $45.45 85% = $51.55
15254	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15245, 15248 or 15251 **Fee:** $60.60 **Benefit:** 75% = $45.45 85% = $51.55
15257	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to secondary site **Fee:** $60.60 **Benefit:** 75% = $45.45 85% = $51.55
15260	RADIATION ORADIATION ONCOLOGY treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10mv photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (lung) **Derived Fee:** The fee for item 15245 plus for each field in excess of 1, an amount of $38.55

T2. RADIATION ONCOLOGY	3. MEGAVOLTAGE
15263	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate) **Derived Fee:** The fee for item 15248 plus for each field in excess of 1, an amount of $38.55
15266	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast) **Derived Fee:** The fee for item 15251 plus for each field in excess of 1, an amount of $38.55
15269	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15260, 15263 or 15266 **Derived Fee:** The fee for item 15254 plus for each field in excess of 1, an amount of $38.55
15272	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to secondary site **Derived Fee:** The fee for item 15257 plus for each field in excess of 1, an amount of $38.55
15275	RADIATION ONCOLOGY TREATMENT with IGRT imaging facilities undertaken: (a) to implement an IMRT dosimetry plan prepared in accordance with item 15565; and (b) utilising an intensity modulated treatment delivery mode (delivered by a fixed or dynamic gantry linear accelerator or by a helical non C-arm based linear accelerator), once only at each attendance at which treatment is given. **Fee:** $185.85 **Benefit:** 75% = $139.40 85% = $158.00

T2. RADIATION ONCOLOGY	4. BRACHYTHERAPY
	Group T2. Radiation Oncology
	Subgroup 4. Brachytherapy
15303	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) **Fee:** $362.70 **Benefit:** 75% = $272.05 85% = $308.30
15304	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) **Fee:** $362.70 **Benefit:** 75% = $272.05 85% = $308.30
15307	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.) **Fee:** $687.65 **Benefit:** 75% = $515.75 85% = $602.95

15308	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.) **Fee:** $687.65 **Benefit:** 75% = $515.75 85% = $602.95
15311	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) **Fee:** $338.55 **Benefit:** 75% = $253.95 85% = $287.80
15312	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) **Fee:** $336.10 **Benefit:** 75% = $252.10 85% = $285.70
15315	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.) **Fee:** $664.70 **Benefit:** 75% = $498.55 85% = $580.00
15316	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.) **Fee:** $664.70 **Benefit:** 75% = $498.55 85% = $580.00
15319	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) **Fee:** $412.55 **Benefit:** 75% = $309.45 85% = $350.70
15320	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) **Fee:** $412.55 **Benefit:** 75% = $309.45 85% = $350.70
15323	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.) **Fee:** $733.55 **Benefit:** 75% = $550.20 85% = $648.85
15324	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.) **Fee:** $733.55 **Benefit:** 75% = $550.20 85% = $648.85
15327	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using manual afterloading techniques (Anaes.) **Fee:** $798.00 **Benefit:** 75% = $598.50 85% = $713.30
15328	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using automatic afterloading techniques (Anaes.) **Fee:** $798.00 **Benefit:** 75% = $598.50 85% = $713.30

15331	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using manual afterloading techniques (Anaes.) **Fee:** $757.75 **Benefit:** 75% = $568.35 85% = $673.05
15332	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using automatic afterloading techniques (Anaes.) **Fee:** $757.75 **Benefit:** 75% = $568.35 85% = $673.05
15335	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using manual afterloading techniques (Anaes.) **Fee:** $687.65 **Benefit:** 75% = $515.75 85% = $602.95
15336	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using automatic afterloading techniques (Anaes.) **Fee:** $687.65 **Benefit:** 75% = $515.75 85% = $602.95
15338	PROSTATE, radioactive seed implantation of, radiation oncology component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate), with a Gleason score of less than or equal to 7 and a prostate specific antigen (PSA) of less than or equal to 10ng/ml at the time of diagnosis. The procedure must be performed at an approved site in association with a urologist. (See para TN.2.2 of explanatory notes to this Category) **Fee:** $950.55 **Benefit:** 75% = $712.95 85% = $865.85
15339	REMOVAL OF A SEALED RADIOACTIVE SOURCE under general anaesthesia, or under epidural or spinal nerve block (Anaes.) **Fee:** $77.40 **Benefit:** 75% = $58.05 85% = $65.80
15342	CONSTRUCTION AND APPLICATION OF A RADIOACTIVE MOULD using a sealed source having a half-life of greater than 115 days, to treat intracavity, intraoral or intranasal site **Fee:** $193.35 **Benefit:** 75% = $145.05 85% = $164.35
15345	CONSTRUCTION AND APPLICATION OF A RADIOACTIVE MOULD using a sealed source having a half-life of less than 115 days including iodine, gold, iridium or tantalum to treat intracavity, intraoral or intranasal sites **Fee:** $515.90 **Benefit:** 75% = $386.95 85% = $438.55
15348	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15342 or 15345 each attendance **Fee:** $59.35 **Benefit:** 75% = $44.55 85% = $50.45
15351	CONSTRUCTION WITH OR WITHOUT INITIAL APPLICATION OF RADIOACTIVE MOULD not exceeding 5 cm. diameter to an external surface **Fee:** $118.45 **Benefit:** 75% = $88.85 85% = $100.70

T2. RADIATION ONCOLOGY	4. BRACHYTHERAPY
15354	CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD 5 cm. or more in diameter to an external surface **Fee:** $143.75 **Benefit:** 75% = $107.85 85% = $122.20
15357	"SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD, 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" **Fee:** $40.70 **Benefit:** 75% = $30.55 85% = $34.60

T2. RADIATION ONCOLOGY	5. COMPUTERISED PLANNING
	Group T2. Radiation Oncology
	Subgroup 5. Computerised Planning
	RADIOTHERAPY PLANNING
15500	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15509 applies) (See para TN.2.3 of explanatory notes to this Category) **Fee:** $246.55 **Benefit:** 75% = $184.95 85% = $209.60
15503	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15512 applies) (See para TN.2.3 of explanatory notes to this Category) **Fee:** $316.55 **Benefit:** 75% = $237.45 85% = $269.10
15506	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15515 applies) (See para TN.2.3 of explanatory notes to this Category) **Fee:** $472.75 **Benefit:** 75% = $354.60 85% = $401.85
15509	RADIATION FIELD SETTING using a diagnostic xray unit of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15500 applies) (See para TN.2.3 of explanatory notes to this Category) **Fee:** $213.65 **Benefit:** 75% = $160.25 85% = $181.65
15512	RADIATION FIELD SETTING using a diagnostic xray unit of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15503 applies) (See para TN.2.3 of explanatory notes to this Category) **Fee:** $275.45 **Benefit:** 75% = $206.60 85% = $234.15
15513	RADIATION SOURCE LOCALISATION using a simulator or x-ray machine or CT of a single area, where views in more than 1 plane are required, for brachytherapy treatment planning for I125 seed implantation of localised prostate cancer, in association with item 15338 (See para TN.2.3 of explanatory notes to this Category)

	Fee: $311.45 **Benefit:** 75% = $233.60 85% = $264.75
15515	RADIATION FIELD SETTING using a diagnostic xray unit of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15506 applies) (See para TN.2.3 of explanatory notes to this Category) **Fee:** $398.80 **Benefit:** 75% = $299.10 85% = $339.00
15518	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks (See para TN.2.3 of explanatory notes to this Category) **Fee:** $78.25 **Benefit:** 75% = $58.70 85% = $66.55
15521	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used (See para TN.2.3 of explanatory notes to this Category) **Fee:** $345.35 **Benefit:** 75% = $259.05 85% = $293.55
15524	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields (See para TN.2.3 of explanatory notes to this Category) **Fee:** $647.55 **Benefit:** 75% = $485.70 85% = $562.85
15527	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks (See para TN.2.3 of explanatory notes to this Category) **Fee:** $80.20 **Benefit:** 75% = $60.15 85% = $68.20
15530	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used (See para TN.2.3 of explanatory notes to this Category) **Fee:** $357.80 **Benefit:** 75% = $268.35 85% = $304.15
15533	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields, or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields (See para TN.2.3 of explanatory notes to this Category) **Fee:** $678.40 **Benefit:** 75% = $508.80 85% = $593.70
15536	BRACHYTHERAPY PLANNING, computerised radiation dosimetry (See para TN.2.3 of explanatory notes to this Category) **Fee:** $271.15 **Benefit:** 75% = $203.40 85% = $230.50
15539	BRACHYTHERAPY PLANNING, computerised radiation dosimetry for I125 seed implantation of localised prostate cancer, in association with item 15338 (See para TN.2.3 of explanatory notes to this Category) **Fee:** $637.35 **Benefit:** 75% = $478.05 85% = $552.65
15550	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY without intravenous

	contrast medium, where: (a) treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and (b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and three dimensional conformal radiotherapy treatment; and (c) a high-quality CT-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and (d) the image set must be suitable for the generation of quality digitally reconstructed radiographic images (See para TN.2.3 of explanatory notes to this Category) **Fee:** $669.15 **Benefit:** 75% = $501.90 85% = $584.45
15553	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY pre and post intravenous contrast medium, where: (a) treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and (b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and three dimensional conformal radiotherapy treatment; and (c) a high-quality CT-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and (d) the image set must be suitable for the generation of quality digitally reconstructed radiographic images (See para TN.2.3 of explanatory notes to this Category) **Fee:** $721.90 **Benefit:** 75% = $541.45 85% = $637.20
15555	SIMULATION FOR INTENSITY-MODULATED RADIATION THERAPY (IMRT), with or without intravenous contrast medium, if: 1. treatment set-up and technique specifications are in preparations for three-dimensional conformal radiotherapy dose planning; and 2. patient set-up and immobilisation techniques are suitable for reliable CT-image volume data acquisition and three-dimensional conformal radiotherapy; and 3. a high-quality CT-image volume dataset is acquired for the relevant region of interest to be planned and treated; and 4. the image set is suitable for the generation of quality digitally-reconstructed radiographic images. (See para TN.2.3 of explanatory notes to this Category) **Fee:** $721.90 **Benefit:** 75% = $541.45 85% = $637.20
15556	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 1 COMPLEXITY where: (a) dosimetry for a single phase three dimensional conformal treatment plan using CT image volume dataset and having a single treatment target volume and organ at risk; and

	(b) one gross tumour volume or clinical target volume, plus one planning target volume plus at least one relevant organ at risk as defined in the prescription must be rendered as volumes; and (c) the organ at risk must be nominated as a planning dose goal or constraint and the prescription must specify the organ at risk dose goal or constraint; and (d) dose volume histograms must be generated, approved and recorded with the plan; and (e) a CT image volume dataset must be used for the relevant region to be planned and treated; and (f) the CT images must be suitable for the generation of quality digitally reconstructed radiographic images (See para TN.2.3 of explanatory notes to this Category) **Fee:** $675.05 **Benefit:** 75% = $506.30 85% = $590.35
15559	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 2 COMPLEXITY where: (a) dosimetry for a two phase three dimensional conformal treatment plan using CT image volume dataset(s) with at least one gross tumour volume, two planning target volumes and one organ at risk defined in the prescription; or (b) dosimetry for a one phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, one planning target volume and two organ at risk dose goals or constraints defined in the prescription; or (c) image fusion with a secondary image (CT, MRI or PET) volume dataset used to define target and organ at risk volumes in conjunction with and as specified in dosimetry for three dimensional conformal radiotherapy of level 1 complexity. All gross tumour targets, clinical targets, planning targets and organs at risk as defined in the prescription must be rendered as volumes. The organ at risk must be nominated as planning dose goals or constraints and the prescription must specify the organs at risk as dose goals or constraints. Dose volume histograms must be generated, approved and recorded with the plan. A CT image volume dataset must be used for the relevant region to be planned and treated. The CT images must be suitable for the generation of quality digitally reconstructed radiographic images (See para TN.2.3 of explanatory notes to this Category) **Fee:** $880.40 **Benefit:** 75% = $660.30 85% = $795.70
15562	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 3 COMPLEXITY - where: (a) dosimetry for a three or more phase three dimensional conformal treatment plan using CT image volume dataset(s) with at least one gross tumour volume, three planning target volumes and one organ at risk defined in the prescription; or (b) dosimetry for a two phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, and (i) two planning target volumes; or (ii) two organ at risk dose goals or constraints defined in the prescription.

	or (c) dosimetry for a one phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, one planning target volume and three organ at risk dose goals or constraints defined in the prescription; or (d) image fusion with a secondary image (CT, MRI or PET) volume dataset used to define target and organ at risk volumes in conjunction with and as specified in dosimetry for three dimensional conformal radiotherapy of level 2 complexity. All gross tumour targets, clinical targets, planning targets and organs at risk as defined in the prescription must be rendered as volumes. The organ at risk must be nominated as planning dose goals or constraints and the prescription must specify the organs at risk as dose goals or constraints. Dose volume histograms must be generated, approved and recorded with the plan. A CT image volume dataset must be used for the relevant region to be planned and treated. The CT images must be suitable for the generation of quality digitally reconstructed radiographic images (See para TN.2.3 of explanatory notes to this Category) **Fee:** $1,138.70 **Benefit:** 75% = $854.05 85% = $1054.00
15565	Preparation of an IMRT DOSIMETRY PLAN, which uses one or more CT image volume datasets, if: (a) in preparing the IMRT dosimetry plan: (i) the differential between target dose and normal tissue dose is maximised, based on a review and assessment by a radiation oncologist; and (ii) all gross tumour targets, clinical targets, planning targets and organs at risk are rendered as volumes as defined in the prescription; and (iii) organs at risk are nominated as planning dose goals or constraints and the prescription specifies the organs at risk as dose goals or constraints; and (iv) dose calculations and dose volume histograms are generated in an inverse planned process, using a specialised calculation algorithm, with prescription and plan details approved and recorded in the plan; and (v) a CT image volume dataset is used for the relevant region to be planned and treated; and (vi) the CT images are suitable for the generation of quality digitally reconstructed radiographic images; and (b) the final IMRT dosimetry plan is validated by the radiation therapist and the medical physicist, using robust quality assurance processes that include: (i) determination of the accuracy of the dose fluence delivered by the multi-leaf collimator and gantryposition (static or dynamic); and (ii) ensuring that the plan is deliverable, data transfer is acceptable and validation checks are completed on a linear accelerator; and (iii) validating the accuracy of the derived IMRT dosimetry plan; and

T2. RADIATION ONCOLOGY	5. COMPUTERISED PLANNING
	(c) the final IMRT dosimetry plan is approved by the radiation oncologist prior to delivery. (See para TN.2.3 of explanatory notes to this Category) **Fee:** $3,366.85 **Benefit:** 75% = $2525.15 85% = $3282.15

T2. RADIATION ONCOLOGY	6. STEREOTACTIC RADIOSURGERY
	Group T2. Radiation Oncology
	Subgroup 6. Stereotactic Radiosurgery
15600	STEREOTACTIC RADIOSURGERY, including all radiation oncology consultations, planning, simulation, dosimetry and treatment **Fee:** $1,729.55 **Benefit:** 75% = $1297.20 85% = $1644.85

T2. RADIATION ONCOLOGY	7. RADIATION ONCOLOGY TREATMENT VERIFICATION
	Group T2. Radiation Oncology
	Subgroup 7. Radiation Oncology Treatment Verification
15700	RADIATION ONCOLOGY TREATMENT VERIFICATION - single projection (with single or double exposures) - when prescribed and reviewed by a radiation oncologist and not associated with item 15705 or 15710 - each attendance at which treatment is verified (ie maximum one per attendance). (See para TN.2.4 of explanatory notes to this Category) **Fee:** $46.70 **Benefit:** 75% = $35.05 85% = $39.70
15705	RADIATION ONCOLOGY TREATMENT VERIFICATION - multiple projection acquisition when prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15710 - each attendance at which treatment involving three or more fields is verified (ie maximum one per attendance). (See para TN.2.4 of explanatory notes to this Category) **Fee:** $77.85 **Benefit:** 75% = $58.40 85% = $66.20
15710	RADIATION ONCOLOGY TREATMENT VERIFICATION - volumetric acquisition, when prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15705 - each attendance at which treatment involving three fields or more is verified (ie maximum one per attendance). (see para T2.5 of explanatory notes to this Category) (See para TN.2.4 of explanatory notes to this Category) **Fee:** $77.85 **Benefit:** 75% = $58.40 85% = $66.20
15715	RADIATION ONCOLOGY TREATMENT VERIFICATION of planar or volumetric IGRT for IMRT, involving the use of at least 2 planar image views or projections or 1 volumetric image set to facilitate a 3-dimensional adjustment to radiation treatment field positioning, if: (a) the treatment technique is classified as IMRT; and (b) the margins applied to volumes (clinical target volume or planning target volume) are tailored or reduced to minimise treatment related exposure of healthy or normal tissues; and (c) the decisions made using acquired images are based on action algorithms and are given effect immediately prior to or during treatment delivery by qualified and trained staff considering complex

T2. RADIATION ONCOLOGY	7. RADIATION ONCOLOGY TREATMENT VERIFICATION
	competing factors and using software driven modelling programs; and (d) the radiation treatment field positioning requires accuracy levels of less than 5mm (curative cases) or up to 10mm (palliative cases) to ensure accurate dose delivery to the target; and (e) the image decisions and actions are documented in the patient's record; and (f) the radiation oncologist is responsible for supervising the process, including specifying the type and frequency of imaging, tolerance and action levels to be incorporated in the process, reviewing the trend analysis and any reports and relevant images during the treatment course and specifying action protocols as required; and (g) when treatment adjustments are inadequate to satisfy treatment protocol requirements, replanning is required; and (h) the imaging infrastructure (hardware and software) is linked to the treatment unit and networked to an image database, enabling both on line and off line reviews. (See para TN.2.4 of explanatory notes to this Category) **Fee:** $77.85 **Benefit:** 75% = $58.40 85% = $66.20

T2. RADIATION ONCOLOGY	8. BRACHYTHERAPY PLANNING AND VERIFICATION
	Group T2. Radiation Oncology
	Subgroup 8. Brachytherapy Planning And Verification
15800	BRACHYTHERAPY TREATMENT VERIFICATION - maximum of one only for each attendance. (See para TN.2.4 of explanatory notes to this Category) **Fee:** $97.85 **Benefit:** 75% = $73.40 85% = $83.20
15850	RADIATION SOURCE LOCALISATION using a simulator, x-ray machine, CT or ultrasound of a single area, where views in more than one plane are required, for brachytherapy treatment planning, not being a service to which Item 15513 applies. **Fee:** $202.70 **Benefit:** 75% = $152.05 85% = $172.30

T2. RADIATION ONCOLOGY	10. TARGETTED INTRAOPERATIVE RADIOTHERAPY
	Group T2. Radiation Oncology
	Subgroup 10. Targetted Intraoperative Radiotherapy
	INTRAOPERATIVE RADIOTHERAPY
15900	BREAST, MALIGNANT TUMOUR, targeted intraoperative radiotherapy, using an Intrabeam® device, delivered at the time of breast-conserving surgery (partial mastectomy or lumpectomy) for a patient who: a) is 45 years of age or more; and b) has a T1 or small T2 (less than or equal to 3cm in diameter) primary tumour; and

	c) has an histologic Grade 1 or 2 tumour; and d) has an oestrogen-receptor positive tumour; and e) has a node negative malignancy; and f) is suitable for wide local excision of a primary invasive ductal carcinoma that was diagnosed as unifocal on conventional examination and imaging; and g) has no contra-indications to breast irradiation **Fee:** $254.00 **Benefit:** 75% = $190.50

T3. THERAPEUTIC NUCLEAR MEDICINE

	Group T3. Therapeutic Nuclear Medicine
16003	INTRACAVITY ADMINISTRATION OF A THERAPEUTIC DOSE OF YTTRIUM 90 not including preliminary paracentesis, not being a service associated with selective internal radiation therapy or to which item 35404, 35406 or 35408 applies (Anaes.) (See para TN.3.1 of explanatory notes to this Category) **Fee:** $660.90 **Benefit:** 75% = $495.70 85% = $576.20
16006	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique **Fee:** $507.85 **Benefit:** 75% = $380.90 85% = $431.70
16009	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique **Fee:** $346.60 **Benefit:** 75% = $259.95 85% = $294.65
16012	INTRAVENOUS ADMINISTRATION OF A THERAPEUTIC DOSE OF PHOSPHOROUS 32 **Fee:** $299.85 **Benefit:** 75% = $224.90 85% = $254.90
16015	ADMINISTRATION OF STRONTIUM 89 for painful bony metastases from carcinoma of the prostate where hormone therapy has failed and either: (i) the disease is poorly controlled by conventional radiotherapy; or (ii) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain **Fee:** $4,151.05 **Benefit:** 75% = $3113.30 85% = $4066.35
16018	ADMINISTRATION OF ^{153} SM-LEXIDRONAM for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan) where hormonal therapy and/or chemotherapy have failed and either the disease is poorly controlled by conventional radiotherapy or conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain. **Fee:** $2,481.55 **Benefit:** 75% = $1861.20 85% = $2396.85

T4. OBSTETRICS

	Group T4. Obstetrics

T4. OBSTETRICS	
16399	Professional attendance on a patient by a specialist practising in his or her specialty of obstetrics if: (a) the attendance is by video conference; and (b) item 16401, 16404, 16406, 16500, 16590 or 16591 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies (See para TN.4.12 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 16401,16404,16406,16500,16590 or 16591. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** $24.10
16400	ANTENATAL CARE Antenatal service provided by a midwife, nurse or an Aboriginal and Torres Strait Islander health practitionerif: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; (b) the service is provided at, or from, a practice location in a regional, rural or remote area; (c) the service is not performed in conjunction with another antenatal attendance item (same patient, same practitioner on the same day); (d) the service is not provided for an admitted patient of a hospital; and to a maximum of 10 service per pregnancy (See para TN.4.1 of explanatory notes to this Category) **Fee:** $27.70 **Benefit:** 85% = $23.55 **Extended Medicare Safety Net Cap:** $11.05
16401	Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics, after referral of the patient to him or her - each attendance, other than a second or subsequent attendance in a single course of treatment (See para TN.4.2 of explanatory notes to this Category) **Fee:** $86.90 **Benefit:** 75% = $65.20 85% = $73.90 **Extended Medicare Safety Net Cap:** $54.90
16404	Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics after referral of the patient to him or her - each attendance SUBSEQUENT to the first attendance in a single course of treatment. (See para AN.0.70, TN.4.2 of explanatory notes to this Category) **Fee:** $43.70 **Benefit:** 75% = $32.80 85% = $37.15 **Extended Medicare Safety Net Cap:** $32.95
16406	Antenatal professional attendance, by an obstetrician or general practitioner, as part of a single course of treatment when the patient is referred by a participating midwife. Payable only once for a pregnancy

T4. OBSTETRICS	
	Fee: $136.10 **Benefit:** 75% = $102.10 85% = $115.70 **Extended Medicare Safety Net Cap:** $108.15
16407	Postnatal professional attendance (other than a service to which any other item applies) if the attendance: (a) is by an obstetrician or general practitioner; and (b) is in hospital or at consulting rooms; and (c) is between 4 and 8 weeks after the birth; and (d) lasts at least 20 minutes; and (e) includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (f) is for a pregnancy in relation to which a service to which item 82140 applies is not provided Payable once only for a pregnancy (See para TN.4.13 of explanatory notes to this Category) **Fee:** $72.85 **Benefit:** 75% = $54.65 85% = $61.95 **Extended Medicare Safety Net Cap:** $47.40
16408	Postnatal attendance (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which any other item applies) if the attendance: (a) is by: (i) a midwife (on behalf of and under the supervision of the medical practitioner who attended the birth); or (ii) an obstetrician; or (iii) a general practitioner; and (b) is between 1 week and 4 weeks after the birth; and (c) lasts at least 20 minutes; and (d) is for a patient who was privately admitted for the birth; and (e) is for a pregnancy in relation to which a service to which item 82130, 82135 or 82140 applies is not provided Payable once only for a pregnancy **Fee:** $54.25 **Benefit:** 85% = $46.15 **Extended Medicare Safety Net Cap:** $35.30
16500	ANTENATAL ATTENDANCE (See para TN.4.3 of explanatory notes to this Category) **Fee:** $47.90 **Benefit:** 75% = $35.95 85% = $40.75 **Extended Medicare Safety Net Cap:** $32.95
16501	EXTERNAL CEPHALIC VERSION for breech presentation, after 36 weeks where no contraindication exists, in a Unit with facilities for Caesarean Section, including pre- and post version CTG, with or without tocolysis, not being a service to which items 55718 to 55728 and 55768 to 55774 apply - chargeable whether or not the version is successful and limited to a maximum of 2 ECV's per pregnancy

T4. OBSTETRICS	
	(See para TN.4.3, TN.4.4 of explanatory notes to this Category) **Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40 **Extended Medicare Safety Net Cap:** $65.90
16502	POLYHYDRAMNIOS, UNSTABLE LIE, MULTIPLE PREGNANCY, PREGNANCY COMPLICATED BY DIABETES OR ANAEMIA, THREATENED PREMATURE LABOUR treated by bed rest only or oral medication, requiring admission to hospital each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day (See para TN.4.3 of explanatory notes to this Category) **Fee:** $47.90 **Benefit:** 75% = $35.95 85% = $40.75 **Extended Medicare Safety Net Cap:** $22.00
16505	THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS GRAVIDARUM, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance (See para TN.4.3 of explanatory notes to this Category) **Fee:** $47.90 **Benefit:** 75% = $35.95 85% = $40.75 **Extended Medicare Safety Net Cap:** $22.00
16508	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital - each professional attendance (other than a service to which item 16533 applies) that is not a routine antenatal attendance, to a maximum of one visit per day (See para TN.4.3 of explanatory notes to this Category) **Fee:** $47.90 **Benefit:** 75% = $35.95 85% = $40.75 **Extended Medicare Safety Net Cap:** $22.00
16509	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of - each professional attendance (other than a service to which item 16534 applies) that is not a routine antenatal attendance (See para TN.4.3 of explanatory notes to this Category) **Fee:** $47.90 **Benefit:** 75% = $35.95 85% = $40.75 **Extended Medicare Safety Net Cap:** $22.00
16511	CERVIX, purse string ligation of (Anaes.) (See para TN.4.3 of explanatory notes to this Category) **Fee:** $223.45 **Benefit:** 75% = $167.60 85% = $189.95 **Extended Medicare Safety Net Cap:** $109.75
16512	CERVIX, removal of purse string ligature of (Anaes.) (See para TN.4.3 of explanatory notes to this Category) **Fee:** $64.50 **Benefit:** 75% = $48.40 85% = $54.85 **Extended Medicare Safety Net Cap:** $32.95
16514	ANTENATAL CARDIOTOCOGRAPHY in the management of high risk pregnancy (not during the course of the confinement) (See para TN.4.3 of explanatory notes to this Category) **Fee:** $37.25 **Benefit:** 75% = $27.95 85% = $31.70 **Extended Medicare Safety Net Cap:** $16.55
16515	Management of vaginal birth as an independent procedure, if the patient's care has been transferred by another medical practitioner for management of the birth and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the birth (Anaes.) (See para TN.4.5, TN.4.10 of explanatory notes to this Category)

T4. OBSTETRICS	
	Fee: $640.95 **Benefit:** 75% = $480.75 85% = $556.25 **Extended Medicare Safety Net Cap:** $175.60
16518	Management of labour, incomplete, if the patient's care has been transferred to another medical practitioner for completion of the birth (Anaes.) (See para TN.4.5, TN.4.10 of explanatory notes to this Category) **Fee:** $457.85 **Benefit:** 75% = $343.40 85% = $389.20 **Extended Medicare Safety Net Cap:** $175.60
16519	Management of labour and birth by any means (including Caesarean section) including post-partum care for 5 days (Anaes.) (See para TN.4.5, TN.4.6, TN.4.10 of explanatory notes to this Category) **Fee:** $705.05 **Benefit:** 75% = $528.80 85% = $620.35 **Extended Medicare Safety Net Cap:** $329.15
16520	Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (Anaes.) (See para TN.4.6, TN.4.10 of explanatory notes to this Category) **Fee:** $640.95 **Benefit:** 75% = $480.75 85% = $556.25 **Extended Medicare Safety Net Cap:** $329.15
16522	Management of labour and birth, or birth alone, (including caesarean section), on or after 23 weeks gestation, if in the course of antenatal supervision or intrapartum management one or more of the following conditions is present, including postnatal care for 7 days: (a) fetal loss; (b) multiple pregnancy; (c) antepartum haemorrhage that is: (i) of greater than 200 ml; or (ii) associated with disseminated intravascular coagulation; (d) placenta praevia on ultrasound in the third trimester with the placenta within 2 cm of the internal cervical os; (e) baby with a birth weight less than or equal to 2,500 g; (f) trial of vaginal birth in a patient with uterine scar where there has been a planned vaginal birth after caesarean section; (g) trial of vaginal breech birth where there has been a planned vaginal breech birth; (h) prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress as evidenced by cervical dilatation at less than 1 cm/hr in the active phase of labour (after 3 cm cervical dilatation and effacement until full dilatation of the cervix); (i) acute fetal compromise evidenced by: (i) scalp pH less than 7.15; or (ii) scalp lactate greater than 4.0;

(j) acute fetal compromise evidenced by at least one of the following significant cardiotocograph abnormalities:

(i) prolonged bradycardia (less than 100 bpm for more than 2 minutes);

(ii) absent baseline variability (less than 3 bpm);

(iii) sinusoidal pattern;

(iv) complicated variable decelerations with reduced (3 to 5 bpm) or absent baseline variability;

(v) late decelerations;

(k) pregnancy induced hypertension of at least 140/90 mm Hg associated with:

(i) at least 2+ proteinuria on urinalysis; or

(ii) protein-creatinine ratio greater than 30 mg/mmol; or

(iii) platelet count less than 150 x 10^9/L; or

(iv) uric acid greater than 0.36 mmol/L;

(l) gestational diabetes mellitus requiring at least daily blood glucose monitoring;

(m) mental health disorder (whether arising prior to pregnancy, during pregnancy or postpartum) that is demonstrated by:

(i) the patient requiring hospitalisation; or

(ii) the patient receiving ongoing care by a psychologist or psychiatrist to treat the symptoms of a mental health disorder; or

(iii) the patient having a GP mental health treatment plan; or

(iv) the patient having a management plan prepared in accordance with item 291;

(n) disclosure or evidence of domestic violence;

(o) any of the following conditions either diagnosed pre-pregnancy or evident at the first antenatal visit before 20 weeks gestation:

(i) pre-existing hypertension requiring antihypertensive medication prior to pregnancy;

(ii) cardiac disease (co-managed with a specialist physician and with echocardiographic evidence of myocardial dysfunction);

(iii) previous renal or liver transplant;

(iv) renal dialysis;

(v) chronic liver disease with documented oesophageal varices;

(vi) renal insufficiency in early pregnancy (serum creatinine greater than 110 mmol/L);

(vii) neurological disorder that confines the patient to a wheelchair throughout pregnancy;

	(viii) maternal height of less than 148 cm; (ix) a body mass index greater than or equal to 40; (x) pre-existing diabetes mellitus on medication prior to pregnancy; (xi) thyrotoxicosis requiring medication; (xii) previous thrombosis or thromboembolism requiring anticoagulant therapy through pregnancy and the early puerperium; (xiii) thrombocytopenia with platelet count of less than 100,000 prior to 20 weeks gestation; (xiv) HIV, hepatitis B or hepatitis C carrier status positive; (xv) red cell or platelet iso-immunisation; (xvi) cancer with metastatic disease; (xvii) illicit drug misuse during pregnancy (Anaes.) (See para TN.4.7 of explanatory notes to this Category) **Fee:** $1,655.40 **Benefit:** 75% = $1241.55 **Extended Medicare Safety Net Cap:** $438.90
16527	Management of vaginal birth, if the patient's care has been transferred by a participating midwife for management of the birth, including all attendances related to the birth. Payable once only for a pregnancy. (Anaes.) (See para TN.4.8 of explanatory notes to this Category) **Fee:** $640.95 **Benefit:** 75% = $480.75 85% = $556.25 **Extended Medicare Safety Net Cap:** $175.60
16528	Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by a participating midwife for management of the birth. Payable once only for a pregnancy. (Anaes.) (See para TN.4.8 of explanatory notes to this Category) **Fee:** $640.95 **Benefit:** 75% = $480.75 85% = $556.25 **Extended Medicare Safety Net Cap:** $329.15
16530	Management of pregnancy loss, from 14 weeks to 15 weeks and 6 days gestation, other than a service to which item 16531, 35640 or 35643 applies (Anaes.) (See para TN.4.5 of explanatory notes to this Category) **Fee:** $390.50 **Benefit:** 75% = $292.90 85% = $331.95 **Extended Medicare Safety Net Cap:** $253.85
16531	Management of pregnancy loss, from 16 weeks to 22 weeks and 6 days gestation, other than a service to which item 16530, 35640 or 35643 applies (Anaes.) (See para TN.4.5, TN.4.14 of explanatory notes to this Category) **Fee:** $781.00 **Benefit:** 75% = $585.75 **Extended Medicare Safety Net Cap:** $507.65
16533	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital—each professional attendance lasting at least 40 minutes that is not a

T4. OBSTETRICS	
	routine antenatal attendance, to a maximum of 3 services per pregnancy (See para TN.4.3, TN.4.14 of explanatory notes to this Category) **Fee:** $107.25 **Benefit:** 75% = $80.45 **Extended Medicare Safety Net Cap:** $69.75
16534	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of—each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, to a maximum of 3 services per pregnancy (See para TN.4.3, TN.4.14 of explanatory notes to this Category) **Fee:** $107.25 **Benefit:** 75% = $80.45 **Extended Medicare Safety Net Cap:** $69.75
16564	POST-PARTUM CARE EVACUATION OF RETAINED PRODUCTS OF CONCEPTION (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure (Anaes.) (See para TN.4.10 of explanatory notes to this Category) **Fee:** $221.50 **Benefit:** 75% = $166.15 85% = $188.30 **Extended Medicare Safety Net Cap:** $219.45
16567	MANAGEMENT OF POSTPARTUM HAEMORRHAGE by special measures such as packing of uterus, as an independent procedure (Anaes.) (See para TN.4.10 of explanatory notes to this Category) **Fee:** $323.90 **Benefit:** 75% = $242.95 85% = $275.35 **Extended Medicare Safety Net Cap:** $219.45
16570	ACUTE INVERSION OF THE UTERUS, vaginal correction of, as an independent procedure (Anaes.) (See para TN.4.10 of explanatory notes to this Category) **Fee:** $422.70 **Benefit:** 75% = $317.05 85% = $359.30 **Extended Medicare Safety Net Cap:** $219.45
16571	CERVIX, repair of extensive laceration or lacerations (Anaes.) (See para TN.4.10 of explanatory notes to this Category) **Fee:** $323.90 **Benefit:** 75% = $242.95 85% = $275.35 **Extended Medicare Safety Net Cap:** $219.45
16573	THIRD DEGREE TEAR, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.) (See para TN.4.10 of explanatory notes to this Category) **Fee:** $263.95 **Benefit:** 75% = $198.00 85% = $224.40 **Extended Medicare Safety Net Cap:** $219.45
16590	Planning and management, by a practitioner, of a pregnancy if: (a) the practitioner intends to take primary responsibility for management of the pregnancy and any complications, and to be available for the birth; and (b) the patient intends to be privately admitted for the birth; and (c) the pregnancy has progressed beyond 28 weeks gestation; and (d) the practitioner has maternity privileges at a hospital or birth centre; and (e) the service includes a mental health assessment (including screening for drug and alcohol use and

	domestic violence) of the patient; and (f) a service to which item 16591 applies is not provided in relation to the same pregnancy Payable once only for a pregnancy (See para TN.4.13, TN.4.9 of explanatory notes to this Category) **Fee:** $378.70 **Benefit:** 75% = $284.05 85% = $321.90 **Extended Medicare Safety Net Cap:** $219.45
16591	Planning and management, by a practitioner, of a pregnancy if: (a) the pregnancy has progressed beyond 28 weeks gestation; and (b) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (c) a service to which item 16590 applies is not provided in relation to the same pregnancy Payable once only for a pregnancy (See para TN.4.13, TN.4.9 of explanatory notes to this Category) **Fee:** $144.95 **Benefit:** 75% = $108.75 85% = $123.25 **Extended Medicare Safety Net Cap:** $109.75
	INTERVENTIONAL TECHNIQUES
16600	AMNIOCENTESIS, diagnostic (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $64.50 **Benefit:** 75% = $48.40 85% = $54.85 **Extended Medicare Safety Net Cap:** $32.95
16603	CHORIONIC VILLUS SAMPLING, by any route (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $123.80 **Benefit:** 75% = $92.85 85% = $105.25 **Extended Medicare Safety Net Cap:** $65.90
16606	Fetal blood sampling, using interventional techniques from umbilical cord or fetus, including fetal neuromuscular blockade and amniocentesis (Anaes.) (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $247.15 **Benefit:** 75% = $185.40 85% = $210.10 **Extended Medicare Safety Net Cap:** $131.75
16609	FOETAL INTRAVASCULAR BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling (Anaes.) (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $503.95 **Benefit:** 75% = $378.00 85% = $428.40 **Extended Medicare Safety Net Cap:** $252.40
16612	FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling - not performed in conjunction with a

	service described in item 16609 (Anaes.) (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $396.50 **Benefit:** 75% = $297.40 85% = $337.05
16615	FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling - performed in conjunction with a service described in item 16609 (Anaes.) (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $211.20 **Benefit:** 75% = $158.40 85% = $179.55
16618	AMNIOCENTESIS, THERAPEUTIC, when indicated because of polyhydramnios with at least 500ml being aspirated (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $211.20 **Benefit:** 75% = $158.40 85% = $179.55 **Extended Medicare Safety Net Cap:** $104.30
16621	AMNIOINFUSION, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $211.20 **Benefit:** 75% = $158.40 85% = $179.55
16624	FOETAL FLUID FILLED CAVITY, drainage of (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $303.90 **Benefit:** 75% = $227.95 85% = $258.35 **Extended Medicare Safety Net Cap:** $142.65
16627	FETO-AMNIOTIC SHUNT, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis (See para TN.4.11, TN.4.3 of explanatory notes to this Category) **Fee:** $618.70 **Benefit:** 75% = $464.05 85% = $534.00 **Extended Medicare Safety Net Cap:** $307.25

T6. ANAESTHETICS — 1. ANAESTHESIA CONSULTATIONS

	Group T6. Anaesthetics
	Subgroup 1. Anaesthesia Consultations
17609	Professional attendance on a patient by a specialist practising in his or her specialty of anaesthesia if: (a) the attendance is by video conference; and (b) item 17610, 17615, 17620, 17625, 17640, 17645, 17650, or 17655 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist; or

	(ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19 (2) of the Act applies (See para TN.6.4 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 17610, 17615, 17620, 17625, 17640, 17645, 17650, or 17655. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
17610	ANAESTHETIST, PRE-ANAESTHESIA CONSULTATION (Professional attendance by a medical practitioner in the practice of ANAESTHESIA) - a BRIEF consultation involving a targeted history and limited examination (including the cardio-respiratory system) - *AND of not more than 15 minutes s duration,* not being a service associated with a service to which items 2801 - 3000 apply (See para TN.6.1 of explanatory notes to this Category) **Fee:** $44.35 **Benefit:** 75% = $33.30 85% = $37.70 **Extended Medicare Safety Net Cap:** $133.05
17615	Professional attendance by a medical practitioner in the practice of anaesthesia for a consultation on a patient undergoing advanced surgery or who has complex medical problems, involving a selective history and an extensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes - and of more than 15 minutes but not more than 30 minutes duration, not being a service associated with a service to which items 2801 - 3000 applies (See para TN.6.1 of explanatory notes to this Category) **Fee:** $88.25 **Benefit:** 75% = $66.20 85% = $75.05 **Extended Medicare Safety Net Cap:** $264.75
17620	Professional attendance by a medical practitioner in the practice of anaesthesia for a consultation on a patient undergoing advanced surgery or who has complex medical problems involving a detailed history and comprehensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes - and of more than 30 minutes but not more than 45 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply (See para TN.6.1 of explanatory notes to this Category) **Fee:** $122.20 **Benefit:** 75% = $91.65 85% = $103.90 **Extended Medicare Safety Net Cap:** $366.60
17625	Professional attendance by a medical practitioner in the practice of anaesthesia for a consultation on a

	patient undergoing advanced surgery or who has complex medical problems involving an exhaustive history and comprehensive examination of multiple systems , the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of high complexity documented in the patient notes - and of more than 45 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply (See para TN.6.1 of explanatory notes to this Category) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30 **Extended Medicare Safety Net Cap:** $466.80
17640	ANAESTHETIST, REFERRED CONSULTATION (other than prior to anaesthesia) (Professional attendance by a specialist anaesthetist in the practice of ANAESTHESIA where the patient is referred to him or her) - a BRIEF consultation involving a short history and limited examination - *AND of not more than 15 minutes duration*, not being a service associated with a service to which items 2801 - 3000 apply (See para TN.6.2 of explanatory notes to this Category) **Fee:** $44.35 **Benefit:** 75% = $33.30 85% = $37.70 **Extended Medicare Safety Net Cap:** $133.05
17645	- a consultation involving a selective history and examination of multiple systems and the formulation of a written patient management plan - *AND of more than 15 minutes but not more than 30 minutes duration*, not being a service associated with a service to which items 2801 - 3000 apply. (See para TN.6.2 of explanatory notes to this Category) **Fee:** $88.25 **Benefit:** 75% = $66.20 85% = $75.05 **Extended Medicare Safety Net Cap:** $264.75
17650	- a consultation involving a detailed history and comprehensive examination of multiple systems and the formulation of a written patient management plan - *AND of more than 30 minutes but not more than 45 minutes duration*, not being a service associated with a service to which items 2801 - 3000 apply (See para TN.6.2 of explanatory notes to this Category) **Fee:** $122.20 **Benefit:** 75% = $91.65 85% = $103.90 **Extended Medicare Safety Net Cap:** $366.60
17655	- a consultation involving an exhaustive history and comprehensive examination of multiple systems and the formulation of a written patient management plan following discussion with relevant health care

	professionals and/or the patient, involving medical planning of high complexity, - *AND of more than 45 minutes duration,* not being a service associated with a service to which items 2801 - 3000 apply. (See para TN.6.2 of explanatory notes to this Category) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30 **Extended Medicare Safety Net Cap:** $466.80
17680	ANAESTHETIST, CONSULTATION, OTHER (Professional attendance by an anaesthetist in the practice of ANAESTHESIA) - a consultation immediately prior to the institution of a major regional blockade in a patient in labour, where no previous anaesthesia consultation has occurred, not being a service associated with a service to which items 2801 - 3000 apply. (See para TN.6.3 of explanatory notes to this Category) **Fee:** $88.25 **Benefit:** 75% = $66.20 85% = $75.05 **Extended Medicare Safety Net Cap:** $264.75
17690	- Where a pre-anaesthesia consultation covered by an item in the range 17615-17625 is performed in-rooms if: (a) the service is provided to a patient prior to an admitted patient episode of care involving anaesthesia; and (b) the service is not provided to an admitted patient of a hospital; and (c) the service is not provided on the day of admission to hospital for the subsequent episode of care involving anaesthesia services; and (d) the service is of more than 15 minutes duration not being a service associated with a service to which items 2801 - 3000 apply. (See para TN.6.3 of explanatory notes to this Category) **Fee:** $40.80 **Benefit:** 75% = $30.60 85% = $34.70 **Extended Medicare Safety Net Cap:** $122.40

T7. REGIONAL OR FIELD NERVE BLOCKS	
	Group T7. Regional Or Field Nerve Blocks
18213	INTRAVENOUS REGIONAL ANAESTHESIA of limb by retrograde perfusion **Fee:** $90.05 **Benefit:** 75% = $67.55 85% = $76.55
Amend 18216	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner Applicable once per presentation, per medical practitioner, per complete new procedure (Anaes.) (See para TN.10.7 of explanatory notes to this Category) **Fee:** $192.95 **Benefit:** 75% = $144.75 85% = $164.05
Amend 18219	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, if continuous attendance by the medical practitioner extends beyond the first hour (Anaes.) **Derived Fee:** The fee for item 18216 plus $19.30 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner.
18222	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is 15 minutes or less (See para TN.7.2, TN.10.7 of explanatory notes to this Category) **Fee:** $38.25 **Benefit:** 75% = $28.70 85% = $32.55
18225	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is more than 15 minutes (See para TN.7.2, TN.10.7 of explanatory notes to this Category) **Fee:** $50.85 **Benefit:** 75% = $38.15 85% = $43.25
Amend 18226	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner, for a patient in labour, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday. Applicable once per presentation, per medical practitioner, per complete new procedure (See para TN.7.4, TN.10.7 of explanatory notes to this Category) **Fee:** $289.35 **Benefit:** 75% = $217.05 85% = $245.95
Amend 18227	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, where continuous attendance by a medical practitioner extends beyond the first hour, for a patient in labour, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday. (See para TN.7.4, TN.10.7 of explanatory notes to this Category) **Derived Fee:** The fee for item 18226 plus $29.05 for each additional 15 minutes or part there of beyond the first hour of attendance by the medical practitioner.
18228	INTERPLEURAL BLOCK, initial injection or commencement of infusion of a therapeutic substance **Fee:** $63.50 **Benefit:** 75% = $47.65 85% = $54.00
18230	INTRATHECAL or EPIDURAL INJECTION of neurolytic substance (Anaes.) **Fee:** $242.25 **Benefit:** 75% = $181.70 85% = $205.95

T7. REGIONAL OR FIELD NERVE BLOCKS	
18232	INTRATHECAL or EPIDURAL INJECTION of substance other than anaesthetic, contrast or neurolytic solutions, not being a service to which another item in this Group applies (Anaes.) (See para TN.7.3 of explanatory notes to this Category) **Fee:** $192.95 **Benefit:** 75% = $144.75 85% = $164.05
18233	EPIDURAL INJECTION of blood for blood patch (Anaes.) **Fee:** $192.95 **Benefit:** 75% = $144.75 85% = $164.05
18234	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $126.85 **Benefit:** 75% = $95.15 85% = $107.85
18236	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $63.50 **Benefit:** 75% = $47.65 85% = $54.00
18238	FACIAL NERVE, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies (See para TN.7.5 of explanatory notes to this Category) **Fee:** $38.25 **Benefit:** 75% = $28.70 85% = $32.55
18240	RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $95.10 **Benefit:** 75% = $71.35 85% = $80.85
18242	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $38.25 **Benefit:** 75% = $28.70 85% = $32.55
18244	VAGUS NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05
18248	PHRENIC NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $90.05 **Benefit:** 75% = $67.55 85% = $76.55
18250	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $63.50 **Benefit:** 75% = $47.65 85% = $54.00
18252	CERVICAL PLEXUS, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05
18254	BRACHIAL PLEXUS, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05
18256	SUPRASCAPULAR NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category)

T7. REGIONAL OR FIELD NERVE BLOCKS	
	Fee: $63.50 **Benefit:** 75% = $47.65 85% = $54.00
18258	INTERCOSTAL NERVE (single), injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $63.50 **Benefit:** 75% = $47.65 85% = $54.00
18260	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $90.05 **Benefit:** 75% = $67.55 85% = $76.55
18262	ILIO-INGUINAL, ILIOHYPOGASTRIC OR GENITOFEMORAL NERVES, 1 or more of, injection of an anaesthetic agent (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $63.50 **Benefit:** 75% = $47.65 85% = $54.00
18264	PUDENDAL NERVE and or dorsal nerve, injection of anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05
18266	ULNAR, RADIAL OR MEDIAN NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent, not being associated with a brachial plexus block (See para TN.7.5 of explanatory notes to this Category) **Fee:** $63.50 **Benefit:** 75% = $47.65 85% = $54.00
18268	OBTURATOR NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $90.05 **Benefit:** 75% = $67.55 85% = $76.55
18270	FEMORAL NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $90.05 **Benefit:** 75% = $67.55 85% = $76.55
18272	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $63.50 **Benefit:** 75% = $47.65 85% = $54.00
18274	PARAVERTEBRAL, CERVICAL, THORACIC, LUMBAR, SACRAL OR COCCYGEAL NERVES, injection of an anaesthetic agent, (single vertebral level) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $90.05 **Benefit:** 75% = $67.55 85% = $76.55
18276	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $126.85 **Benefit:** 75% = $95.15 85% = $107.85
18278	SCIATIC NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $90.05 **Benefit:** 75% = $67.55 85% = $76.55
18280	SPHENOPALATINE GANGLION, injection of an anaesthetic agent (Anaes.) (See para TN.7.5 of explanatory notes to this Category)

T7. REGIONAL OR FIELD NERVE BLOCKS	
	Fee: $126.85 **Benefit:** 75% = $95.15 85% = $107.85
18282	CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure (See para TN.7.5 of explanatory notes to this Category) **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05
18284	STELLATE GANGLION, injection of an anaesthetic agent, (cervical sympathetic block) (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50
18286	LUMBAR OR THORACIC NERVES, injection of an anaesthetic agent, (paravertebral sympathetic block) (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50
18288	COELIAC PLEXUS OR SPLANCHNIC NERVES, injection of an anaesthetic agent (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50
18290	CRANIAL NERVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent, not being a service associated with the injection of botulinum toxin (Anaes.) **Fee:** $253.75 **Benefit:** 75% = $190.35 85% = $215.70
18292	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies or a service associated with the injection of botulinum toxin except those services to which item 18354 applies (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $126.85 **Benefit:** 75% = $95.15 85% = $107.85
18294	COELIAC PLEXUS OR SPLANCHNIC NERVES, destruction by a neurolytic agent (Anaes.) **Fee:** $178.80 **Benefit:** 75% = $134.10 85% = $152.00
18296	LUMBAR SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.) **Fee:** $152.95 **Benefit:** 75% = $114.75 85% = $130.05
New 18297	Assistance at the administration of an epidural blood patch (a service to which item 18233 applies) by another medical practitioner **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
18298	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.) **Fee:** $178.80 **Benefit:** 75% = $134.10 85% = $152.00

T8. SURGICAL OPERATIONS	1. GENERAL
	Group T8. Surgical Operations
	Subgroup 1. General
30001	OPERATIVE PROCEDURE, not being a service to which any other item in this Group applies, being a service to which an item in this Group would have applied had the procedure not been discontinued on medical grounds (See para TN.8.5 of explanatory notes to this Category)

	Derived Fee: 50% of the fee which would have applied had the procedure not been discontinued
30003	LOCALISED BURNS, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation **Fee:** $36.90 **Benefit:** 75% = $27.70 85% = $31.40
30006	EXTENSIVE BURNS, dressing of, without anaesthesia (not involving grafting) each attendance at which the procedure is performed, including any associated consultation **Fee:** $47.25 **Benefit:** 75% = $35.45 85% = $40.20
30010	LOCALISED BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.) **Fee:** $75.10 **Benefit:** 75% = $56.35
30014	EXTENSIVE BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.) **Fee:** $157.90 **Benefit:** 75% = $118.45
30017	BURNS, excision of, under general anaesthesia, involving not more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60
30020	BURNS, excision of, under general anaesthesia, involving more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.) **Fee:** $645.15 **Benefit:** 75% = $483.90
30023	WOUND OF SOFT TISSUE, traumatic, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60
30024	WOUND OF SOFT TISSUE, debridement of extensively infected post-surgical incision or Fournier's Gangrene, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60
30026	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $53.05 **Benefit:** 75% = $39.80 85% = $45.10
30029	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $91.45 **Benefit:** 75% = $68.60 85% = $77.75
30032	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes.) (See para TN.8.6 of explanatory notes to this Category)

	Fee: $83.80 **Benefit:** 75% = $62.85 85% = $71.25
30035	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 75% = $89.60 85% = $101.55
30038	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $91.45 **Benefit:** 75% = $68.60 85% = $77.75
30042	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 7 CM LONG), involving deeper tissue, other than a service to which another item in Group T4 applies (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $188.55 **Benefit:** 75% = $141.45 85% = $160.30
30045	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 75% = $89.60 85% = $101.55
30049	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $188.55 **Benefit:** 75% = $141.45 85% = $160.30
30052	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.) **Fee:** $258.05 **Benefit:** 75% = $193.55 85% = $219.35
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.) **Fee:** $75.10 **Benefit:** 75% = $56.35 85% = $63.85
30058	POSTOPERATIVE HAEMORRHAGE, control of, under general anaesthesia, as an independent procedure (Anaes.) **Fee:** $146.65 **Benefit:** 75% = $110.00 85% = $124.70
30061	SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea or sclera), as an independent procedure (Anaes.) **Fee:** $23.90 **Benefit:** 75% = $17.95 85% = $20.35
30062	Etonogestrel subcutaneous implant, removal of, as an independent procedure (Anaes.) **Fee:** $61.70 **Benefit:** 75% = $46.30 85% = $52.45

30064	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.) **Fee:** $111.65 **Benefit:** 75% = $83.75 85% = $94.95
30068	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.) **Fee:** $281.25 **Benefit:** 75% = $210.95 85% = $239.10
30071	Diagnostic biopsy of skin, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $53.05 **Benefit:** 75% = $39.80 85% = $45.10 **Extended Medicare Safety Net Cap:** $42.45
30072	Diagnostic biopsy of mucous membrane, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $53.05 **Benefit:** 75% = $39.80 85% = $45.10
Amend 30075	DIAGNOSTIC BIOPSY OF LYMPH NODE, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.) **Fee:** $152.15 **Benefit:** 75% = $114.15 85% = $129.35
Amend 30078	DIAGNOSTIC DRILL BIOPSY OF LYMPH NODE, DEEP TISSUE OR ORGAN, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $49.25 **Benefit:** 75% = $36.95 85% = $41.90
30081	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using open approach, where the biopsy specimen is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $111.65 **Benefit:** 75% = $83.75 85% = $94.95
30084	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using percutaneous approach where the biopsy is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $59.75 **Benefit:** 75% = $44.85 85% = $50.80
30087	DIAGNOSTIC BIOPSY OF BONE MARROW by aspiration or PUNCH BIOPSY OF SYNOVIAL MEMBRANE, where the biopsy is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $29.90 **Benefit:** 75% = $22.45 85% = $25.45
30090	DIAGNOSTIC BIOPSY OF PLEURA, PERCUTANEOUS 1 or more biopsies on any 1 occasion, where the biopsy is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $130.60 **Benefit:** 75% = $97.95 85% = $111.05
30093	DIAGNOSTIC NEEDLE BIOPSY OF VERTEBRA, where the biopsy is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category)

	Fee: $174.30 **Benefit:** 75% = $130.75 85% = $148.20
30094	DIAGNOSTIC PERCUTANEOUS ASPIRATION BIOPSY of deep organ using interventional imaging techniques - but not including imaging, where the biopsy is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $192.45 **Benefit:** 75% = $144.35 85% = $163.60
30096	DIAGNOSTIC SCALENE NODE BIOPSY, by open procedure, where the specimen excised is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $186.85 **Benefit:** 75% = $140.15 85% = $158.85
30097	Personal performance of a Synacthen Stimulation Test, including associated consultation; by a medical practitioner with resuscitation training and access to facilities where life support procedures can be implemented, if: • serum cortisol at 0830-0930 hours on any day in the preceding month has been measured at greater than 100 nmol/L but less than 400 nmol/L; or • in a patient who is acutely unwell and adrenal insufficiency is suspected. (See para TN.8.139 of explanatory notes to this Category) **Fee:** $98.70 **Benefit:** 75% = $74.05 85% = $83.90
30099	SINUS, excision of, involving superficial tissue only (Anaes.) **Fee:** $91.45 **Benefit:** 75% = $68.60 85% = $77.75
30103	SINUS, excision of, involving muscle and deep tissue (Anaes.) **Fee:** $186.85 **Benefit:** 75% = $140.15 85% = $158.85
30104	PRE-AURICULAR SINUS, on a person 10 years of age or over. Excision of, (Anaes.) **Fee:** $128.95 **Benefit:** 75% = $96.75 85% = $109.65
30105	PRE-AURICULAR SINUS, on a person under 10 years of age. Excision of, (Anaes.) **Fee:** $167.60 **Benefit:** 75% = $125.70 85% = $142.50
30107	GANGLION OR SMALL BURSA, excision of, other than a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $223.45 **Benefit:** 75% = $167.60 85% = $189.95
30111	BURSA (LARGE), INCLUDING OLECRANON, CALCANEUM OR PATELLA, excision of (Anaes.) (Assist.) **Fee:** $377.45 **Benefit:** 75% = $283.10 85% = $320.85
30114	BURSA, SEMIMEMBRANOSUS (Baker's cyst), excision of (Anaes.) (Assist.) **Fee:** $377.45 **Benefit:** 75% = $283.10
30165	Lipectomy, wedge excision of abdominal apron that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30168, 30171, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and

	(b) the abdominal apron interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (H) (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $462.15 **Benefit:** 75% = $346.65
30168	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30171, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy; and (d) the procedure involves 1 excision only (H) (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $462.15 **Benefit:** 75% = $346.65
30171	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30168, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy; and (d) the procedure involves 2 excisions only (H) (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $702.80 **Benefit:** 75% = $527.10
30172	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30168, 30171, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the

	lipectomy; and (d) the procedure involves 3 or more excisions (H) (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $702.80 **Benefit:** 75% = $527.10
30176	Lipectomy, radical abdominoplasty (Pitanguy type or similar), with excision of skin and subcutaneous tissue, repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30177, 30179, 45530, 45564 or 45565 applies, if the patient has previously had a massive intra-abdominal or pelvic tumour surgically removed (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $1,001.45 **Benefit:** 75% = $751.10
30177	Lipectomy, excision of skin and subcutaneous tissue associated with redundant abdominal skin and fat that is a direct consequence of significant weight loss, in conjunction with a radical abdominoplasty (Pitanguy type or similar), with or without repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (H) (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $1,001.45 **Benefit:** 75% = $751.10
30179	Circumferential lipectomy, as an independent procedure, to correct circumferential excess of redundant skin and fat that is a direct consequence of significant weight loss, with or without a radical abdominoplasty (Pitanguy type or similar), not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 45530, 45564 or 45565 applies, if: (a) the circumferential excess of redundant skin and fat is complicated by intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and (b) the circumferential excess of redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (H) (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $1,232.55 **Benefit:** 75% = $924.45
30180	AXILLARY HYPERHIDROSIS, partial excision for (Anaes.) **Fee:** $138.70 **Benefit:** 75% = $104.05 85% = $117.90

30183	AXILLARY HYPERHIDROSIS, total excision of sweat gland bearing area (Anaes.) **Fee:** $250.45 **Benefit:** 75% = $187.85 85% = $212.90
30187	PALMAR OR PLANTAR WARTS, removal of, by carbon dioxide laser or erbium laser, requiring admission to a hospital, or when performed by a specialist in the practice of his/her specialty, (5 or more warts) (Anaes.) (See para TN.8.9 of explanatory notes to this Category) **Fee:** $261.05 **Benefit:** 75% = $195.80 85% = $221.90
30189	WARTS or MOLLUSCUM CONTAGIOSUM (one or more), removal of, by any method (other than by chemical means), where undertaken in the operating theatre of a hospital, not being a service associated with a service to which another item in this Group applies (H) (Anaes.) (See para TN.8.9 of explanatory notes to this Category) **Fee:** $149.65 **Benefit:** 75% = $112.25
30190	Angiofibromas, trichoepitheliomas or other severely disfiguring tumours of the face or neck (excluding melanocytic naevi, sebaceous hyperplasia, dermatosis papulosa nigra, Campbell De Morgan angiomas and seborrheic or viral warts), suitable for laser ablation as confirmed by the opinion of a specialist in the specialty of dermatology—removal of, by carbon dioxide laser or erbium laser ablation, including associated resurfacing (10 or more tumours) (Anaes.) **Fee:** $404.10 **Benefit:** 75% = $303.10 85% = $343.50
30191	Angiofibromas, trichoepithelioma, epidermal naevi, xanthelasma, pyogenic granuloma, genital angiokeratomas, hereditary haemorrhagic telangiectasia and other severely disfiguring or recurrently bleeding tumours (excluding melanocytic naevi, sebaceous hyperplasia, dermatosis papulosa nigra, Campbell De Morgan angiomas and seborrheic or viral warts), treatment of, with carbon dioxide/erbium or other appropriate laser (or curettage and fine point diathermy for pyogenic granuloma only), if confirmed by the opinion of a specialist in the specialty of dermatology, one or more lesions. **Fee:** $64.50 **Benefit:** 75% = $48.40 85% = $54.85
30192	PREMALIGNANT SKIN LESIONS (including solar keratoses), treatment of, by ablative technique (10 or more lesions) (Anaes.) (See para TN.8.9 of explanatory notes to this Category) **Fee:** $40.20 **Benefit:** 75% = $30.15 85% = $34.20
30196	Malignant neoplasm of skin or mucous membrane that has been: (a) proven by histopathology; or (b) confirmed by the opinion of a specialist in the specialty of dermatology where a specimen has been submitted for histologic confirmation; removal of, by serial curettage, or carbon dioxide laser or erbium laser excision-ablation, including any associated cryotherapy or diathermy (Anaes.) (See para TN.8.10 of explanatory notes to this Category) **Fee:** $128.30 **Benefit:** 75% = $96.25 85% = $109.10
30202	Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by the opinion of a specialist in the specialty of dermatology—removal of, by liquid nitrogen cryotherapy using repeat freeze thaw cycles (See para TN.8.10 of explanatory notes to this Category) **Fee:** $49.10 **Benefit:** 75% = $36.85 85% = $41.75

30207	Skin lesions, multiple injections with glucocorticoid preparations (Anaes.) **Fee:** $45.30 **Benefit:** 75% = $34.00 85% = $38.55
30210	Keloid and other skin lesions, extensive, multiple injections of glucocorticoid preparations, if undertaken in the operating theatre of a hospital on a patient less than 16 years of age (Anaes.) **Fee:** $165.55 **Benefit:** 75% = $124.20
30216	HAEMATOMA, aspiration of (Anaes.) **Fee:** $27.80 **Benefit:** 75% = $20.85 85% = $23.65
30219	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital - INCISION WITH DRAINAGE OF (excluding aftercare) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $27.80 **Benefit:** 75% = $20.85 85% = $23.65
30223	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $165.55 **Benefit:** 75% = $124.20
30224	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $241.40 **Benefit:** 75% = $181.05 85% = $205.20
30225	ABSCESS DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $271.95 **Benefit:** 75% = $204.00 85% = $231.20
30226	MUSCLE, excision of (LIMITED), or fasciotomy (Anaes.) **Fee:** $152.15 **Benefit:** 75% = $114.15 85% = $129.35
30229	MUSCLE, excision of (EXTENSIVE) (Anaes.) (Assist.) **Fee:** $277.30 **Benefit:** 75% = $208.00 85% = $235.75
30232	MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.) **Fee:** $227.20 **Benefit:** 75% = $170.40 85% = $193.15
30235	MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.) **Fee:** $300.45 **Benefit:** 75% = $225.35 85% = $255.40
30238	FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE (Anaes.) **Fee:** $152.15 **Benefit:** 75% = $114.15 85% = $129.35
30241	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $362.05 **Benefit:** 75% = $271.55 85% = $307.75
30244	STYLOID PROCESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.) **Fee:** $362.05 **Benefit:** 75% = $271.55

30246	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.) **Fee:** $700.85 **Benefit:** 75% = $525.65
30247	PAROTID GLAND, total extirpation of (Anaes.) (Assist.) **Fee:** $751.20 **Benefit:** 75% = $563.40
30250	PAROTID GLAND, total extirpation of, with preservation of facial nerve (Anaes.) (Assist.) **Fee:** $1,271.10 **Benefit:** 75% = $953.35
30251	RECURRENT PAROTID TUMOUR, excision of, with preservation of facial nerve (Anaes.) (Assist.) **Fee:** $1,952.50 **Benefit:** 75% = $1464.40 85% = $1867.80
30253	PAROTID GLAND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anaes.) (Assist.) **Fee:** $847.40 **Benefit:** 75% = $635.55
30255	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.) **Fee:** $1,128.40 **Benefit:** 75% = $846.30
30256	SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.) **Fee:** $452.55 **Benefit:** 75% = $339.45
30259	SUBLINGUAL GLAND, extirpation of (Anaes.) **Fee:** $201.70 **Benefit:** 75% = $151.30 85% = $171.45
30262	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.) **Fee:** $59.75 **Benefit:** 75% = $44.85 85% = $50.80
30266	Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, 1 or more such procedures. (Anaes.) **Fee:** $152.15 **Benefit:** 75% = $114.15 85% = $129.35
30269	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes.) **Fee:** $152.15 **Benefit:** 75% = $114.15 85% = $129.35
30272	TONGUE, partial excision of (Anaes.) (Assist.) **Fee:** $300.45 **Benefit:** 75% = $225.35 85% = $255.40
Amend 30275	RADICAL EXCISION OF INTRAORAL TUMOUR INVOLVING RESECTION OF MANDIBLE AND LYMPH NODES OF NECK (commandotype operation) (Anaes.) (Assist.) **Fee:** $1,790.95 **Benefit:** 75% = $1343.25
30278	TONGUE TIE, repair of, not being a service to which another item in this Group applies (Anaes.) **Fee:** $47.25 **Benefit:** 75% = $35.45 85% = $40.20
30281	TONGUE TIE, MANDIBULAR FRENULUM or MAXILLARY FRENULUM, repair of, in a person aged 2 years and over, under general anaesthesia (Anaes.) **Fee:** $121.40 **Benefit:** 75% = $91.05 85% = $103.20

30283	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.) **Fee:** $208.00 **Benefit:** 75% = $156.00 85% = $176.80
30286	BRANCHIAL CYST, on a person 10 years of age or over. Removal of, (Anaes.) (Assist.) **Fee:** $404.20 **Benefit:** 75% = $303.15 85% = $343.60
30287	BRANCHIAL CYST, on a person under 10 years of age. Removal of, (Anaes.) (Assist.) **Fee:** $525.50 **Benefit:** 75% = $394.15 85% = $446.70
30289	BRANCHIAL FISTULA, on a person 10 years of age or over. Removal of, (Anaes.) (Assist.) **Fee:** $510.30 **Benefit:** 75% = $382.75
30293	CERVICAL OESOPHAGOSTOMY or CLOSURE OF CERVICAL OESOPHAGOSTOMY with or without plastic repair (Anaes.) (Assist.) **Fee:** $452.55 **Benefit:** 75% = $339.45 85% = $384.70
30294	CERVICAL OESOPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction (Anaes.) (Assist.) **Fee:** $1,790.95 **Benefit:** 75% = $1343.25
30296	THYROIDECTOMY, total (Anaes.) (Assist.) (See para TN.8.137 of explanatory notes to this Category) **Fee:** $1,040.10 **Benefit:** 75% = $780.10
30297	THYROIDECTOMY following previous thyroid surgery (Anaes.) (Assist.) (See para TN.8.138 of explanatory notes to this Category) **Fee:** $1,040.10 **Benefit:** 75% = $780.10
30299	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level I axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30300, 30302 or 30303 applies (Anaes.) (Assist.) (See para TN.8.12 of explanatory notes to this Category) **Fee:** $647.65 **Benefit:** 75% = $485.75
30300	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level II/III axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30299, 30302 or 30303 applies (Anaes.) (Assist.) (See para TN.8.12 of explanatory notes to this Category) **Fee:** $777.15 **Benefit:** 75% = $582.90
30302	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level I axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30303 applies (Anaes.) (Assist.) (See para TN.8.12 of explanatory notes to this Category) **Fee:** $518.10 **Benefit:** 75% = $388.60
30303	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level II/III axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30302 applies (Anaes.) (Assist.) (See para TN.8.12 of explanatory notes to this Category)

	Fee: $621.65 **Benefit:** 75% = $466.25
30306	TOTAL HEMITHYROIDECTOMY (Anaes.) (Assist.) (See para TN.8.137, TN.8.138 of explanatory notes to this Category) **Fee:** $811.45 **Benefit:** 75% = $608.60
30310	Partial or subtotal thyroidectomy (Anaes.) (Assist.) (See para TN.8.137 of explanatory notes to this Category) **Fee:** $811.45 **Benefit:** 75% = $608.60
30314	THYROGLOSSAL CYST or FISTULA or both, on a person 10 years of age or over. Radical removal of, including thyroglossal duct and portion of hyoid bone (Anaes.) (Assist.) **Fee:** $464.70 **Benefit:** 75% = $348.55
30315	Minimally invasive parathyroidectomy. Removal of 1 or more parathyroid adenoma through a small cervical incision for an image localised adenoma, including thymectomy. For any particular patient - applicable only once per occasion on which the service is provided. Not in association with a service to which item 30318, 30317 or 30320 applies. (Anaes.) (Assist.) **Fee:** $1,158.15 **Benefit:** 75% = $868.65
30317	Redo parathyroidectomy. Cervical re-exploration for persistent or recurrent hyperparathyroidism, including thymectomy and cervical exploration of the mediastinum. For any particular patient - applicable only once per occasion on which the service is provided. Not in association with a service to which item 30315, 30318 or 30320 applies. (Anaes.) (Assist.) **Fee:** $1,386.75 **Benefit:** 75% = $1040.10
30318	Open parathyroidectomy, exploration and removal of 1 or more adenoma or hyperplastic glands via a cervical incision including thymectomy and cervical exploration of the mediastinum when performed. For any particular patient - applicable only once per occasion on which the service is provided. Not in association with a service to which item 30315, 30317 or 30320 applies. (Anaes.) (Assist.) **Fee:** $1,158.15 **Benefit:** 75% = $868.65
30320	Removal of a mediastinal parathyroid adenoma via sternotomy or mediastinal thorascopic approach. For any particular patient - applicable only once per occasion on which the service is provided. Not in association with a service to which item 30315, 30317 or 30318 applies. (Anaes.) (Assist.) **Fee:** $1,386.75 **Benefit:** 75% = $1040.10
30323	Excision of phaeochromocytoma or extraadrenal paraganglioma via endoscopic or open approach. (Anaes.) (Assist.) **Fee:** $1,386.75 **Benefit:** 75% = $1040.10
30324	Excision of an adrenocortical tumour or hyperplasia via endoscopic or open approach. (Anaes.) (Assist.) **Fee:** $1,386.75 **Benefit:** 75% = $1040.10
30326	THYROGLOSSAL CYST or FISTULA or both, radical removal of, including thyroglossal duct and

	portion of hyoid bone, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $604.10 **Benefit:** 75% = $453.10
Amend 30329	LYMPH NODES of GROIN, limited excision of (Anaes.) **Fee:** $250.90 **Benefit:** 75% = $188.20 85% = $213.30
Amend 30330	LYMPH NODES of GROIN, radical excision of (Anaes.) (Assist.) **Fee:** $730.25 **Benefit:** 75% = $547.70
30332	LYMPH NODES of AXILLA, limited excision of (sampling) (Anaes.) (Assist.) **Fee:** $352.30 **Benefit:** 75% = $264.25
30335	LYMPH NODES of AXILLA, complete excision of, to level I (Anaes.) (Assist.) (See para TN.8.13 of explanatory notes to this Category) **Fee:** $880.70 **Benefit:** 75% = $660.55
30336	LYMPH NODES of AXILLA, complete excision of, to level II or level III (Anaes.) (Assist.) (See para TN.8.13 of explanatory notes to this Category) **Fee:** $1,056.90 **Benefit:** 75% = $792.70
30373	LAPAROTOMY (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.) **Fee:** $491.00 **Benefit:** 75% = $368.25
30375	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, Gastrostomy, Gastrotomy, on a person 10 years of age or over. Reduction of intussusception, Removal of Meckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty (adult) or Drainage of pancreas (Anaes.) (Assist.) (See para TN.8.14 of explanatory notes to this Category) **Fee:** $529.60 **Benefit:** 75% = $397.20
30376	LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESIONS (where no other intraabdominal procedure is performed) on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $529.60 **Benefit:** 75% = $397.20
30378	LAPAROTOMY involving division of adhesions in conjunction with another intraabdominal procedure where the time taken to divide the adhesions is between 45 minutes and 2 hours, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $532.10 **Benefit:** 75% = $399.10
30379	LAPAROTOMY WITH DIVISION OF EXTENSIVE ADHESIONS (duration greater than 2 hours) with or without insertion of long intestinal tube (Anaes.) (Assist.) **Fee:** $943.00 **Benefit:** 75% = $707.25
30382	ENTEROCUTANEOUS FISTULA, radical repair of, involving extensive dissection and resection of bowel (Anaes.) (Assist.) **Fee:** $1,327.80 **Benefit:** 75% = $995.85
30384	LAPAROTOMY FOR GRADING OF LYMPHOMA, including splenectomy, liver biopsies, lymph node biopsies and oophoropexy (Anaes.) (Assist.)

	Fee: $1,117.00 **Benefit:** 75% = $837.75
30385	LAPAROTOMY FOR CONTROL OF POSTOPERATIVE HAEMORRHAGE, where no other procedure is performed (Anaes.) (Assist.) **Fee:** $572.30 **Benefit:** 75% = $429.25
30387	LAPAROTOMY INVOLVING OPERATION ON ABDOMINAL VISCERA (including pelvic viscera), not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $645.15 **Benefit:** 75% = $483.90
30388	LAPAROTOMY for trauma involving 3 or more organs (Anaes.) (Assist.) **Fee:** $1,623.10 **Benefit:** 75% = $1217.35
30390	LAPAROSCOPY, diagnostic, not being a service associated with any other laparoscopic procedure, on a person 10 years of age or over (Anaes.) (See para TN.8.15 of explanatory notes to this Category) **Fee:** $223.45 **Benefit:** 75% = $167.60
30391	LAPAROSCOPY with biopsy (Anaes.) (Assist.) **Fee:** $288.90 **Benefit:** 75% = $216.70
30392	RADICAL OR DEBULKING OPERATION for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (Anaes.) (Assist.) **Fee:** $685.30 **Benefit:** 75% = $514.00
30393	LAPAROSCOPIC DIVISION OF ADHESIONS in association with another intra-abdominal procedure where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.) **Fee:** $532.10 **Benefit:** 75% = $399.10
30394	LAPAROTOMY for drainage of subphrenic abscess, pelvic abscess, appendiceal abscess, ruptured appendix or for peritonitis from any cause, with or without appendicectomy (Anaes.) (Assist.) **Fee:** $500.75 **Benefit:** 75% = $375.60
30396	LAPAROTOMY for gross intra peritoneal sepsis requiring debridement of fibrin, with or without removal of foreign material or enteric contents, with lavage of the entire peritoneal cavity via a major abdominal incision, with or without closure of abdomen and with or without mesh or zipper insertion (Anaes.) (Assist.) (See para TN.8.16 of explanatory notes to this Category) **Fee:** $1,032.80 **Benefit:** 75% = $774.60
30397	LAPAROSTOMY, via wound previously made and left open or closed with zipper, involving change of dressings or packs, and with or without drainage of loculated collections (Anaes.) **Fee:** $236.05 **Benefit:** 75% = $177.05
30399	LAPAROSTOMY, final closure of wound made at previous operation, after removal of dressings or packs and removal of mesh or zipper if previously inserted (Anaes.) (Assist.) **Fee:** $324.70 **Benefit:** 75% = $243.55
30400	LAPAROTOMY WITH INSERTION OF PORTACATH for administration of cytotoxic therapy including placement of reservoir (Anaes.) (Assist.) **Fee:** $642.60 **Benefit:** 75% = $481.95

30402	RETROPERITONEAL ABSCESS, drainage of, not involving laparotomy (Anaes.) (Assist.) **Fee:** $472.05 **Benefit:** 75% = $354.05
30403	VENTRAL, INCISIONAL, OR RECURRENT HERNIA OR BURST ABDOMEN, repair of with or without mesh (Anaes.) (Assist.) **Fee:** $529.60 **Benefit:** 75% = $397.20
30405	VENTRAL OR INCISIONAL HERNIA, (excluding recurrent inguinal or femoral hernia), repair of, requiring muscle transposition, mesh hernioplasty or resection of strangulated bowel (Anaes.) (Assist.) **Fee:** $929.60 **Benefit:** 75% = $697.20
30406	PARACENTESIS ABDOMINIS (Anaes.) **Fee:** $53.05 **Benefit:** 75% = $39.80 85% = $45.10
30408	PERITONEOVENOUS shunt, insertion of (Anaes.) (Assist.) **Fee:** $398.35 **Benefit:** 75% = $298.80
30409	LIVER BIOPSY, percutaneous (Anaes.) **Fee:** $177.25 **Benefit:** 75% = $132.95 85% = $150.70
30411	LIVER BIOPSY by wedge excision when performed in conjunction with another intraabdominal procedure (Anaes.) **Fee:** $90.20 **Benefit:** 75% = $67.65
30412	LIVER BIOPSY by core needle, when performed in conjunction with another intra-abdominal procedure (Anaes.) **Fee:** $53.20 **Benefit:** 75% = $39.90 85% = $45.25
30414	LIVER, subsegmental resection of, (local excision), other than for trauma (Anaes.) (Assist.) **Fee:** $700.85 **Benefit:** 75% = $525.65
30415	LIVER, segmental resection of, other than for trauma (Anaes.) (Assist.) **Fee:** $1,401.55 **Benefit:** 75% = $1051.20
30416	LIVER CYST, laparoscopic marsupialisation of, where the size of the cyst is greater than 5cm in diameter (Anaes.) (Assist.) **Fee:** $760.95 **Benefit:** 75% = $570.75
30417	LIVER CYSTS, laparoscopic marsupialisation of 5 or more, including any cyst greater than 5cm in diameter (Anaes.) (Assist.) **Fee:** $1,141.35 **Benefit:** 75% = $856.05
30418	LIVER, lobectomy of, other than for trauma (Anaes.) (Assist.) **Fee:** $1,623.10 **Benefit:** 75% = $1217.35
30419	LIVER TUMOURS, destruction of, by hepatic cryotherapy, not being a service associated with a service to which item 50950 or 50952 applies (Anaes.) (Assist.) **Fee:** $830.15 **Benefit:** 75% = $622.65 85% = $745.45
30421	LIVER, TRI-SEGMENTAL RESECTION (extended lobectomy) of, other than for trauma (Anaes.)

	(Assist.) **Fee:** $2,028.50 **Benefit:** 75% = $1521.40
30422	LIVER, repair of superficial laceration of, for trauma (Anaes.) (Assist.) **Fee:** $686.15 **Benefit:** 75% = $514.65
30425	LIVER, repair of deep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.) **Fee:** $1,327.80 **Benefit:** 75% = $995.85
30427	LIVER, segmental resection of, for trauma (Anaes.) (Assist.) **Fee:** $1,585.95 **Benefit:** 75% = $1189.50
30428	LIVER, lobectomy of, for trauma (Anaes.) (Assist.) **Fee:** $1,696.70 **Benefit:** 75% = $1272.55 85% = $1612.00
30430	LIVER, extended lobectomy (tri-segmental resection) of, for trauma (Anaes.) (Assist.) **Fee:** $2,360.45 **Benefit:** 75% = $1770.35 85% = $2275.75
30431	LIVER ABSCESS, open abdominal drainage of (Anaes.) (Assist.) **Fee:** $529.60 **Benefit:** 75% = $397.20 85% = $450.20
30433	LIVER ABSCESS (multiple), open abdominal drainage of (Anaes.) (Assist.) **Fee:** $737.65 **Benefit:** 75% = $553.25
30434	HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles (Anaes.) (Assist.) **Fee:** $597.55 **Benefit:** 75% = $448.20
30436	HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles, with omentoplasty or myeloplasty (Anaes.) (Assist.) **Fee:** $663.90 **Benefit:** 75% = $497.95
30437	HYDATID CYST OF LIVER, total excision of, by cysto-pericystectomy (membrane plus fibrous wall) (Anaes.) (Assist.) **Fee:** $826.30 **Benefit:** 75% = $619.75
30438	HYDATID CYST OF LIVER, excision of, with drainage and excision of liver tissue (Anaes.) (Assist.) **Fee:** $1,169.25 **Benefit:** 75% = $876.95 85% = $1084.55
30439	OPERATIVE CHOLANGIOGRAPHY OR OPERATIVE PANCREATOGRAPHY OR INTRA OPERATIVE ULTRASOUND of the biliary tract (including 1 or more examinations performed during the 1 operation) (Anaes.) (Assist.) **Fee:** $188.55 **Benefit:** 75% = $141.45
30440	CHOLANGIOGRAM, percutaneous transhepatic, and insertion of biliary drainage tube, using interventional imaging techniques - but not including imaging, not being a service associated with a service to which item 30451 applies (Anaes.) (Assist.) **Fee:** $534.80 **Benefit:** 75% = $401.10 85% = $454.60

30441	INTRA OPERATIVE ULTRASOUND for staging of intra abdominal tumours (Anaes.) **Fee:** $138.45 **Benefit:** 75% = $103.85
30442	CHOLEDOCHOSCOPY in conjunction with another procedure (Anaes.) **Fee:** $188.55 **Benefit:** 75% = $141.45
30443	CHOLECYSTECTOMY (Anaes.) (Assist.) **Fee:** $751.20 **Benefit:** 75% = $563.40
30445	LAPAROSCOPIC CHOLECYSTECTOMY (Anaes.) (Assist.) **Fee:** $751.20 **Benefit:** 75% = $563.40
30446	LAPAROSCOPIC CHOLECYSTECTOMY when procedure is completed by laparotomy (Anaes.) (Assist.) **Fee:** $751.20 **Benefit:** 75% = $563.40
30448	LAPAROSCOPIC CHOLECYSTECTOMY, involving removal of common duct calculi via the cystic duct (Anaes.) (Assist.) **Fee:** $988.45 **Benefit:** 75% = $741.35
30449	LAPAROSCOPIC CHOLECYSTECTOMY with removal of common duct calculi via laparoscopic choledochotomy (Anaes.) (Assist.) **Fee:** $1,099.15 **Benefit:** 75% = $824.40
30450	CALCULUS OF BILIARY OR RENAL TRACT, extraction of, using interventional imaging techniques - not being a service associated with a service to which items 36627, 36630, 36645 or 36648 applies (Anaes.) (Assist.) **Fee:** $532.80 **Benefit:** 75% = $399.60 85% = $452.90
30451	BILIARY DRAINAGE TUBE, exchange of, using interventional imaging techniques - but not including imaging, not being a service associated with a service to which item 30440 applies (Anaes.) (Assist.) **Fee:** $271.95 **Benefit:** 75% = $204.00 85% = $231.20
30452	CHOLEDOCHOSCOPY with balloon dilation of a stricture or passage of stent or extraction of calculi (Anaes.) (Assist.) **Fee:** $383.55 **Benefit:** 75% = $287.70
30454	CHOLEDOCHOTOMY (with or without cholecystectomy), with or without removal of calculi (Anaes.) (Assist.) **Fee:** $876.30 **Benefit:** 75% = $657.25
30455	CHOLEDOCHOTOMY (with or without cholecystectomy), with removal of calculi including biliary intestinal anastomosis (Anaes.) (Assist.) **Fee:** $1,030.25 **Benefit:** 75% = $772.70
30457	CHOLEDOCHOTOMY, intrahepatic, involving removal of intrahepatic bile duct calculi (Anaes.) (Assist.) **Fee:** $1,401.55 **Benefit:** 75% = $1051.20 85% = $1316.85
30458	TRANSDUODENAL OPERATION ON SPHINCTER OF ODDI, involving 1 or more of, removal of calculi, sphincterotomy, sphincteroplasty, biopsy, local excision of peri-ampullary or duodenal tumour,

	sphincteroplasty of the pancreatic duct, pancreatic duct septoplasty, with or without choledochotomy (Anaes.) (Assist.) **Fee:** $1,030.25 **Benefit:** 75% = $772.70
30460	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (Anaes.) (Assist.) **Fee:** $876.30 **Benefit:** 75% = $657.25
30461	RADICAL RESECTION of porta hepatis with biliary-enteric anastomoses, not being a service associated with a service to which item 30443, 30454, 30455, 30458 or 30460 applies (Anaes.) (Assist.) **Fee:** $1,502.05 **Benefit:** 75% = $1126.55
30463	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, with 2 duct anastomoses (Anaes.) (Assist.) **Fee:** $1,844.25 **Benefit:** 75% = $1383.20
30464	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, involving more than 2 anastomoses or resection of segment or major portion of segment of liver (Anaes.) (Assist.) **Fee:** $2,213.10 **Benefit:** 75% = $1659.85
30466	INTRAHEPATIC biliary bypass of left hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.) **Fee:** $1,276.15 **Benefit:** 75% = $957.15
30467	INTRAHEPATIC BYPASS of right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.) **Fee:** $1,578.55 **Benefit:** 75% = $1183.95
30469	BILIARY STRICTURE, repair of, after 1 or more operations on the biliary tree (Anaes.) (Assist.) **Fee:** $1,748.45 **Benefit:** 75% = $1311.35 85% = $1663.75
30472	HEPATIC OR COMMON BILE DUCT, repair of, as the primary procedure subsequent to partial or total transection of bile duct or ducts (Anaes.) (Assist.) **Fee:** $944.20 **Benefit:** 75% = $708.15 85% = $859.50
30473	Oesophagoscopy (not being a service to which item 41816 or 41822 applies), gastroscopy, duodenoscopy or panendoscopy (1 or more such procedures), with or without biopsy, not being a service associated with a service to which item 30478 or 30479 applies. (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $179.95 **Benefit:** 75% = $135.00 85% = $153.00
30475	Endoscopic dilatation of stricture of upper gastrointestinal tract (including the use of imaging intensification where clinically indicated) (Anaes.) (See para TN.8.17, TN.8.133 of explanatory notes to this Category) **Fee:** $354.55 **Benefit:** 75% = $265.95 85% = $301.40
30478	Oesophagoscopy (other than a service to which item 41816, 41822 or 41825 applies), gastroscopy, duodenoscopy, panendoscopy or push enteroscopy, one or more such procedures, if:

	(a) the procedures are performed using one or more of the following endoscopic procedures: (i) polypectomy; (ii) sclerosing or adrenalin injections; (iii) banding; (iv) endoscopic clips; (v) haemostatic powders; (vi) diathermy; (vii) argon plasma coagulation; and (b) the procedures are for the treatment of one or more of the following: (i) upper gastrointestinal tract bleeding; (ii) polyps; (iii) removal of foreign body; (iv) oesophageal or gastric varices; (v) peptic ulcers; (vi) neoplasia; (vii) benign vascular lesions; (viii) strictures of the gastrointestinal tract; (ix) tumorous overgrowth through or over oesophageal stents; other than a service associated with a service to which item 30473 or 30479 applies (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $249.50 **Benefit:** 75% = $187.15 85% = $212.10
30479	Endoscopy with laser therapy, for the treatment of one or more of the following: (a) neoplasia; (b) benign vascular lesions; (c) strictures of the gastrointestinal tract; (d) tumorous overgrowth through or over oesophageal stents; (e) peptic ulcers;

	(f) angiodysplasia; (g) gastric antral vascular ectasia; (h) post-polypectomy bleeding; other than a service associated with a service to which item 30473 or 30478 applies (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $483.70 **Benefit:** 75% = $362.80 85% = $411.15
30481	PERCUTANEOUS GASTROSTOMY (initial procedure): (a) including any associated imaging services; and (b) excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $362.70 **Benefit:** 75% = $272.05 85% = $308.30
30482	PERCUTANEOUS GASTROSTOMY (repeat procedure): (a) including any associated imaging services; and (b) excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.) **Fee:** $257.90 **Benefit:** 75% = $193.45 85% = $219.25
30483	GASTROSTOMY BUTTON, CAECOSTOMY ANTEGRADE ENEMA DEVICE (CHAIT etc.) or STOMAL INDWELLING DEVICE: (a) non-endoscopic insertion of; or (b) non-endoscopic replacement of; on a person 10 years of age or over, excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.) **Fee:** $179.90 **Benefit:** 75% = $134.95 85% = $152.95
30484	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $370.75 **Benefit:** 75% = $278.10 85% = $315.15
30485	ENDOSCOPIC SPHINCTEROTOMY with or without extraction of stones from common bile duct (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $572.30 **Benefit:** 75% = $429.25 85% = $487.60
30488	SMALL BOWEL INTUBATION as an independent procedure (Anaes.) **Fee:** $91.45 **Benefit:** 75% = $68.60 85% = $77.75
30490	OESOPHAGEAL PROSTHESIS, insertion of, including endoscopy and dilatation (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $534.80 **Benefit:** 75% = $401.10 85% = $454.60

30491	BILE DUCT, ENDOSCOPIC STENTING OF (including endoscopy and dilatation) (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $564.25 **Benefit:** 75% = $423.20 85% = $479.65
30492	BILE DUCT, PERCUTANEOUS STENTING OF (including dilatation when performed), using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $799.90 **Benefit:** 75% = $599.95
30494	ENDOSCOPIC BILIARY DILATATION (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $427.25 **Benefit:** 75% = $320.45
30495	PERCUTANEOUS BILIARY DILATATION for biliary stricture, using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $799.90 **Benefit:** 75% = $599.95
30496	VAGOTOMY, truncal or selective, with or without pyloroplasty or gastroenterostomy (Anaes.) (Assist.) **Fee:** $597.55 **Benefit:** 75% = $448.20 85% = $512.85
30497	VAGOTOMY and ANTRECTOMY (Anaes.) (Assist.) **Fee:** $712.50 **Benefit:** 75% = $534.40
30499	VAGOTOMY, highly selective (Anaes.) (Assist.) **Fee:** $847.40 **Benefit:** 75% = $635.55
30500	VAGOTOMY, highly selective with duodenoplasty for peptic stricture (Anaes.) (Assist.) **Fee:** $907.40 **Benefit:** 75% = $680.55 85% = $822.70
30502	VAGOTOMY, highly selective, with dilatation of pylorus (Anaes.) (Assist.) **Fee:** $1,001.45 **Benefit:** 75% = $751.10
30503	VAGOTOMY or ANTRECTOMY, or both, for peptic ulcer following previous operation for peptic ulcer (Anaes.) (Assist.) **Fee:** $1,121.45 **Benefit:** 75% = $841.10 85% = $1036.75
30505	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision (Anaes.) (Assist.) **Fee:** $560.70 **Benefit:** 75% = $420.55
30506	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy (Anaes.) (Assist.) **Fee:** $981.20 **Benefit:** 75% = $735.90
30508	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and highly selective vagotomy (Anaes.) (Assist.) **Fee:** $1,032.80 **Benefit:** 75% = $774.60
30509	BLEEDING PEPTIC ULCER, control of, involving gastric resection (other than wedge resection) (Anaes.) (Assist.) **Fee:** $1,032.80 **Benefit:** 75% = $774.60 85% = $948.10

30515	Gastroenterostomy (including gastroduodenostomy) or enterocolostomy or enteroenterostomy, not being a service to which any of items 31569 to 31581 apply (Anaes.) (Assist.) **Fee:** $715.60 **Benefit:** 75% = $536.70
30517	GASTROENTEROSTOMY, PYLOROPLASTY or GASTRODUODENOSTOMY, reconstruction of (Anaes.) (Assist.) **Fee:** $936.95 **Benefit:** 75% = $702.75
30518	Partial gastrectomy, not being a service associated with a service to which any of items 31569 to 31581 apply (Anaes.) (Assist.) **Fee:** $1,003.30 **Benefit:** 75% = $752.50
30520	GASTRIC TUMOUR, removal of, by local excision, not being a service to which item 30518 applies (Anaes.) (Assist.) **Fee:** $686.15 **Benefit:** 75% = $514.65
30521	GASTRECTOMY, TOTAL, for benign disease (Anaes.) (Assist.) **Fee:** $1,468.00 **Benefit:** 75% = $1101.00
30523	GASTRECTOMY, SUBTOTAL RADICAL, for carcinoma, (including splenectomy when performed) (Anaes.) (Assist.) (See para TN.8.18 of explanatory notes to this Category) **Fee:** $1,534.25 **Benefit:** 75% = $1150.70
30524	GASTRECTOMY, TOTAL RADICAL, for carcinoma (including extended node dissection and distal pancreatectomy and splenectomy when performed) (Anaes.) (Assist.) **Fee:** $1,689.25 **Benefit:** 75% = $1266.95
30526	GASTRECTOMY, TOTAL, and including lower oesophagus, performed by left thoraco-abdominal incision or opening of diaphragmatic hiatus, (including splenectomy when performed) (Anaes.) (Assist.) **Fee:** $2,190.85 **Benefit:** 75% = $1643.15
30527	ANTIREFLUX OPERATION by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus not being a service to which item 30601 applies (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $885.25 **Benefit:** 75% = $663.95
30529	ANTIREFLUX operation by fundoplasty, with OESOPHAGOPLASTY for stricture or short oesophagus (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $1,327.80 **Benefit:** 75% = $995.85
30530	ANTIREFLUX operation by cardiopexy, with or without fundoplasty (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $796.75 **Benefit:** 75% = $597.60
30532	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $914.85 **Benefit:** 75% = $686.15

30533	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, WITH FUNDOPLASTY, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $1,088.15 **Benefit:** 75% = $816.15
30535	OESOPHAGECTOMY with gastric reconstruction by abdominal mobilisation and thoracotomy (Anaes.) (Assist.) **Fee:** $1,723.80 **Benefit:** 75% = $1292.85
30536	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,748.45 **Benefit:** 75% = $1311.35
30538	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest- conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,209.85 **Benefit:** 75% = $907.40
30539	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - conjoint surgery, co-surgeon (Assist.) **Fee:** $885.25 **Benefit:** 75% = $663.95
30541	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,541.80 **Benefit:** 75% = $1156.35
30542	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,047.60 **Benefit:** 75% = $785.70
30544	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, co-surgeon (Assist.) **Fee:** $767.30 **Benefit:** 75% = $575.50
30545	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,866.50 **Benefit:** 75% = $1399.90
30547	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,283.55 **Benefit:** 75% = $962.70 85% = $1198.85
30548	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, co-surgeon (Assist.) **Fee:** $958.90 **Benefit:** 75% = $719.20 85% = $874.20
30550	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - 1 surgeon (Anaes.) (Assist.)

	Fee: $2,095.20 **Benefit:** 75% = $1571.40
30551	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,445.90 **Benefit:** 75% = $1084.45
30553	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,069.50 **Benefit:** 75% = $802.15 85% = $984.80
30554	OESOPHAGECTOMY with reconstruction by free jejunal graft - 1 surgeon (Anaes.) (Assist.) **Fee:** $2,331.15 **Benefit:** 75% = $1748.40
30556	OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,608.10 **Benefit:** 75% = $1206.10
30557	OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,187.70 **Benefit:** 75% = $890.80
30559	OESOPHAGUS, local excision for tumour of (Anaes.) (Assist.) **Fee:** $863.15 **Benefit:** 75% = $647.40 85% = $778.45
30560	OESOPHAGEAL PERFORATION, repair of, by thoracotomy (Anaes.) (Assist.) **Fee:** $958.90 **Benefit:** 75% = $719.20
30562	ENTEROSTOMY or COLOSTOMY, closure of (not involving resection of bowel), on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $604.50 **Benefit:** 75% = $453.40
30563	COLOSTOMY OR ILEOSTOMY, refashioning of, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $604.50 **Benefit:** 75% = $453.40 85% = $519.80
30564	SMALL BOWEL STRICTUREPLASTY for chronic inflammatory bowel disease (Anaes.) (Assist.) **Fee:** $784.65 **Benefit:** 75% = $588.50
30565	SMALL INTESTINE, resection of, without anastomosis (including formation of stoma) (Anaes.) (Assist.) **Fee:** $885.25 **Benefit:** 75% = $663.95
30566	SMALL INTESTINE, resection of, with anastomosis, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $983.35 **Benefit:** 75% = $737.55
30568	INTRAOPERATIVE ENTEROTOMY for visualisation of the small intestine by endoscopy (Anaes.) (Assist.) **Fee:** $737.65 **Benefit:** 75% = $553.25
30569	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed at laparotomy,

	with or without biopsies (Anaes.) (Assist.) **Fee:** $376.10 **Benefit:** 75% = $282.10
30571	APPENDICECTOMY, not being a service to which item 30574 applies on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $452.55 **Benefit:** 75% = $339.45
30572	LAPAROSCOPIC APPENDICECTOMY, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $452.55 **Benefit:** 75% = $339.45
30574	NOTE: *Multiple Operation and Multiple Anaesthetic rules apply to this item* APPENDICECTOMY, when performed in conjunction with any other intraabdominal procedure through the same incision (Anaes.) **Fee:** $125.20 **Benefit:** 75% = $93.90
30575	PANCREATIC ABSCESS, laparotomy and external drainage of, not requiring retro-pancreatic dissection (Anaes.) (Assist.) **Fee:** $520.90 **Benefit:** 75% = $390.70
30577	PANCREATIC NECROSECTOMY for PANCREATIC NECROSIS or ABSCESS FORMATION requiring major pancreatic or retro-pancreatic dissection, excluding aftercare (Anaes.) (Assist.) **Fee:** $1,106.60 **Benefit:** 75% = $829.95
30578	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of pancreatic tumour (Anaes.) (Assist.) **Fee:** $1,165.55 **Benefit:** 75% = $874.20
30580	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of duodenal tumour (Anaes.) (Assist.) **Fee:** $1,062.15 **Benefit:** 75% = $796.65
30581	ENDOCRINE TUMOUR, exploration of pancreas or duodenum for, but no tumour found (Anaes.) (Assist.) **Fee:** $774.55 **Benefit:** 75% = $580.95
30583	DISTAL PANCREATECTOMY (Anaes.) (Assist.) **Fee:** $1,213.35 **Benefit:** 75% = $910.05
30584	PANCREATICO-DUODENECTOMY, WHIPPLE'S OPERATION, with or without preservation of pylorus (Anaes.) (Assist.) **Fee:** $1,790.95 **Benefit:** 75% = $1343.25
30586	PANCREATIC CYST ANASTOMOSIS TO STOMACH OR DUODENUM - by open or endoscopic means (Anaes.) (Assist.) **Fee:** $712.50 **Benefit:** 75% = $534.40
30587	PANCREATIC CYST, anastomosis to Roux loop of jejunum (Anaes.) (Assist.) **Fee:** $737.65 **Benefit:** 75% = $553.25

30589	PANCREATICO-JEJUNOSTOMY for pancreatitis or trauma (Anaes.) (Assist.) **Fee:** $1,271.10 **Benefit:** 75% = $953.35
30590	PANCREATICO-JEJUNOSTOMY following previous pancreatic surgery (Anaes.) (Assist.) **Fee:** $1,401.55 **Benefit:** 75% = $1051.20
30593	PANCREATECTOMY, near total or total (including duodenum), with or without splenectomy (Anaes.) (Assist.) **Fee:** $1,917.95 **Benefit:** 75% = $1438.50 85% = $1833.25
30594	PANCREATECTOMY for pancreatitis following previously attempted drainage procedure or partial resection (Anaes.) (Assist.) **Fee:** $2,213.10 **Benefit:** 75% = $1659.85
30596	SPLENORRHAPHY OR PARTIAL SPLENECTOMY (Anaes.) (Assist.) **Fee:** $911.65 **Benefit:** 75% = $683.75
30597	SPLENECTOMY (Anaes.) (Assist.) **Fee:** $731.70 **Benefit:** 75% = $548.80
30599	SPLENECTOMY, for massive spleen (weighing more than 1500 grams) or involving thoraco-abdominal incision (Anaes.) (Assist.) **Fee:** $1,327.80 **Benefit:** 75% = $995.85
30600	DIAPHRAGMATIC HERNIA, TRAUMATIC, repair of (Anaes.) (Assist.) **Fee:** $789.55 **Benefit:** 75% = $592.20
30601	Diaphragmatic hernia, congential repair of, by thoracic or abdominal approach, not being a service to which any of items 31569 to 31581 apply, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $972.60 **Benefit:** 75% = $729.45
30602	PORTAL HYPERTENSION, porto-caval shunt for (Anaes.) (Assist.) **Fee:** $1,578.55 **Benefit:** 75% = $1183.95
30603	PORTAL HYPERTENSION, meso-caval shunt for (Anaes.) (Assist.) **Fee:** $1,667.15 **Benefit:** 75% = $1250.40 85% = $1582.45
30605	PORTAL HYPERTENSION, selective spleno-renal shunt for (Anaes.) (Assist.) **Fee:** $1,895.80 **Benefit:** 75% = $1421.85
30606	PORTAL HYPERTENSION, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (Anaes.) (Assist.) **Fee:** $1,128.55 **Benefit:** 75% = $846.45
30608	SMALL INTESTINE, resection of, with anastomosis, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $1,278.35 **Benefit:** 75% = $958.80
30609	FEMORAL OR INGUINAL HERNIA, laparoscopic repair of, not being a service associated with a

	service to which item 30614 applies (Anaes.) (Assist.) **Fee:** $471.95 **Benefit:** 75% = $354.00
30611	BENIGN TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage, and bone, simple lipomas covered by item 31345 and lipomata - removal of by surgical excision, where the specimen excised is sent for histological confirmation of diagnosis, on a person under 10 years of age , not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $572.35 **Benefit:** 75% = $429.30 85% = $487.65
30614	FEMORAL OR INGUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to which item 30403 or 30615 applies, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $471.95 **Benefit:** 75% = $354.00
30615	STRANGULATED, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel resection, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $529.60 **Benefit:** 75% = $397.20
30618	LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck, on a person under 10 years of age (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $530.60 **Benefit:** 75% = $397.95 85% = $451.05
30619	LAPAROSCOPIC SPLENECTOMY, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $951.25 **Benefit:** 75% = $713.45
30621	Repair of symptomatic umbilical, epigastric or linea alba hernia requiring mesh or other formal repair of, in a person 10 years of age or over, other than a service to which item 30403 or 30405 applies (Anaes.) (Assist.) **Fee:** $414.00 **Benefit:** 75% = $310.50
30622	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, Gastrostomy, Gastrotomy, Reduction of intussusception, Removal of Meckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty or Drainage of pancreas on a person under 10 years of age (Anaes.) (Assist.) (See para TN.8.14 of explanatory notes to this Category) **Fee:** $688.50 **Benefit:** 75% = $516.40
30623	LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESIONS (where no other intraabdominal procedure is performed) on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $688.50 **Benefit:** 75% = $516.40
30626	LAPAROTOMY involving division of adhesions in conjunction with another intraabdominal procedure where the time taken to divide the adhesions is between 45 minutes and 2 hours, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $691.70 **Benefit:** 75% = $518.80
30627	LAPAROSCOPY, diagnostic, not being a service associated with any other laparoscopic procedure, on a person under 10 years of age (Anaes.) (See para TN.8.15 of explanatory notes to this Category) **Fee:** $290.55 **Benefit:** 75% = $217.95

30628	HYDROCELE, tapping of **Fee:** $36.15 **Benefit:** 75% = $27.15 85% = $30.75
30631	Hydrocele, removal of, other than a service associated with a service to which item 30641, 30642 or 30644 applies (Anaes.) **Fee:** $240.45 **Benefit:** 75% = $180.35 85% = $204.40
30635	Varicocele, surgical correction of, other than a service associated with a service to which item 30641, 30642 or 30644 applies—one procedure (Anaes.) (Assist.) **Fee:** $296.45 **Benefit:** 75% = $222.35
30636	GASTROSTOMY BUTTON, caecostomy antegrade enema device (chait etc) and/or stomal indwelling device, non-endoscopic insertion of, or non-endoscopic replacement of, on a person under 10 years of age (Anaes.) **Fee:** $236.90 **Benefit:** 75% = $177.70 85% = $201.40
30637	ENTEROSTOMY or COLOSTOMY, closure of not involving resection of bowel, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $785.90 **Benefit:** 75% = $589.45
30639	COLOSTOMY OR ILEOSTOMY, refashioning of, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $785.90 **Benefit:** 75% = $589.45 85% = $701.20
30640	Repair of large and irreducible scrotal hernia, where duration of surgery exceeds 2 hours, in a person 10 years of age or over, other than a service to which item 30403, 30405, 30614, 30615 or 30621 applies (Anaes.) (Assist.) **Fee:** $929.60 **Benefit:** 75% = $697.20
30641	ORCHIDECTOMY, simple or subscapsular, unilateral with or without insertion of testicular prosthesis (Anaes.) (Assist.) **Fee:** $414.00 **Benefit:** 75% = $310.50
30642	Orchidectomy, radical, unilateral, with or without insertion of testicular prosthesis, other than a service associated with a service to which item 30631, 30635, 30641, 30643 or 30644 applies (Anaes.) (Assist.) **Fee:** $529.60 **Benefit:** 75% = $397.20
30643	EXPLORATION OF SPERMATIC CORD, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $688.50 **Benefit:** 75% = $516.40
30644	EXPLORATION OF SPERMATIC CORD, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $529.60 **Benefit:** 75% = $397.20
30645	APPENDICECTOMY, not being a service to which item 30574 applies, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $588.25 **Benefit:** 75% = $441.20
30646	LAPAROSCOPIC APPENDICECTOMY, on a person under 10 years of age (Anaes.) (Assist.)

	Fee: $588.25 **Benefit:** 75% = $441.20
30649	HAEMORRHAGE, arrest of, following circumcision requiring general anaesthesia on a person under 10 years of age (Anaes.) **Fee:** $190.65 **Benefit:** 75% = $143.00 85% = $162.10
30654	Circumcision of the penis (other than a service to which item 30658 applies) **Fee:** $47.25 **Benefit:** 75% = $35.45 85% = $40.20
30658	Circumcision of the penis, when performed in conjunction with a service to which an item in Group T7 or Group T10 applies (Anaes.) **Fee:** $144.25 **Benefit:** 75% = $108.20 85% = $122.65
30663	HAEMORRHAGE, arrest of, following circumcision requiring general anaesthesia on a person 10 years of age or over (Anaes.) **Fee:** $146.65 **Benefit:** 75% = $110.00 85% = $124.70
30666	PARAPHIMOSIS or PHIMOSIS, reduction of, under general anaesthesia, with or without dorsal incision, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $48.20 **Benefit:** 75% = $36.15 85% = $41.00
30672	COCCYX, excision of (Anaes.) (Assist.) **Fee:** $452.55 **Benefit:** 75% = $339.45
30676	PILONIDAL SINUS OR CYST, OR SACRAL SINUS OR CYST, excision of (Anaes.) **Fee:** $385.10 **Benefit:** 75% = $288.85 85% = $327.35
30679	PILONIDAL SINUS, injection of sclerosant fluid under anaesthesia (Anaes.) **Fee:** $97.85 **Benefit:** 75% = $73.40 85% = $83.20
30680	Balloon enteroscopy, examination of the small bowel (oral approach), with or without biopsy, WITHOUT intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30682 or 30686) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $1,188.70 **Benefit:** 75% = $891.55 85% = $1104.00
30682	Balloon enteroscopy, examination of the small bowel (anal approach), with or without biopsy, WITHOUT intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30680 or 30684)

	The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $1,188.70 **Benefit:** 75% = $891.55 85% = $1104.00
30684	Balloon enteroscopy, examination of the small bowel (oral approach), with or without biopsy, WITH 1 or more of the following procedures (snare polypectomy, removal of foreign body, diathermy, heater probe, laser coagulation or argon plasma coagulation), for diagnosis and management of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30682 or 30686) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $1,462.90 **Benefit:** 75% = $1097.20 85% = $1378.20
30686	Balloon enteroscopy, examination of the small bowel (anal approach), with or without biopsy, WITH 1 or more of the following procedures (snare polypectomy, removal of foreign body, diathermy, heater probe, laser coagulation or argon plasma coagulation), for diagnosis and management of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30680 or 30684) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $1,462.90 **Benefit:** 75% = $1097.20 85% = $1378.20
30687	ENDOSCOPY with RADIOFREQUENCY ABLATION of mucosal metaplasia for the treatment of

	Barrett's Oesophagus in a single course of treatment, following diagnosis of high grade dysplasia confirmed by histological examination (Anaes.) (See para TN.8.17, TN.8.20 of explanatory notes to this Category) **Fee:** $483.70 **Benefit:** 75% = $362.80 85% = $411.15
30688	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.) (See para TN.8.21, TN.8.17 of explanatory notes to this Category) **Fee:** $370.75 **Benefit:** 75% = $278.10 85% = $315.15
30690	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with fine needle aspiration, including aspiration of the locoregional lymph nodes if performed, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.) (See para TN.8.21, TN.8.17 of explanatory notes to this Category) **Fee:** $572.30 **Benefit:** 75% = $429.25 85% = $487.60
30692	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.) (See para TN.8.21, TN.8.17 of explanatory notes to this Category) **Fee:** $370.75 **Benefit:** 75% = $278.10 85% = $315.15
30694	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with fine needle aspiration, for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.) (See para TN.8.21, TN.8.17 of explanatory notes to this Category) **Fee:** $572.30 **Benefit:** 75% = $429.25 85% = $487.60
30696	ENDOSCOPIC ULTRASOUND GUIDED FINE NEEDLE ASPIRATION BIOPSY(S) (endoscopy with ultrasound imaging) to obtain one or more specimens from either: (a) mediastinal mass(es) or (b) locoregional nodes to stage non-small cell lung carcinoma not being a service associated with another item in this subgroup or to which items 30710 and 55054 apply (Anaes.) (See para TN.8.21 of explanatory notes to this Category) **Fee:** $572.30 **Benefit:** 75% = $429.25 85% = $487.60
30710	ENDOBRONCHIAL ULTRASOUND GUIDED BIOPSY(S) (bronchoscopy with ultrasound imaging, with or without associated fluoroscopic imaging) to obtain one or more specimens by either:

	(a) transbronchial biopsy(s) of peripheral lung lesions; or (b) fine needle aspiration(s) of a mediastinal mass(es); or (c) fine needle aspiration(s) of locoregional nodes to stage non-small cell lung carcinoma not being a service associated with another item in this subgroup or to which items 30696, 41892, 41898, and 60500 to 60509 applies (Anaes.) (See para TN.8.21 of explanatory notes to this Category) **Fee:** $572.30 **Benefit:** 75% = $429.25 85% = $487.60
31000	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (below knee) or foot, utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—6 or fewer sections (Anaes.) (See para TN.8.151 of explanatory notes to this Category) **Fee:** $590.20 **Benefit:** 75% = $442.65 85% = $505.50
31001	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (below knee) or foot, utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—7 to 12 sections (inclusive) (Anaes.) (See para TN.8.151 of explanatory notes to this Category) **Fee:** $737.65 **Benefit:** 75% = $553.25 85% = $652.95
31002	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (below knee) or foot, utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—13 or more sections (Anaes.) (See para TN.8.151 of explanatory notes to this Category) **Fee:** $885.25 **Benefit:** 75% = $663.95 85% = $800.55
31003	Mohs surgery 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, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—6 or fewer sections Not applicable to a service performed in association with a service to which item 31000 applies (Anaes.) (See para TN.8.151 of explanatory notes to this Category) **Fee:** $590.20 **Benefit:** 75% = $442.65 85% = $505.50
31004	Mohs surgery 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, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—7 to 12 sections (inclusive) Not applicable to a service performed in association with a service to which item 31001 applies (Anaes.) (See para TN.8.151 of explanatory notes to this Category) **Fee:** $737.65 **Benefit:** 75% = $553.25 85% = $652.95

31005	Mohs surgery 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, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—13 or more sections Not applicable to a service performed in association with a service to which item 31002 applies (Anaes.) (See para TN.8.151 of explanatory notes to this Category) **Fee:** $885.25 **Benefit:** 75% = $663.95 85% = $800.55
31206	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is not more than 10 mm in diameter; and (b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination (Anaes.) **Fee:** $97.00 **Benefit:** 75% = $72.75 85% = $82.45
31211	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is more than 10 mm, but not more than 20 mm, in diameter; and (b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination (Anaes.) **Fee:** $125.05 **Benefit:** 75% = $93.80 85% = $106.30
31216	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is more than 20 mm in diameter; and (b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination (Anaes.) **Fee:** $145.85 **Benefit:** 75% = $109.40 85% = $124.00
31220	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of 4 to 10 lesions and suture, if: (a) the size of each lesion is not more than 10 mm in diameter; and (b) each removal is from cutaneous or subcutaneous tissue by surgical excision (other than by shave excision); and (c) all of the specimens excised are sent for histological examination (Anaes.) **Fee:** $218.00 **Benefit:** 75% = $163.50 85% = $185.30
31221	Tumours, cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of 4 to 10 lesions, if:

	(a) the size of each lesion is not more than 10 mm in diameter; and (b) each removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) each site of excision is closed by suture; and (d) all of the specimens excised are sent for histological examination (Anaes.) **Fee:** $218.00 **Benefit:** 75% = $163.50 85% = $185.30
31225	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of more than 10 lesions, if: (a) the size of each lesion is not more than 10 mm in diameter; and (b) each removal is from cutaneous or subcutaneous tissue or mucous membrane by surgical excision (other than by shave excision); and (c) each site of excision is closed by suture; and (d) all of the specimens excised are sent for histological examination (Anaes.) **Fee:** $387.40 **Benefit:** 75% = $290.55 85% = $329.30
31245	SKIN AND SUBCUTANEOUS TISSUE, extensive excision of, in the treatment of SUPPURATIVE HIDRADENITIS (excision from axilla, groin or natal cleft) or SYCOSIS BARBAE or NUCHAE (excision from face or neck) (Anaes.) (See para TN.8.23 of explanatory notes to this Category) **Fee:** $374.90 **Benefit:** 75% = $281.20 85% = $318.70
31250	GIANT HAIRY or COMPOUND NAEVUS, excision of an area at least 1 percent of body surface *where the specimen excised is sent for histological confirmation of diagnosis* (Anaes.) **Fee:** $374.90 **Benefit:** 75% = $281.20 85% = $318.70
31340	Muscle, bone or cartilage, excision of one or more of, if clinically indicated, and if: (a) the specimen excised is sent for histological confirmation; and (b) a malignant tumour of skin covered by item 31000, 31001, 31002, 31003, 31004, 31005, 31356, 31358, 31359, 31361, 31363, 31365, 31367, 31369, 31371, 31372, 31373, 31374, 31375 or 31376 is excised (Anaes.) **Derived Fee:** 75% of the fee for excision of malignant tumour
31345	LIPOMA, removal of by surgical excision or liposuction, where lesion is subcutaneous and <u>50mm or more in diameter</u>, or is sub-fascial, *where the specimen is sent for histological confirmation of diagnosis* (Anaes.) **Fee:** $214.35 **Benefit:** 75% = $160.80 85% = $182.20
31346	Liposuction (suction assisted lipolysis) to one regional area for contour problems of abdominal, upper arm or thigh fat because of repeated insulin injections, if: (a) the lesion is subcutaneous; and

	(b) the lesion is 50 mm or more in diameter; and (c) photographic and/or diagnostic imaging evidence demonstrating the need for this service is documented in the patient notes (Anaes.) (See para TN.8.101 of explanatory notes to this Category) **Fee:** $214.35 **Benefit:** 75% = $160.80 85% = $182.20
31350	BENIGN TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage, and bone, simple lipomas covered by item 31345 and lipomata, removal of by surgical excision, where the specimen excised is sent for histological confirmation of diagnosis, on a person 10 years of age or over, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $440.30 **Benefit:** 75% = $330.25 85% = $374.30
31355	MALIGNANT TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage and bone, removal of by surgical excision, where *histological proof of malignancy has been obtained*, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $725.90 **Benefit:** 75% = $544.45 85% = $641.20
31356	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is less than 6 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $224.90 **Benefit:** 75% = $168.70 85% = $191.20
31357	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is less than 6 mm; and (c) the excised specimen is sent for histological examination; not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $111.45 **Benefit:** 75% = $83.60 85% = $94.75
31358	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous

	area; and (b) the necessary excision diameter is 6 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $275.20 **Benefit:** 75% = $206.40 85% = $233.95
31359	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision), if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia (the applicable site); and (b) the necessary excision area is at least one third of the surface area of the applicable site; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (H) (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $335.45 **Benefit:** 75% = $251.60
31360	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is 6 mm or more; and (c) the excised specimen is sent for histological examination (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $170.75 **Benefit:** 75% = $128.10 85% = $145.15
31361	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is less than 14 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) (See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $189.70 **Benefit:** 75% = $142.30 85% = $161.25

31362	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is less than 14 mm; and (c) the excised specimen is sent for histological examination; not in association with item 45201 (Anaes.) (See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $136.05 **Benefit:** 75% = $102.05 85% = $115.65
31363	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is 14 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) (See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $248.20 **Benefit:** 75% = $186.15 85% = $211.00
31364	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is 14 mm or more; and (c) the excised specimen is sent for histological examination (Anaes.) (See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $170.75 **Benefit:** 75% = $128.10 85% = $145.15
31365	Malignant skin lesion (other than a malignant skin lesion covered by item 31369, 31370, 31371, 31372 or 31373), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and

	(b) the necessary excision diameter is less than 15 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $160.85 **Benefit:** 75% = $120.65 85% = $136.75
31366	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31357, 31360, 31362 or 31364; and (b) the necessary excision diameter is less than 15 mm; and (c) the excised specimen is sent for histological examination; not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $97.00 **Benefit:** 75% = $72.75 85% = $82.45
31367	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45
31368	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31357, 31360, 31362 or 31364; and (b) the necessary excision diameter is at least 15 mm but not more than 30mm; and (c) the excised specimen is sent for histological examination; not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $127.55 **Benefit:** 75% = $95.70 85% = $108.45

31369	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $249.85 **Benefit:** 75% = $187.40 85% = $212.40
31370	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31357, 31360, 31362 or 31364; and (b) the necessary excision diameter is more than 30 mm; and (c) the excised specimen is sent for histological examination (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $145.85 **Benefit:** 75% = $109.40 85% = $124.00
31371	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (a) the tumour is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is 6 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $362.70 **Benefit:** 75% = $272.05 85% = $308.30
31372	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is less than 14 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy;

	not in association with item 45201 (Anaes.) (See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $313.65 **Benefit:** 75% = $235.25 85% = $266.65
31373	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is 14 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) (See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $362.50 **Benefit:** 75% = $271.90 85% = $308.15
31374	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and (b) the necessary excision diameter is less than 15 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) (See para TN.8.125, TN.1.21 of explanatory notes to this Category) **Fee:** $286.40 **Benefit:** 75% = $214.80 85% = $243.45
31375	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and (b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $308.25 **Benefit:** 75% = $231.20 85% = $262.05
31376	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and

	(b) the necessary excision diameter is more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $357.25 **Benefit:** 75% = $267.95 85% = $303.70
31400	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR up to and including 20mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.) **Fee:** $265.25 **Benefit:** 75% = $198.95 85% = $225.50
31403	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 20mm and up to and including 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.) **Fee:** $306.15 **Benefit:** 75% = $229.65
31406	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.) **Fee:** $510.20 **Benefit:** 75% = $382.65 85% = $433.70
31409	PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) **Fee:** $1,585.10 **Benefit:** 75% = $1188.85
31412	RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) **Fee:** $1,952.50 **Benefit:** 75% = $1464.40
31420	LYMPH NODE OF NECK, biopsy of (Anaes.) **Fee:** $186.85 **Benefit:** 75% = $140.15 85% = $158.85
31423	LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck, on a person 10 years of age or over (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $408.20 **Benefit:** 75% = $306.15 85% = $347.00
31426	LYMPH NODES OF NECK, selective dissection of 3 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $816.30 **Benefit:** 75% = $612.25
31429	LYMPH NODES OF NECK, selective dissection of 4 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $1,272.15 **Benefit:** 75% = $954.15
31432	LYMPH NODES OF NECK, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections) (Anaes.) (Assist.)

	(See para TN.8.24 of explanatory notes to this Category) **Fee:** $1,360.60 **Benefit:** 75% = $1020.45
31435	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $1,000.05 **Benefit:** 75% = $750.05
31438	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes.) (Assist.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $1,585.10 **Benefit:** 75% = $1188.85
31450	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken is 1 hour or less (Anaes.) (Assist.) **Fee:** $413.15 **Benefit:** 75% = $309.90
31452	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken in more than 1 hour (Anaes.) (Assist.) **Fee:** $722.90 **Benefit:** 75% = $542.20
31454	LAPAROSCOPY with drainage of pus, bile or blood, as an independent procedure (Anaes.) (Assist.) **Fee:** $572.30 **Benefit:** 75% = $429.25
31456	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition (Anaes.) **Fee:** $249.50 **Benefit:** 75% = $187.15
31458	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition, and where the use of imaging intensification is clinically indicated (Anaes.) **Fee:** $299.35 **Benefit:** 75% = $224.55
31460	PERCUTANEOUS GASTROSTOMY TUBE, jejunal extension to, including any associated imaging services (Anaes.) (Assist.) **Fee:** $362.70 **Benefit:** 75% = $272.05
31462	OPERATIVE FEEDING JEJUNOSTOMY performed in conjunction with major upper gastro-intestinal resection (Anaes.) (Assist.) **Fee:** $529.60 **Benefit:** 75% = $397.20
31464	ANTIREFLUX OPERATION BY FUNDOPLASTY, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopic technique - not being a service to which item 30601 applies (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $885.25 **Benefit:** 75% = $663.95
31466	ANTIREFLUX OPERATION BY FUNDOPLASTY, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, revision procedure, by laparoscopy or open operation (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category)

	Fee: $1,327.85 **Benefit:** 75% = $995.90
31468	PARA-OESOPHAGEAL HIATUS HERNIA, repair of, with complete reduction of hernia, resection of sac and repair of hiatus, with or without fundoplication (Anaes.) (Assist.) **Fee:** $1,458.80 **Benefit:** 75% = $1094.10
31470	LAPAROSCOPIC SPLENECTOMY, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $731.70 **Benefit:** 75% = $548.80
31472	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY OR ROUX-EN-Y as a bypass procedure where prior biliary surgery has been performed (Anaes.) (Assist.) **Fee:** $1,188.50 **Benefit:** 75% = $891.40
31500	BREAST, BENIGN LESION up to and including 50mm in diameter, including simple cyst, fibroadenoma or fibrocystic disease, open surgical biopsy or excision of, with or without frozen section histology (Anaes.) (See para TN.8.25 of explanatory notes to this Category) **Fee:** $264.20 **Benefit:** 75% = $198.15 85% = $224.60
31503	BREAST, BENIGN LESION more than 50mm in diameter, excision of (Anaes.) (Assist.) (See para TN.8.25 of explanatory notes to this Category) **Fee:** $352.30 **Benefit:** 75% = $264.25 85% = $299.50
31506	BREAST, ABNORMALITY detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of (Anaes.) (Assist.) (See para TN.8.25 of explanatory notes to this Category) **Fee:** $396.35 **Benefit:** 75% = $297.30
31509	BREAST, MALIGNANT TUMOUR, open surgical biopsy of, with or without frozen section histology (Anaes.) (See para TN.8.25 of explanatory notes to this Category) **Fee:** $352.30 **Benefit:** 75% = $264.25 85% = $299.50
31512	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology (Anaes.) (Assist.) **Fee:** $660.55 **Benefit:** 75% = $495.45
31515	BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excision of malignant tumour (Anaes.) (Assist.) (See para TN.8.25 of explanatory notes to this Category) **Fee:** $443.15 **Benefit:** 75% = $332.40
31516	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology when targeted intraoperative radiotherapy (using an Intrabeam® device) is performed concurrently, if the requirements of item 15900 are met for the patient (Anaes.) (Assist.) **Fee:** $880.85 **Benefit:** 75% = $660.65
31519	BREAST, total mastectomy (H) (Anaes.) (Assist.) **Fee:** $747.85 **Benefit:** 75% = $560.90

31524	BREAST, subcutaneous mastectomy (H) (Anaes.) (Assist.) **Fee:** $1,056.90 **Benefit:** 75% = $792.70
31525	BREAST, mastectomy for gynecomastia, with or without liposuction (suction assisted lipolysis), not being a service associated with a service to which item 45585 applies (H) (Anaes.) (Assist.) **Fee:** $528.30 **Benefit:** 75% = $396.25
31530	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a vacuum-assisted breast biopsy device under imaging guidance, for histological examination, where imaging has demonstrated: (a) microcalcification of lesion; or (b) impalpable lesion less than 1cm in diameter - including pre-operative localisation of lesion where performed, not being a service to which items 31539, 31545 or 31548 apply **Fee:** $605.20 **Benefit:** 75% = $453.90 85% = $520.50
31533	FINE NEEDLE ASPIRATION of an impalpable breast lesion detected by mammography or ultrasound, imaging guided - but not including imaging (Anaes.) (See para TN.8.26 of explanatory notes to this Category) **Fee:** $140.10 **Benefit:** 75% = $105.10 85% = $119.10
31536	BREAST, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques - but not including imaging, not being a service to which item 31539, 31542 or 31545 applies (Anaes.) **Fee:** $192.45 **Benefit:** 75% = $144.35 85% = $163.60
31539	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a bore-enbloc stereotactic biopsy, for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons, and where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, not being a service to which item 31530, 31536 or 31548 applies (Anaes.) (See para TN.8.27 of explanatory notes to this Category) **Fee:** $405.20 **Benefit:** 75% = $303.90
31542	BREAST, initial guidewire localisation of lesion, by hookwire or similar device, when conducted by a radiologist as determined by the Royal Australian and New Zealand College of Radiologists, using interventional imaging techniques prior to using a bore-enbloc stereotactic biopsy - including imaging not being a service associated with a service to which item 31536 applies (Anaes.) (See para TN.8.28 of explanatory notes to this Category) **Fee:** $200.10 **Benefit:** 75% = $150.10 85% = $170.10
31545	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a bore-enbloc stereotactic biopsy, for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons; where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, including initial guidewire localisation of lesion, by hookwire or similar device, using interventional imaging techniques and including imaging not being a service associated with a service to which item 31530, 31536 or 31548 applies (Anaes.) (See para TN.8.27 of explanatory notes to this Category) **Fee:** $605.20 **Benefit:** 75% = $453.90 85% = $520.50
31548	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using mechanical biopsy device, for

	histological examination, not being a service to which items 31530, 31539 or 31545 apply (Anaes.) **Fee:** $140.10 **Benefit:** 75% = $105.10 85% = $119.10
31551	BREAST, HAEMATOMA, SEROMA OR INFLAMMATORY CONDITION including abscess, granulomatous mastitis or similar, exploration and drainage of when undertaken in the operating theatre of a hospital, excluding aftercare (Anaes.) **Fee:** $220.20 **Benefit:** 75% = $165.15
31554	BREAST, microdochotomy of, for benign or malignant condition (Anaes.) (Assist.) **Fee:** $440.45 **Benefit:** 75% = $330.35
31557	BREAST CENTRAL DUCTS, excision of, for benign condition (Anaes.) (Assist.) **Fee:** $352.30 **Benefit:** 75% = $264.25 85% = $299.50
31560	ACCESSORY BREAST TISSUE, excision of (Anaes.) (Assist.) **Fee:** $352.30 **Benefit:** 75% = $264.25 85% = $299.50 **Extended Medicare Safety Net Cap:** $281.85
31563	INVERTED NIPPLE, surgical eversion of (Anaes.) **Fee:** $263.90 **Benefit:** 75% = $197.95 85% = $224.35
31566	ACCESSORY NIPPLE, excision of (Anaes.) **Fee:** $132.05 **Benefit:** 75% = $99.05 85% = $112.25
	BARIATRIC
31569	Adjustable gastric band, placement of, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.) (See para TN.8.29 of explanatory notes to this Category) **Fee:** $863.15 **Benefit:** 75% = $647.40
31572	Gastric bypass by Roux-en-Y including associated anastomoses, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity not being associated with a service to which item 30515 applies (Anaes.) (Assist.) (See para TN.8.29 of explanatory notes to this Category) **Fee:** $1,062.15 **Benefit:** 75% = $796.65
31575	Sleeve gastrectomy, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.) (See para TN.8.29 of explanatory notes to this Category) **Fee:** $863.15 **Benefit:** 75% = $647.40
31578	Gastroplasty (excluding by gastric plication), with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.) (See para TN.8.29 of explanatory notes to this Category) **Fee:** $863.15 **Benefit:** 75% = $647.40
31581	Gastric bypass by biliopancreatic diversion with or without duodenal switch including gastric resection and anastomoses, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.) (See para TN.8.29 of explanatory notes to this Category)

	Fee: $1,062.15 **Benefit:** 75% = $796.65
31584	Surgical reversal of adjustable gastric banding (removal or replacement of gastric band), gastric bypass, gastroplasty (excluding by gastric plication) or biliopancreatic diversion being services to which items 31569 to 31581 apply (Anaes.) (Assist.) (See para TN.8.30 of explanatory notes to this Category) **Fee:** $1,563.75 **Benefit:** 75% = $1172.85
31587	Adjustment of gastric band as an independent procedure including any associated consultation **Fee:** $99.50 **Benefit:** 75% = $74.65 85% = $84.60
31590	Adjustment of gastric band reservoir, repair, revision or replacement of (Anaes.) (Assist.) **Fee:** $255.75 **Benefit:** 75% = $191.85 85% = $217.40

	Group T8. Surgical Operations
	Subgroup 2. Colorectal
32000	LARGE INTESTINE, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Anaes.) (Assist.) **Fee:** $1,047.85 **Benefit:** 75% = $785.90
32003	LARGE INTESTINE, resection of, with anastomosis, including right hemicolectomy (Anaes.) (Assist.) **Fee:** $1,096.05 **Benefit:** 75% = $822.05
32004	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) without anastomosis, not being a service associated with a service to which item 32000, 32003, 32005 or 32006 applies (Anaes.) (Assist.) **Fee:** $1,168.75 **Benefit:** 75% = $876.60
32005	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) with anastomosis, not being a service associated with a service to which item 32000, 32003, 32004 or 32006 applies (Anaes.) (Assist.) **Fee:** $1,320.35 **Benefit:** 75% = $990.30
32006	LEFT HEMICOLECTOMY, including the descending and sigmoid colon (including formation of stoma) (Anaes.) (Assist.) **Fee:** $1,168.75 **Benefit:** 75% = $876.60
32009	TOTAL COLECTOMY AND ILEOSTOMY (Anaes.) (Assist.) **Fee:** $1,386.45 **Benefit:** 75% = $1039.85
32012	TOTAL COLECTOMY AND ILEORECTAL ANASTOMOSIS (Anaes.) (Assist.) **Fee:** $1,531.50 **Benefit:** 75% = $1148.65
32015	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY 1 surgeon (Anaes.) (Assist.) **Fee:** $1,882.15 **Benefit:** 75% = $1411.65
32018	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED

	SYNCHRONOUS OPERATION; ABDOMINAL RESECTION (including aftercare) (Anaes.) (Assist.) **Fee:** $1,596.00 **Benefit:** 75% = $1197.00
32021	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; PERINEAL RESECTION (Assist.) **Fee:** $572.30 **Benefit:** 75% = $429.25
32023	Endoscopic insertion of stent or stents for large bowel obstruction, stricture or stenosis, including colonoscopy and any image intensification, where the obstruction is due to: a) a pre-diagnosed colorectal cancer, or cancer of an organ adjacent to the bowel; or b) an unknown diagnosis (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $564.25 **Benefit:** 75% = $423.20
32024	RECTUM, HIGH RESTORATIVE ANTERIOR RESECTION WITH INTRAPERITONEAL ANASTOMOSIS (of the rectum) greater than 10 centimetres from the anal verge excluding resection of sigmoid colon alone not being a service associated with a service to which item 32103, 32104 or 32106 applies (Anaes.) (Assist.) **Fee:** $1,386.45 **Benefit:** 75% = $1039.85
32025	RECTUM, LOW RESTORATIVE ANTERIOR RESECTION WITH EXTRAPERITONEAL ANASTOMOSIS (of the rectum) less than 10 centimetres from the anal verge, with or without covering stoma not being a service associated with a service to which item 32103, 32104 or 32106 applies (Anaes.) (Assist.) **Fee:** $1,854.50 **Benefit:** 75% = $1390.90
32026	RECTUM, ULTRA LOW RESTORATIVE RESECTION, with or without covering stoma, where the anastomosis is sited in the anorectal region and is 6cm or less from the anal verge (Anaes.) (Assist.) **Fee:** $1,997.10 **Benefit:** 75% = $1497.85
32028	RECTUM, LOW OR ULTRA LOW RESTORATIVE RESECTION, with peranal sutured coloanal anastomosis, with or without covering stoma (Anaes.) (Assist.) **Fee:** $2,139.90 **Benefit:** 75% = $1604.95
32029	COLONIC RESERVOIR, construction of, being a service associated with a service to which any other item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $427.95 **Benefit:** 75% = $321.00
32030	RECTOSIGMOIDECTOMY (Hartmann's operation) (Anaes.) (Assist.) **Fee:** $1,047.85 **Benefit:** 75% = $785.90
32033	RESTORATION OF BOWEL following Hartmann's or similar operation, including dismantling of the stoma (Anaes.) (Assist.) **Fee:** $1,531.50 **Benefit:** 75% = $1148.65
32036	SACROCOCCYGEAL AND PRESACRAL TUMOUR excision of (Anaes.) (Assist.) **Fee:** $1,942.40 **Benefit:** 75% = $1456.80

32039	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF 1 surgeon (Anaes.) (Assist.) **Fee:** $1,559.60 **Benefit:** 75% = $1169.70
32042	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION abdominal resection (Anaes.) (Assist.) **Fee:** $1,313.85 **Benefit:** 75% = $985.40
32045	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION perineal resection (Assist.) **Fee:** $491.70 **Benefit:** 75% = $368.80
32046	RECTUM and ANUS, abdomino-perineal resection of, combined synchronous operation - perineal resection where the perineal surgeon also provides assistance to the abdominal surgeon (Assist.) **Fee:** $759.85 **Benefit:** 75% = $569.90
32047	PERINEAL PROCTECTOMY (Anaes.) (Assist.) **Fee:** $885.25 **Benefit:** 75% = $663.95
32051	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy 1 surgeon (Anaes.) (Assist.) **Fee:** $2,353.65 **Benefit:** 75% = $1765.25
32054	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $2,160.20 **Benefit:** 75% = $1620.15
32057	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir conjoint surgery, perineal surgeon (Assist.) **Fee:** $572.30 **Benefit:** 75% = $429.25
32060	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy 1 surgeon (Anaes.) (Assist.) **Fee:** $2,353.65 **Benefit:** 75% = $1765.25
32063	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $2,160.20 **Benefit:** 75% = $1620.15
32066	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, perineal surgeon (Assist.) **Fee:** $572.30 **Benefit:** 75% = $429.25
32069	ILEOSTOMY RESERVOIR, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes.) **Fee:** $1,741.05 **Benefit:** 75% = $1305.80
32072	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), with or without biopsy

	Fee: $48.60 **Benefit:** 75% = $36.45 85% = $41.35
32075	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), UNDER GENERAL ANAESTHESIA, with or without biopsy, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $76.25 **Benefit:** 75% = $57.20 85% = $64.85
Amend 32084	Flexible fibreoptic sigmoidoscopy or fibreoptic colonoscopy up to the hepatic flexure, with or without biopsy, other than a service associated with a service to which any of items 32222 to 32228 applies. (Anaes.) (See para TN.8.17, TN.8.134 of explanatory notes to this Category) **Fee:** $113.15 **Benefit:** 75% = $84.90 85% = $96.20
Amend 32087	Endoscopic examination of the colon up to the hepatic flexure by flexible fibreoptic sigmoidoscopy or fibreoptic colonoscopy for the removal of 1 or more polyps or the treatment of radiation proctitis, angiodysplasia or post-polypectomy bleeding by argon plasma coagulation, one or more of, other than a service associated with a service to which any of items 32222 to 32228 applies (Anaes.) (See para TN.8.17, TN.8.134 of explanatory notes to this Category) **Fee:** $208.00 **Benefit:** 75% = $156.00 85% = $176.80
32094	ENDOSCOPIC DILATATION OF COLORECTAL STRICTURES including colonoscopy (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $560.70 **Benefit:** 75% = $420.55
32095	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed by stoma, with or without biopsies (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $129.85 **Benefit:** 75% = $97.40 85% = $110.40
32096	RECTAL BIOPSY, full thickness, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital (Anaes.) (Assist.) **Fee:** $261.05 **Benefit:** 75% = $195.80
32099	RECTAL TUMOUR of 5 centimetres or less in diameter, per anal submucosal excision of (Anaes.) (Assist.) **Fee:** $338.55 **Benefit:** 75% = $253.95
32102	RECTAL TUMOUR of greater than 5 centimetres in diameter, indicated by pathological examination, per anal submucosal excision of (Anaes.) (Assist.) **Fee:** $644.85 **Benefit:** 75% = $483.65
32103	RECTAL TUMOUR, of less than 4 cm in diameter, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy or by local excision, other than a service associated with a service to which item 32024, 32025, 32104 or 32106 applies (Anaes.) (Assist.) (See para TN.8.31, TN.8.17 of explanatory notes to this Category)

	Fee: $784.65 **Benefit:** 75% = $588.50
32104	RECTAL TUMOUR, of 4 cm or greater in diameter, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy or by local excision, other than a service associated with a service to which item 32024, 32025, 32103 or 32106 applies (Anaes.) (Assist.) (See para TN.8.31, TN.8.17 of explanatory notes to this Category) **Fee:** $1,015.65 **Benefit:** 75% = $761.75
32105	ANORECTAL CARCINOMA per anal full thickness excision of (Anaes.) (Assist.) **Fee:** $491.70 **Benefit:** 75% = $368.80 85% = $417.95
32106	ANTEROLATERAL INTRAPERITONEAL RECTAL TUMOUR, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy and if removal requires dissection within the peritoneal cavity, other than a service associated with a service to which item 32024, 32025, 32103 or 32104 applies (Anaes.) (Assist.) (See para TN.8.31, TN.8.17 of explanatory notes to this Category) **Fee:** $1,386.45 **Benefit:** 75% = $1039.85 85% = $1301.75
32108	RECTAL TUMOUR, transsphincteric excision of (Kraske or similar operation) (Anaes.) (Assist.) **Fee:** $1,015.65 **Benefit:** 75% = $761.75
32111	RECTAL PROLAPSE Delorme procedure for (Anaes.) (Assist.) **Fee:** $644.85 **Benefit:** 75% = $483.65
32112	RECTAL PROLAPSE, perineal recto-sigmoidectomy for (Anaes.) (Assist.) **Fee:** $784.65 **Benefit:** 75% = $588.50
32114	RECTAL STRICTURE, per anal release of (Anaes.) **Fee:** $177.25 **Benefit:** 75% = $132.95 85% = $150.70
32115	RECTAL STRICTURE, dilatation of (Anaes.) **Fee:** $128.90 **Benefit:** 75% = $96.70
32117	RECTAL PROLAPSE, abdominal rectopexy of (Anaes.) (Assist.) **Fee:** $1,015.65 **Benefit:** 75% = $761.75
32120	RECTAL PROLAPSE, perineal repair of (Anaes.) (Assist.) **Fee:** $261.05 **Benefit:** 75% = $195.80
32123	ANAL STRICTURE, anoplasty for (Anaes.) (Assist.) **Fee:** $338.55 **Benefit:** 75% = $253.95 85% = $287.80
32126	ANAL INCONTINENCE, Parks' intersphincteric procedure for (Anaes.) (Assist.) **Fee:** $491.70 **Benefit:** 75% = $368.80
32129	ANAL SPHINCTER, direct repair of (Anaes.) (Assist.) **Fee:** $644.85 **Benefit:** 75% = $483.65

32131	RECTOCELE, transanal repair of rectocele (Anaes.) (Assist.) **Fee:** $542.15 **Benefit:** 75% = $406.65
32132	HAEMORRHOIDS OR RECTAL PROLAPSE sclerotherapy for (Anaes.) **Fee:** $45.80 **Benefit:** 75% = $34.35 85% = $38.95
32135	HAEMORRHOIDS OR RECTAL PROLAPSE rubber band ligation of, with or without sclerotherapy, cryotherapy or infra red therapy for (Anaes.) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
32138	HAEMORRHOIDECTOMY including excision of anal skin tags when performed (Anaes.) **Fee:** $373.65 **Benefit:** 75% = $280.25 85% = $317.65
32139	HAEMORRHOIDECTOMY involving third or fourth degree haemorrhoids, including excision of anal skin tags when performed (Anaes.) (Assist.) **Fee:** $373.65 **Benefit:** 75% = $280.25
32142	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of (Anaes.) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
32145	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $137.20 **Benefit:** 75% = $102.90
32147	PERIANAL THROMBOSIS, incision of (Anaes.) **Fee:** $45.80 **Benefit:** 75% = $34.35 85% = $38.95
32150	OPERATION FOR FISSUREINANO, including excision or sphincterotomy, but excluding dilatation only (Anaes.) (Assist.) **Fee:** $261.05 **Benefit:** 75% = $195.80 85% = $221.90
32153	ANUS, DILATATION OF, under general anaesthesia, with or without disimpaction of faeces, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $71.20 **Benefit:** 75% = $53.40
32156	FISTULA-IN-ANO, SUBCUTANEOUS, excision of (Anaes.) **Fee:** $133.85 **Benefit:** 75% = $100.40 85% = $113.80
32159	ANAL FISTULA, treatment of, by excision or by insertion of a Seton, or by a combination of both procedures, involving the lower half of the anal sphincter mechanism (Anaes.) (Assist.) **Fee:** $338.55 **Benefit:** 75% = $253.95
32162	ANAL FISTULA, treatment of, by excision or by insertion of a Seton, or by a combination of both procedures, involving the upper half of the anal sphincter mechanism (Anaes.) (Assist.) **Fee:** $491.70 **Benefit:** 75% = $368.80
32165	ANAL FISTULA, repair of, by mucosal flap advancement (Anaes.) (Assist.) **Fee:** $644.85 **Benefit:** 75% = $483.65 85% = $560.15

32166	ANAL FISTULA - readjustment of Seton (Anaes.) **Fee:** $209.50 **Benefit:** 75% = $157.15 85% = $178.10
32168	FISTULA WOUND, review of, under general or regional anaesthetic, as an independent procedure (Anaes.) **Fee:** $133.85 **Benefit:** 75% = $100.40
32171	ANORECTAL EXAMINATION, with or without biopsy, under general anaesthetic, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $90.20 **Benefit:** 75% = $67.65
32174	INTR-AANAL, perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.) **Fee:** $90.20 **Benefit:** 75% = $67.65 85% = $76.70
32175	INTRA-ANAL, PERIANAL or ISCHIO-RECTAL ABSCESS, draining of, undertaken in the operating theatre of a hospital (excluding aftercare) (Anaes.) **Fee:** $165.25 **Benefit:** 75% = $123.95
32177	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.) **Fee:** $177.05 **Benefit:** 75% = $132.80
32180	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.) **Fee:** $261.05 **Benefit:** 75% = $195.80
32183	INTESTINAL SLING PROCEDURE prior to radiotherapy (Anaes.) (Assist.) **Fee:** $570.65 **Benefit:** 75% = $428.00
32186	COLONIC LAVAGE, total, intra operative (Anaes.) (Assist.) **Fee:** $570.65 **Benefit:** 75% = $428.00
32200	DISTAL MUSCLE, devascularisation of (Anaes.) (Assist.) **Fee:** $300.45 **Benefit:** 75% = $225.35 85% = $255.40
32203	ANAL OR PERINEAL GRACILOPLASTY (Anaes.) (Assist.) **Fee:** $645.15 **Benefit:** 75% = $483.90
32206	STIMULATOR AND ELECTRODES, insertion of, following previous graciloplasty (Anaes.) (Assist.) **Fee:** $582.90 **Benefit:** 75% = $437.20
32209	ANAL OR PERINEAL GRACILOPLASTY with insertion of stimulator and electrodes (Anaes.) (Assist.) **Fee:** $936.70 **Benefit:** 75% = $702.55
32210	GRACILIS NEOSPHINCTER PACEMAKER, replacement of (Anaes.) **Fee:** $259.55 **Benefit:** 75% = $194.70 85% = $220.65

32212	ANO-RECTAL APPLICATION OF FORMALIN in the treatment of radiation proctitis, where performed in the operating theatre of a hospital, excluding aftercare (Anaes.) **Fee:** $138.45 **Benefit:** 75% = $103.85
32213	Sacral nerve lead or leads, percutaneous placement using fluoroscopic guidance (or open placement) and intraoperative test stimulation, to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.) **Fee:** $671.55 **Benefit:** 75% = $503.70
32214	Neurostimulator or receiver, subcutaneous placement of, involving placement and connection of an extension wire to a sacral nerve electrode using fluoroscopic guidance, to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or

	i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.) (Assist.) **Fee:** $339.35 **Benefit:** 75% = $254.55
32215	Sacral nerve electrode or electrodes, management, adjustment and electronic programming of the neurostimulator by a medical practitioner, to manage faecal incontinence, other than in a patient who: a) is medically unfit for surgery; or b) is pregnant or planning pregnancy; or c) has irritable bowel syndrome; or d) has congenital anorectal malformations; or e) has active anal abscesses or fistulas; or f) has anorectal organic bowel disease, including cancer; or g) has functional effects of previous pelvic irradiation; or h) has congenital or acquired malformations of the sacrum; or i) has had rectal or anal surgery within the previous 12 months –each day **Fee:** $127.40 **Benefit:** 75% = $95.55 85% = $108.30
32216	Sacral nerve lead or leads, percutaneous surgical repositioning of, using fluoroscopic guidance (or open surgical repositioning of) and interoperative test stimulation, to correct displacement or unsatisfactory positioning, if the lead was inserted to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or

	i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months other than a service to which item 32213 applies (Anaes.) **Fee:** $603.05 **Benefit:** 75% = $452.30
32217	Neurostimulator or receiver, removal of, if the neurostimulator or receiver was inserted to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.) **Fee:** $158.80 **Benefit:** 75% = $119.10
32218	Sacral nerve lead or leads, removal of, if the lead was inserted to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or

	e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.) **Fee:** $158.80 **Benefit:** 75% = $119.10
32220	Insertion of an artificial bowel sphincter for severe faecal incontinence in the treatment of a patient for whom conservative and other less invasive forms of treatment are contraindicated or have failed. Contraindicated in: (a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases or a scarred or fragile perineum; and (b) patients who have had an adverse reaction or radiopaque solution; and (c) patients who enage in receptive anal intercourse (Anaes.) (Assist.) **Fee:** $918.35 **Benefit:** 75% = $688.80 85% = $833.65
32221	Removal or revision of an artificial bowel sphincter (with or without replacement) for severe faecal incontinence in the treatment of a patient for whom conservative and other less invasive forms of treatment are contraindicated or have failed. Contraindicated in: (a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases or a scarred or fragile perineum; and (b) patients who have had an adverse reaction to radiopaque solution; and (c) patients who engage in receptive anal intercourse (Anaes.) (Assist.) **Fee:** $918.35 **Benefit:** 75% = $688.80 85% = $833.65
New 32222	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient: (a) following a positive faecal occult blood test; or (b) who has symptoms consistent with pathology of the colonic mucosa; or (c) with anaemia or iron deficiency; or (d) for whom diagnostic imaging has shown an abnormality of the colon; or (e) who is undergoing the first examination following surgery for colorectal cancer; or (f) who is undergoing pre-operative evaluation; or (g) for whom a repeat colonoscopy is required due to inadequate bowel preparation for the patient's

	previous colonoscopy; or (h) for the management of inflammatory bowel disease Applicable only once on a day under a single episode of anaesthesia or other sedation (Anaes.) (See para TN.8.152, TN.8.17, TN.8.2 of explanatory notes to this Category) **Fee:** $339.70 **Benefit:** 75% = $254.80 85% = $288.75
New 32223	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient: (a) who has had a colonoscopy that revealed 1 to 4 adenomas, each of which were less than 10mm in diameter, had no villous features and had no high grade dysplasia; or (b) with a moderate risk of colorectal cancer due to family history; or (c) with a history of colorectal cancer, who has had an initial post-operative colonoscopy that did not reveal any adenomas or colorectal cancer Applicable only once in any 5 year period (Anaes.) (See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) **Fee:** $339.70 **Benefit:** 75% = $254.80 85% = $288.75
New 32224	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient with a moderate risk of colorectal cancer due to: (a) a history of adenomas, including an adenoma that: (i) was greater than 10mm in diameter; or (ii) had villous features; or (iii) had high grade dysplasia; or (iv) was an advanced serrated adenoma; or (b) having had a previous colonoscopy that revealed 5 to 9 adenomas, each of which was less than 10mm in diameter, had no villous features and had no high grade dysplasia Applicable only once in any 3 year period (Anaes.) (See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) **Fee:** $339.70 **Benefit:** 75% = $254.80 85% = $288.75
New 32225	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient with a high risk of colorectal cancer due to having had a previous colonoscopy that: (a) revealed 10 or more adenomas; or (b) included a piecemeal, or possibly incomplete, excision of a large, sessile polyp Applicable not more than 4 times in any 12 month period (Anaes.) (See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) **Fee:** $339.70 **Benefit:** 75% = $254.80 85% = $288.75
New 32226	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient with a high risk of

	colorectal cancer due to: (a) a known or suspected familial condition, such as familial adenomatous polyposis, Lynch syndrome or serrated polyposis syndrome; or (b) a genetic mutation associated with hereditary colorectal cancer Applicable only once in any 12 month period (Anaes.) (See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) **Fee:** $339.70 **Benefit:** 75% = $254.80 85% = $288.75
New 32227	Endoscopic examination of the colon to the caecum by colonoscopy: (a) for the treatment of bleeding, including one or more of the following: (i) radiation proctitis; (ii) angioectasia; (iii) post-polypectomy bleeding; or (b) for the treatment of colonic strictures with balloon dilatation Applicable only once on a day under a single episode of anaesthesia or other sedation (Anaes.) (See para TN.8.152, TN.8.17, TN.8.2 of explanatory notes to this Category) **Fee:** $476.70 **Benefit:** 75% = $357.55 85% = $405.20
New 32228	Endoscopic examination of the colon to the caecum by colonoscopy, other that a service to which item 32222, 32223, 32224, 32225, or 32226 applies. Applicable only once (Anaes.) (See para TN.8.17, TN.8.2, TN.8.152 of explanatory notes to this Category) **Fee:** $339.70 **Benefit:** 75% = $254.80 85% = $288.75
New 32229	Removal of one or more polyps during colonoscopy, in association with a service to which item 32222, 32223, 32224, 32225, 32226, or 32228 applies (Anaes.) (See para TN.8.152, TN.8.17, TN.8.2 of explanatory notes to this Category) **Fee:** $274.00 **Benefit:** 75% = $205.50 85% = $232.90

	Group T8. Surgical Operations
	Subgroup 3. Vascular
	VARICOSE VEINS
32500	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same leg (excluding after-care) - to a maximum of 6 treatments in a 12 month period (Anaes.) (See para TN.8.4, TN.8.32 of explanatory notes to this Category) **Fee:** $111.55 **Benefit:** 75% = $83.70 85% = $94.85 **Extended Medicare Safety Net Cap:** $122.75

32504	VARICOSE VEINS, multiple excision of tributaries, with or without division of 1 or more perforating veins - 1 leg - not being a service associated with a service to which item 32507, 32508, 32511, 32514 or 32517 applies on the same leg (Anaes.) (See para TN.8.32 of explanatory notes to this Category) **Fee:** $271.95 **Benefit:** 75% = $204.00 85% = $231.20 **Extended Medicare Safety Net Cap:** $217.60
32507	VARICOSE VEINS, sub-fascial surgical exploration of one or more incompetent perforating veins - 1 leg - not being a service associated with a service to which item 32508, 32511, 32514 or 32517 applies on the same leg (Anaes.) (Assist.) (See para TN.8.32 of explanatory notes to this Category) **Fee:** $542.15 **Benefit:** 75% = $406.65 85% = $460.85 **Extended Medicare Safety Net Cap:** $433.75
32508	VARICOSE VEINS, complete dissection at the sapheno-femoral OR sapheno-popliteal junction - 1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) (See para TN.8.32 of explanatory notes to this Category) **Fee:** $542.15 **Benefit:** 75% = $406.65
32511	VARICOSE VEINS, complete dissection at the sapheno-femoral AND sapheno-popliteal junction - 1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) (See para TN.8.32 of explanatory notes to this Category) **Fee:** $806.00 **Benefit:** 75% = $604.50
32514	VARICOSE VEINS, ligation of the long or short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in the same territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) (See para TN.8.32 of explanatory notes to this Category) **Fee:** $941.65 **Benefit:** 75% = $706.25
32517	VARICOSE VEINS, ligation of the long and short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in either territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) (See para TN.8.32 of explanatory notes to this Category) **Fee:** $1,212.50 **Benefit:** 75% = $909.40
32520	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a laser probe introduced by an endovenous catheter, if it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including radiofrequency diathermy, radiofrequency ablation or cyanoacrylate embolisation; and (c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.)

	(See para TN.8.33 of explanatory notes to this Category) **Fee:** $542.15 **Benefit:** 75% = $406.65 85% = $460.85 **Extended Medicare Safety Net Cap:** $81.35
32522	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) and small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a laser probe introduced by an endovenous catheter, if it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including radiofrequency diathermy, radiofrequency ablation or cyanoacrylate embolisation, and not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $806.00 **Benefit:** 75% = $604.50 85% = $721.30 **Extended Medicare Safety Net Cap:** $80.60
32523	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a radiofrequency catheter introduced by an endovenous catheter, if it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including endovenous laser therapy or cyanoacrylate embolisation; and (c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $542.15 **Benefit:** 75% = $406.65 85% = $460.85 **Extended Medicare Safety Net Cap:** $81.35
32526	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) and small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a radiofrequency catheter introduced by an endovenous catheter, if it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including endovenous laser therapy or cyanoacrylate embolisation; and (c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $806.00 **Benefit:** 75% = $604.50 85% = $721.30 **Extended Medicare Safety Net Cap:** $80.60
32528	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using cyanoacrylate adhesive, if it is documented by duplex ultrasound that the great or small saphenous vein

	(whichever is to be treated) demonstrates reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; and (c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $542.15 **Benefit:** 75% = $406.65 85% = $460.85 **Extended Medicare Safety Net Cap:** $81.35
32529	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) and small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using cyanoacrylate adhesive, if it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; and (c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $806.00 **Benefit:** 75% = $604.50 85% = $721.30 **Extended Medicare Safety Net Cap:** $80.60
	BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISEASE
32700	ARTERY OF NECK, bypass using vein or synthetic material (Anaes.) (Assist.) **Fee:** $1,459.30 **Benefit:** 75% = $1094.50
32703	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (Anaes.) (Assist.) **Fee:** $1,207.20 **Benefit:** 75% = $905.40
32708	AORTIC BYPASS for occlusive disease using a straight non-bifurcated graft (Anaes.) (Assist.) **Fee:** $1,444.10 **Benefit:** 75% = $1083.10
32710	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac arteries (Anaes.) (Assist.) **Fee:** $1,604.55 **Benefit:** 75% = $1203.45
32711	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the common femoral or profunda femoris arteries (Anaes.) (Assist.) **Fee:** $1,765.05 **Benefit:** 75% = $1323.80
32712	ILIO-FEMORAL BYPASS GRAFTING (Anaes.) (Assist.) **Fee:** $1,275.90 **Benefit:** 75% = $956.95

32715	AXILLARY or SUBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL ARTERIES (Anaes.) (Assist.) **Fee:** $1,275.90 **Benefit:** 75% = $956.95
32718	FEMORO-FEMORAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.) **Fee:** $1,207.20 **Benefit:** 75% = $905.40
32721	RENAL ARTERY, bypass grafting to (Anaes.) (Assist.) **Fee:** $1,917.55 **Benefit:** 75% = $1438.20
32724	RENAL ARTERIES (both), bypass grafting to (Anaes.) (Assist.) **Fee:** $2,177.40 **Benefit:** 75% = $1633.05
32730	MESENTERIC VESSEL (single), bypass grafting to (Anaes.) (Assist.) **Fee:** $1,650.30 **Benefit:** 75% = $1237.75
32733	MESENTERIC VESSELS (multiple), bypass grafting to (Anaes.) (Assist.) **Fee:** $1,917.55 **Benefit:** 75% = $1438.20
32736	INFERIOR MESENTERIC ARTERY, operation on, when performed in conjunction with another intra-abdominal vascular operation (Anaes.) (Assist.) **Fee:** $420.15 **Benefit:** 75% = $315.15
32739	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with above knee anastomosis (Anaes.) (Assist.) **Fee:** $1,314.10 **Benefit:** 75% = $985.60
32742	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to below knee popliteal artery (Anaes.) (Assist.) **Fee:** $1,505.20 **Benefit:** 75% = $1128.90
32745	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to tibio peroneal trunk or tibial or peroneal artery (Anaes.) (Assist.) **Fee:** $1,719.00 **Benefit:** 75% = $1289.25
32748	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis within 5cms of the ankle joint (Anaes.) (Assist.) **Fee:** $1,864.15 **Benefit:** 75% = $1398.15
32751	FEMORAL ARTERY BYPASS GRAFTING using synthetic graft, with lower anastomosis above or below the knee (Anaes.) (Assist.) **Fee:** $1,207.20 **Benefit:** 75% = $905.40
32754	FEMORAL ARTERY BYPASS GRAFTING, using a composite graft (synthetic material and vein) with lower anastomosis above or below the knee, including use of a cuff or sleeve of vein at 1 or both anastomoses (Anaes.) (Assist.) **Fee:** $1,505.20 **Benefit:** 75% = $1128.90
32757	FEMORAL ARTERY SEQUENTIAL BYPASS GRAFTING, (using a vein or synthetic material) where an additional anastomosis is made to separately revascularise more than 1 artery - each additional artery

	revascularised beyond a femoral bypass (Anaes.) (Assist.) **Fee:** $420.15 **Benefit:** 75% = $315.15
32760	VEIN, HARVESTING OF, FROM LEG OR ARM for bypass or replacement graft when not performed on the limb which is the subject of the bypass or graft - each vein (Anaes.) (Assist.) **Fee:** $412.55 **Benefit:** 75% = $309.45
32763	ARTERIAL BYPASS GRAFTING, using vein or synthetic material, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,207.20 **Benefit:** 75% = $905.40
32766	ARTERIAL OR VENOUS ANASTOMOSIS, not being a service to which another item in this Sub-group applies, as an independent procedure (Anaes.) (Assist.) **Fee:** $802.30 **Benefit:** 75% = $601.75
32769	ARTERIAL OR VENOUS ANASTOMOSIS not being a service to which another item in this Sub-group applies, when performed in combination with another vascular operation (including graft to graft anastomosis) (Anaes.) (Assist.) **Fee:** $278.05 **Benefit:** 75% = $208.55
	BYPASS, REPLACEMENT, LIGATION OF ANEURYSMS
33050	BYPASS GRAFTING to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (Anaes.) (Assist.) **Fee:** $1,478.60 **Benefit:** 75% = $1108.95
33055	BYPASS GRAFTING to replace a popliteal aneurysm using a synthetic graft (Anaes.) (Assist.) **Fee:** $1,185.70 **Benefit:** 75% = $889.30
33070	ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $855.45 **Benefit:** 75% = $641.60 85% = $770.75
33075	ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,088.20 **Benefit:** 75% = $816.15
33080	INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,328.35 **Benefit:** 75% = $996.30
33100	ANEURYSM OF COMMON OR INTERNAL CAROTID ARTERY, OR BOTH, replacement by graft of vein or synthetic material (Anaes.) (Assist.) **Fee:** $1,459.30 **Benefit:** 75% = $1094.50 85% = $1374.60
33103	THORACIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $2,047.55 **Benefit:** 75% = $1535.70
33109	THORACO-ABDOMINAL ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.) **Fee:** $2,475.50 **Benefit:** 75% = $1856.65 85% = $2390.80

33112	SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.) **Fee:** $2,146.90 **Benefit:** 75% = $1610.20
33115	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft, not being a service associated with a service to which item 33116 applies (Anaes.) (Assist.) **Fee:** $1,444.10 **Benefit:** 75% = $1083.10
33116	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.) **Fee:** $1,421.40 **Benefit:** 75% = $1066.05 85% = $1336.70
33118	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision of common iliac aneurysms) not being a service associated with a service to which item 33119 applies (Anaes.) (Assist.) **Fee:** $1,604.55 **Benefit:** 75% = $1203.45
33119	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to one or both iliac arteries using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.) **Fee:** $1,579.40 **Benefit:** 75% = $1184.55 85% = $1494.70
33121	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (with or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.) **Fee:** $1,765.05 **Benefit:** 75% = $1323.80
33124	ANEURYSM OF ILIAC ARTERY (common, external or internal), replacement by graft - unilateral (Anaes.) (Assist.) **Fee:** $1,230.15 **Benefit:** 75% = $922.65
33127	ANEURYSMS OF ILIAC ARTERIES (common, external or internal), replacement by graft - bilateral (Anaes.) (Assist.) **Fee:** $1,612.15 **Benefit:** 75% = $1209.15 85% = $1527.45
33130	ANEURYSM OF VISCERAL ARTERY, excision and repair by direct anastomosis or replacement by graft (Anaes.) (Assist.) **Fee:** $1,405.80 **Benefit:** 75% = $1054.35
33133	ANEURYSM OF VISCERAL ARTERY, dissection and ligation of arteries without restoration of continuity (Anaes.) (Assist.) **Fee:** $1,054.25 **Benefit:** 75% = $790.70
33136	FALSE ANEURYSM, repair of, at aortic anastomosis following previous aortic surgery (Anaes.) (Assist.) **Fee:** $2,658.60 **Benefit:** 75% = $1993.95
33139	FALSE ANEURYSM, repair of, in iliac artery and restoration of arterial continuity (Anaes.) (Assist.) **Fee:** $1,612.15 **Benefit:** 75% = $1209.15
33142	FALSE ANEURYSM, repair of, in femoral artery and restoration of arterial continuity (Anaes.) (Assist.)

	Fee: $1,505.20 **Benefit:** 75% = $1128.90 85% = $1420.50
33145	RUPTURED THORACIC AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $2,590.00 **Benefit:** 75% = $1942.50
33148	RUPTURED THORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $3,216.45 **Benefit:** 75% = $2412.35
33151	RUPTURED SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $3,056.05 **Benefit:** 75% = $2292.05
33154	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft (Anaes.) (Assist.) **Fee:** $2,261.50 **Benefit:** 75% = $1696.15
33157	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.) **Fee:** $2,521.20 **Benefit:** 75% = $1890.90
33160	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (Anaes.) (Assist.) **Fee:** $2,521.20 **Benefit:** 75% = $1890.90
33163	RUPTURED ILIAC ARTERY ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $2,139.40 **Benefit:** 75% = $1604.55
33166	RUPTURED ANEURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (Anaes.) (Assist.) **Fee:** $2,139.40 **Benefit:** 75% = $1604.55 85% = $2054.70
33169	RUPTURED ANEURYSM OF VISCERAL ARTERY, simple ligation of (Anaes.) (Assist.) **Fee:** $1,665.60 **Benefit:** 75% = $1249.20
33172	ANEURYSM OF MAJOR ARTERY, replacement by graft, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,298.80 **Benefit:** 75% = $974.10
33175	RUPTURED ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,196.95 **Benefit:** 75% = $897.75
33178	RUPTURED ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,522.15 **Benefit:** 75% = $1141.65
33181	RUPTURED INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,861.00 **Benefit:** 75% = $1395.75

	ENDARTERECTOMY AND ARTERIAL PATCH
33500	ARTERY OR ARTERIES OF NECK, endarterectomy of, including closure by suture (where endarterectomy of 1 or more arteries is undertaken through 1 arteriotomy incision) (Anaes.) (Assist.) **Fee:** $1,153.55 **Benefit:** 75% = $865.20
33506	INNOMINATE OR SUBCLAVIAN ARTERY, endarterectomy of, including closure by suture (Anaes.) (Assist.) **Fee:** $1,291.25 **Benefit:** 75% = $968.45
33509	AORTIC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the aorta (Anaes.) (Assist.) **Fee:** $1,444.10 **Benefit:** 75% = $1083.10
33512	AORTO-ILIAC ENDARTERECTOMY (1 or both iliac arteries), including closure by suture not being a service associated with a service to which item 33515 applies (Anaes.) (Assist.) **Fee:** $1,604.55 **Benefit:** 75% = $1203.45
33515	AORTO-FEMORAL ENDARTERECTOMY (1 or both femoral arteries) or BILATERAL ILIO-FEMORAL ENDARTERECTOMY, including closure by suture, not being a service associated with a service to which item 33512 applies (Anaes.) (Assist.) **Fee:** $1,765.05 **Benefit:** 75% = $1323.80
33518	ILIAC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the iliac artery (Anaes.) (Assist.) **Fee:** $1,291.25 **Benefit:** 75% = $968.45 85% = $1206.55
33521	ILIO-FEMORAL ENDARTERECTOMY (1 side), including closure by suture (Anaes.) (Assist.) **Fee:** $1,398.10 **Benefit:** 75% = $1048.60
33524	RENAL ARTERY, endarterectomy of (Anaes.) (Assist.) **Fee:** $1,650.30 **Benefit:** 75% = $1237.75
33527	RENAL ARTERIES (both), endarterectomy of (Anaes.) (Assist.) **Fee:** $1,917.55 **Benefit:** 75% = $1438.20
33530	COELIAC OR SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) **Fee:** $1,650.30 **Benefit:** 75% = $1237.75
33533	COELIAC AND SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) **Fee:** $1,917.55 **Benefit:** 75% = $1438.20
33536	INFERIOR MESENTERIC ARTERY, endarterectomy of, not being a service associated with a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,367.65 **Benefit:** 75% = $1025.75
33539	ARTERY OF EXTREMITIES, endarterectomy of, including closure by suture (Anaes.) (Assist.) **Fee:** $985.55 **Benefit:** 75% = $739.20
33542	EXTENDED DEEP FEMORAL ENDARTERECTOMY where the endarterectomy is at least 7cms long

	(Anaes.) (Assist.) **Fee:** $1,405.80 **Benefit:** 75% = $1054.35
33545	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is less than 3cm long (Anaes.) (Assist.) (See para TN.8.36 of explanatory notes to this Category) **Fee:** $278.05 **Benefit:** 75% = $208.55
33548	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is 3cm long or greater (Anaes.) (Assist.) (See para TN.8.36 of explanatory notes to this Category) **Fee:** $565.50 **Benefit:** 75% = $424.15
33551	VEIN, harvesting of from leg or arm for patch when not performed through same incision as operation (Anaes.) (Assist.) (See para TN.8.36 of explanatory notes to this Category) **Fee:** $278.05 **Benefit:** 75% = $208.55
33554	ENDARTERECTOMY, in conjunction with an arterial bypass operation to prepare the site for anastomosis - each site (Anaes.) (Assist.) **Fee:** $276.75 **Benefit:** 75% = $207.60
	EMBOLECTOMY, THROMBECTOMY AND VASCULAR TRAUMA
33800	EMBOLUS, removal of, from artery of neck (Anaes.) (Assist.) **Fee:** $1,199.50 **Benefit:** 75% = $899.65 85% = $1114.80
33803	EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an artery or bypass graft of trunk (Anaes.) (Assist.) **Fee:** $1,146.10 **Benefit:** 75% = $859.60
33806	Embolectomy or thrombectomy (including the infusion of thrombolytic or other agents) from an artery or bypass graft of extremities, or embolectomy of abdominal artery via the femoral artery, item to be claimed once per extremity, regardless of the number of incisions required to access the artery or bypass graft (Anaes.) (Assist.) **Fee:** $825.15 **Benefit:** 75% = $618.90 85% = $740.45
33810	INFERIOR VENA CAVA OR ILIAC VEIN, closed thrombectomy by catheter via the femoral vein (Anaes.) (Assist.) **Fee:** $601.95 **Benefit:** 75% = $451.50 85% = $517.25
33811	INFERIOR VENA CAVA OR ILIAC VEIN, open removal of thrombus or tumour (Anaes.) (Assist.) **Fee:** $1,792.00 **Benefit:** 75% = $1344.00
33812	THROMBUS, removal of, from femoral or other similar large vein (Anaes.) (Assist.) **Fee:** $947.35 **Benefit:** 75% = $710.55 85% = $862.65
33815	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) **Fee:** $871.00 **Benefit:** 75% = $653.25
33818	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by

	direct anastomosis (Anaes.) (Assist.) **Fee:** $1,016.15 **Benefit:** 75% = $762.15
33821	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.) **Fee:** $1,161.30 **Benefit:** 75% = $871.00
33824	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) **Fee:** $1,107.80 **Benefit:** 75% = $830.85
33827	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.) **Fee:** $1,298.80 **Benefit:** 75% = $974.10
33830	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.) **Fee:** $1,489.75 **Benefit:** 75% = $1117.35
33833	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by lateral suture (Anaes.) (Assist.) **Fee:** $1,352.45 **Benefit:** 75% = $1014.35
33836	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by direct anastomosis (Anaes.) (Assist.) **Fee:** $1,612.15 **Benefit:** 75% = $1209.15
33839	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by means of interposition graft (Anaes.) (Assist.) **Fee:** $1,887.10 **Benefit:** 75% = $1415.35
33842	ARTERY OF NECK, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (Anaes.) (Assist.) **Fee:** $932.10 **Benefit:** 75% = $699.10
33845	LAPAROTOMY for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (Anaes.) (Assist.) **Fee:** $649.45 **Benefit:** 75% = $487.10
33848	EXTREMITY, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no other procedure is performed (Anaes.) (Assist.) **Fee:** $649.45 **Benefit:** 75% = $487.10
	LIGATION, EXCISION, ELECTIVE REPAIR, DECOMPRESSION OF VESSELS
34100	MAJOR ARTERY OF NECK, elective ligation or exploration of, not being a service associated with any other vascular procedure (Anaes.) (Assist.) **Fee:** $718.30 **Benefit:** 75% = $538.75
34103	Great artery (aorta or pulmonary artery) or great vein (superior or inferior vena cava), ligation or exploration of immediate branches or tributaries, or ligation or exploration of the subclavian, axillary,

	iliac, femoral or popliteal arteries or veins, if the service is not associated with item 32508, 32511, 32520, 32522, 32523, 32526, 32528 or 32529 - for a maximum of 2 services provided to the same patient on the same occasion (H) (Anaes.) (Assist.) **Fee:** $420.15 **Benefit:** 75% = $315.15
34106	ARTERY OR VEIN (including brachial, radial, ulnar or tibial), ligation of, by elective operation, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508, 32511, 32514 or 32517 apply (Anaes.) (Assist.) **Fee:** $296.35 **Benefit:** 75% = $222.30 85% = $251.90 **Extended Medicare Safety Net Cap:** $237.10
34109	TEMPORAL ARTERY, biopsy of (Anaes.) (Assist.) **Fee:** $343.75 **Benefit:** 75% = $257.85 85% = $292.20
34112	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and ligation (Anaes.) (Assist.) **Fee:** $871.00 **Benefit:** 75% = $653.25
34115	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and ligation (Anaes.) (Assist.) **Fee:** $985.55 **Benefit:** 75% = $739.20
34118	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and ligation (Anaes.) (Assist.) **Fee:** $1,405.80 **Benefit:** 75% = $1054.35 85% = $1321.10
34121	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $1,123.05 **Benefit:** 75% = $842.30
34124	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $1,230.15 **Benefit:** 75% = $922.65
34127	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $1,612.15 **Benefit:** 75% = $1209.15
34130	SURGICALLY CREATED ARTERIO-VENOUS FISTULA OF AN EXTREMITY, closure of (Anaes.) (Assist.) **Fee:** $504.25 **Benefit:** 75% = $378.20 85% = $428.65
34133	SCALENOTOMY (Anaes.) (Assist.) **Fee:** $565.50 **Benefit:** 75% = $424.15
34136	FIRST RIB, resection of portion of (Anaes.) (Assist.) **Fee:** $909.05 **Benefit:** 75% = $681.80
34139	CERVICAL RIB, removal of, or other operation for removal of thoracic outlet compression, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $909.05 **Benefit:** 75% = $681.80
34142	COELIAC ARTERY, decompression of, for coeliac artery compression syndrome, as an independent

	procedure (Anaes.) (Assist.) **Fee:** $1,123.05 **Benefit:** 75% = $842.30
34145	POPLITEAL ARTERY, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (Anaes.) (Assist.) **Fee:** $817.50 **Benefit:** 75% = $613.15
34148	CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is 4cm or less in maximum diameter (Anaes.) (Assist.) **Fee:** $1,459.30 **Benefit:** 75% = $1094.50
34151	CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is greater than 4cm in maximum diameter (Anaes.) (Assist.) **Fee:** $1,994.05 **Benefit:** 75% = $1495.55
34154	RECURRENT CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Anaes.) (Assist.) **Fee:** $2,376.15 **Benefit:** 75% = $1782.15 85% = $2291.45
34157	NECK, excision of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.) **Fee:** $1,207.20 **Benefit:** 75% = $905.40
34160	AORTO-DUODENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes.) (Assist.) **Fee:** $2,261.50 **Benefit:** 75% = $1696.15
34163	AORTO-DUODENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum (Anaes.) (Assist.) **Fee:** $2,903.25 **Benefit:** 75% = $2177.45
34166	AORTO-DUODENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo-bifemoral grafting (Anaes.) (Assist.) **Fee:** $2,903.25 **Benefit:** 75% = $2177.45
34169	INFECTED BYPASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.) (Assist.) **Fee:** $1,612.15 **Benefit:** 75% = $1209.15
34172	INFECTED AXILLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of arteries (Anaes.) (Assist.) **Fee:** $1,314.10 **Benefit:** 75% = $985.60
34175	INFECTED BYPASS GRAFT FROM EXTREMITIES, excision of including closure of arteries (Anaes.) (Assist.) **Fee:** $1,207.20 **Benefit:** 75% = $905.40
	OPERATIONS FOR VASCULAR ACCESS
34500	ARTERIOVENOUS SHUNT, EXTERNAL, insertion of (Anaes.) (Assist.) **Fee:** $313.35 **Benefit:** 75% = $235.05 85% = $266.35

34503	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, in conjunction with another venous or arterial operation (Anaes.) (Assist.) **Fee:** $420.15 **Benefit:** 75% = $315.15
34506	ARTERIOVENOUS SHUNT, EXTERNAL, removal of (Anaes.) (Assist.) **Fee:** $213.80 **Benefit:** 75% = $160.35
34509	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, not in conjunction with another venous or arterial operation (Anaes.) (Assist.) **Fee:** $993.20 **Benefit:** 75% = $744.90
34512	ARTERIOVENOUS ACCESS DEVICE, insertion of (Anaes.) (Assist.) **Fee:** $1,092.60 **Benefit:** 75% = $819.45
34515	ARTERIOVENOUS ACCESS DEVICE, thrombectomy of (Anaes.) (Assist.) **Fee:** $779.25 **Benefit:** 75% = $584.45
34518	STENOSIS OF ARTERIOVENOUS FISTULA OR PROSTHETIC ARTERIOVENOUS ACCESS DEVICE, correction of (Anaes.) (Assist.) **Fee:** $1,306.30 **Benefit:** 75% = $979.75
34521	INTRA-ABDOMINAL ARTERY OR VEIN, cannulation of, for infusion chemotherapy, by open operation (excluding aftercare) (Anaes.) (Assist.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $802.60 **Benefit:** 75% = $601.95
34524	ARTERIAL CANNULATION for infusion chemotherapy by open operation, not being a service to which item 34521 applies (excluding after-care) (Anaes.) (Assist.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $420.15 **Benefit:** 75% = $315.15
34527	CENTRAL VEIN CATHETERISATION by open technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterization, on a person 10 years of age or over (Anaes.) **Fee:** $560.45 **Benefit:** 75% = $420.35 85% = $476.40
34528	CENTRAL VEIN CATHETERISATION by percutaneous technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, on a person 10 years of age or over (Anaes.) **Fee:** $276.75 **Benefit:** 75% = $207.60 85% = $235.25
34529	CENTRAL VEIN CATHETERISATION by open technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterization, on a person under 10 years of age (Anaes.) **Fee:** $728.55 **Benefit:** 75% = $546.45 85% = $643.85
34530	CENTRAL VENOUS LINE, OR OTHER CHEMOTHERAPY DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital on a person 10 years of age or over (Anaes.) **Fee:** $207.50 **Benefit:** 75% = $155.65 85% = $176.40
34533	ISOLATED LIMB PERFUSION, including cannulation of artery and vein at commencement of

	procedure, regional perfusion for chemotherapy, or other therapy, repair of arteriotomy and venotomy at conclusion of procedure (excluding aftercare) (Anaes.) (Assist.) **Fee:** $1,260.50 **Benefit:** 75% = $945.40 85% = $1175.80
34534	CENTRAL VEIN CATHETERISATION by percutaneous technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, on a person under 10 years of age (Anaes.) **Fee:** $359.75 **Benefit:** 75% = $269.85 85% = $305.80
34538	CENTRAL VEIN CATHERTERISATION by percutaneous technique, using subcutaneous tunnelled cuffed catheter or similar device, for the administration of haemodialysis or parenteral nutrition (Anaes.) **Fee:** $276.75 **Benefit:** 75% = $207.60 85% = $235.25
34539	TUNNELLED CUFFED CATHETER, OR SIMILAR DEVICE, removal of, by open surgical procedure (Anaes.) **Fee:** $207.50 **Benefit:** 75% = $155.65 85% = $176.40
34540	CENTRAL VENOUS LINE, OR OTHER CHEMOTHERAPY DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital, on a person under 10 years of age (Anaes.) **Fee:** $269.75 **Benefit:** 75% = $202.35 85% = $229.30
	COMPLEX VENOUS OPERATIONS
34800	INFERIOR VENA CAVA, plication, ligation, or application of caval clip (Anaes.) (Assist.) **Fee:** $825.15 **Benefit:** 75% = $618.90 85% = $740.45
34803	INFERIOR VENA CAVA, reconstruction of or bypass by vein or synthetic material (Anaes.) (Assist.) **Fee:** $1,818.50 **Benefit:** 75% = $1363.90
34806	CROSS LEG BYPASS GRAFTING, saphenous to iliac or femoral vein (Anaes.) (Assist.) **Fee:** $985.55 **Benefit:** 75% = $739.20
34809	SAPHENOUS VEIN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (Anaes.) (Assist.) **Fee:** $985.55 **Benefit:** 75% = $739.20
34812	VENOUS STENOSIS OR OCCLUSION, vein bypass for, using vein or synthetic material, not being a service associated with a service to which item 34806 or 34809 applies (Anaes.) (Assist.) **Fee:** $1,191.80 **Benefit:** 75% = $893.85
34815	VEIN STENOSIS, patch angioplasty for, (excluding vein graft stenosis)-using vein or synthetic material (Anaes.) (Assist.) (See para TN.8.36 of explanatory notes to this Category) **Fee:** $985.55 **Benefit:** 75% = $739.20
34818	VENOUS VALVE, plication or repair to restore valve competency (Anaes.) (Assist.) **Fee:** $1,084.90 **Benefit:** 75% = $813.70
34821	VEIN TRANSPLANT to restore valvular function (Anaes.) (Assist.) **Fee:** $1,474.65 **Benefit:** 75% = $1106.00 85% = $1389.95

34824	EXTERNAL STENT, application of, to restore venous valve competency to superficial vein - 1 stent (Anaes.) (Assist.) **Fee:** $504.25 **Benefit:** 75% = $378.20
34827	EXTERNAL STENTS, application of, to restore venous valve competency to superficial vein or veins - more than 1 stent (Anaes.) (Assist.) **Fee:** $611.30 **Benefit:** 75% = $458.50
34830	EXTERNAL STENT, application of, to restore venous valve competency to deep vein (1 stent) (Anaes.) (Assist.) **Fee:** $718.30 **Benefit:** 75% = $538.75 85% = $633.60
34833	EXTERNAL STENTS, application of, to restore venous valve competency to deep vein or veins (more than 1 stent) (Anaes.) (Assist.) **Fee:** $932.10 **Benefit:** 75% = $699.10
	SYMPATHECTOMY
35000	LUMBAR SYMPATHECTOMY (Anaes.) (Assist.) **Fee:** $718.30 **Benefit:** 75% = $538.75 85% = $633.60
35003	CERVICAL OR UPPER THORACIC SYMPATHECTOMY by any surgical approach (Anaes.) (Assist.) **Fee:** $932.10 **Benefit:** 75% = $699.10
35006	CERVICAL OR UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (Anaes.) (Assist.) **Fee:** $1,168.95 **Benefit:** 75% = $876.75
35009	LUMBAR SYMPATHECTOMY, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (Anaes.) (Assist.) **Fee:** $909.05 **Benefit:** 75% = $681.80
35012	SACRAL or PRE-SACRAL SYMPATHECTOMY (Anaes.) (Assist.) **Fee:** $718.30 **Benefit:** 75% = $538.75
	DEBRIDEMENT AND AMPUTATIONS FOR VASCULAR DISEASE
35100	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, when debridement includes muscle, tendon or bone (Anaes.) (Assist.) **Fee:** $374.45 **Benefit:** 75% = $280.85
35103	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (Anaes.) **Fee:** $238.30 **Benefit:** 75% = $178.75
	MISCELLANEOUS VASCULAR PROCEDURES
35200	OPERATIVE ARTERIOGRAPHY OR VENOGRAPHY, 1 or more of, performed during the course of an operative procedure on an artery or vein, 1 site (Anaes.) **Fee:** $174.25 **Benefit:** 75% = $130.70
35202	MAJOR ARTERIES OR VEINS IN THE NECK, ABDOMEN OR EXTREMITIES, access to, as part of

	RE-OPERATION after prior surgery on these vessels (Anaes.) (Assist.) **Fee:** $830.15 **Benefit:** 75% = $622.65
	ENDOVASCULAR INTERVENTIONAL PROCEDURES
35300	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $523.60 **Benefit:** 75% = $392.70 85% = $445.10
35303	TRANSLUMINAL BALLOON ANGIOPLASTY of aortic arch branches, aortic visceral branches, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $671.35 **Benefit:** 75% = $503.55 85% = $586.65
35306	TRANSLUMINAL STENT INSERTION, 1 or more stents, including associated balloon dilatation for 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare. (Anaes.) (Assist.) **Fee:** $619.65 **Benefit:** 75% = $464.75 85% = $534.95
35307	TRANSLUMINAL STENT INSERTION, 1 or more stents (not drug-eluting), with or without associated balloon dilatation, for 1 carotid artery, percutaneous (not direct), with or without the use of an embolic protection device, in patients who: - meet the indications for carotid endarterectomy; and - have medical or surgical comorbidities that would make them at high risk of perioperative complications from carotid endarterectomy, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.37 of explanatory notes to this Category) **Fee:** $1,139.10 **Benefit:** 75% = $854.35
35309	TRANSLUMINAL STENT INSERTION, 1 or more stents, including associated balloon dilatation for visceral arteries or veins, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare. (Anaes.) (Assist.) **Fee:** $774.55 **Benefit:** 75% = $580.95 85% = $689.85
35312	PERIPHERAL ARTERIAL ATHERECTOMY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $877.85 **Benefit:** 75% = $658.40
35315	PERIPHERAL LASER ANGIOPLASTY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $877.85 **Benefit:** 75% = $658.40
35317	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY CONTINUOUS INFUSION, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35319 or 35320 applies and

	not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) (See para TN.8.38 of explanatory notes to this Category) **Fee:** $361.50 **Benefit:** 75% = $271.15 85% = $307.30
35319	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY PULSE SPRAY TECHNIQUE, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) **Fee:** $648.00 **Benefit:** 75% = $486.00 85% = $563.30
35320	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY OPEN EXPOSURE, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35319 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) **Fee:** $870.40 **Benefit:** 75% = $652.80 85% = $785.70
35321	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION to administer agents to occlude arteries, veins or arterio-venous fistulae or to arrest haemorrhage, (but not for the treatment of uterine fibroids or varicose veins) percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.) (See para TN.8.39 of explanatory notes to this Category) **Fee:** $826.30 **Benefit:** 75% = $619.75 85% = $741.60
35324	ANGIOSCOPY not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $309.85 **Benefit:** 75% = $232.40
35327	ANGIOSCOPY combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $415.25 **Benefit:** 75% = $311.45
35330	INSERTION of INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $523.60 **Benefit:** 75% = $392.70 85% = $445.10
35331	RETRIEVAL OF INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (Anaes.) **Fee:** $601.95 **Benefit:** 75% = $451.50
35360	Retrieval of foreign body in PULMONARY ARTERY, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare *(foreign body does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.) **Fee:** $841.45 **Benefit:** 75% = $631.10

35361	Retrieval of foreign body in RIGHT ATRIUM, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare *(foreign body does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.) **Fee:** $721.65 **Benefit:** 75% = $541.25
35362	Retrieval of foreign body in INFERIOR VENA CAVA or AORTA, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare *(foreign body does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.) **Fee:** $601.95 **Benefit:** 75% = $451.50
35363	Retrieval of foreign body in PERIPHERAL VEIN or PERIPHERAL ARTERY, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare *(foreign body does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.) **Fee:** $482.25 **Benefit:** 75% = $361.70
	INTERVENTIONAL RADIOLOGY PROCEDURES
35404	DOSIMETRY, HANDLING AND INJECTION OF SIR-SPHERES for selective internal radiation therapy of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies The procedure must be performed by a specialist or consultant physician recognised in the specialties of nuclear medicine or radiation oncology on an admitted patient in a hospital. To be claimed once in the patient's lifetime only. (See para TN.3.1, TN.8.40 of explanatory notes to this Category) **Fee:** $352.15 **Benefit:** 75% = $264.15
35406	Trans-femoral catheterisation of the hepatic artery to administer SIR-Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.3.1, TN.8.40 of explanatory notes to this Category) **Fee:** $826.30 **Benefit:** 75% = $619.75
35408	Catheterisation of the hepatic artery via a permanently implanted hepatic artery port to administer SIR-Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which

	item 35317, 35319, 35320 or 35321 applies excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.3.1, TN.8.40 of explanatory notes to this Category) **Fee:** $619.85 **Benefit:** 75% = $464.90
35410	UTERINE ARTERY CATHETERISATION with percutaneous administration of occlusive agents, for the treatment of symptomatic uterine fibroids in a patient who has been referred for uterine artery embolisation by a specialist gynaecologist, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.34 of explanatory notes to this Category) **Fee:** $826.30 **Benefit:** 75% = $619.75 85% = $741.60
35412	Intracranial aneurysm, ruptured or unruptured, endovascular occlusion with detachable coils, and assisted coiling if performed, with parent artery preservation, not for use with liquid embolics only, including aftercare, including intra-operative imaging, but in association with the following pre-operative diagnostic imaging items: - either 60009 or 60010; and - either 60072, 60073, 60075, 60076, 60078 or 60079 (Anaes.) (Assist.) (See para TN.8.35 of explanatory notes to this Category) **Fee:** $2,903.25 **Benefit:** 75% = $2177.45 85% = $2818.55
35414	Mechanical thrombectomy, in a patient with a diagnosis of acute ischaemic stroke caused by occlusion of a large vessel of the anterior cerebral circulation, including intra-operative imaging and aftercare, if: (a) the diagnosis is confirmed by an appropriate imaging modality such as computed tomography, magnetic resonance imaging or angiography; and (b) the service is performed by a specialist or consultant physician with appropriate training that is recognised by the Conjoint Committee for Recognition of Training in Interventional Neuroradiology; and (c) the service is provided in an eligible stroke centre. For any particular patient - applicable once per presentation by the patient at an eligible stroke centre, regardless of the number of times mechanical thrombectomy is attempted during that presentation (Anaes.) (Assist.) (See para TR.8.1 of explanatory notes to this Category) **Fee:** $3,556.00 **Benefit:** 75% = $2667.00

	Group T8. Surgical Operations
	Subgroup 4. Gynaecological
35500	GYNAECOLOGICAL EXAMINATION UNDER ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $82.60 **Benefit:** 75% = $61.95 85% = $70.25
35502	INTRAUTERINE DEVICE, INTRODUCTION OF, for the control of idiopathic menorrhagia, AND ENDOMETRIAL BIOPSY to exclude endometrial pathology, not being a service associated with a

	service to which another item in this Group applies (Anaes.) **Fee:** $81.45 **Benefit:** 75% = $61.10 85% = $69.25
35503	Intra uterine contraceptive device, introduction of, if the service is not associated with a service to which another item in this Group applies (other than a service mentioned in item 30062) (Anaes.) **Fee:** $54.40 **Benefit:** 75% = $40.80 85% = $46.25
35506	INTRAUTERINE CONTRACEPTIVE DEVICE, REMOVAL OF UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
35507	VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Anaes.) **Fee:** $177.25 **Benefit:** 75% = $132.95 85% = $150.70
35508	VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Anaes.) (Assist.) **Fee:** $261.05 **Benefit:** 75% = $195.80 85% = $221.90
35509	HYMENECTOMY (Anaes.) **Fee:** $90.90 **Benefit:** 75% = $68.20 85% = $77.30
35513	BARTHOLIN'S CYST, excision of (Anaes.) **Fee:** $225.25 **Benefit:** 75% = $168.95 85% = $191.50
35517	BARTHOLIN'S CYST OR GLAND, marsupialisation of (Anaes.) **Fee:** $148.35 **Benefit:** 75% = $111.30 85% = $126.10
35518	OVARIAN CYST ASPIRATION, for cysts of at least 4cm in diameter in a premenopausal person and at least 2cm in diameter in a postmenopausal person, by abdominal or vaginal route, using interventional imaging techniques and not associated with services provided for assisted reproductive techniques (Anaes.) (See para TN.4.11 of explanatory notes to this Category) **Fee:** $211.20 **Benefit:** 75% = $158.40 85% = $179.55
35520	BARTHOLIN'S ABSCESS, incision of (Anaes.) **Fee:** $59.25 **Benefit:** 75% = $44.45 85% = $50.40
35523	URETHRA OR URETHRAL CARUNCLE, cauterisation of (Anaes.) **Fee:** $59.25 **Benefit:** 75% = $44.45 85% = $50.40
35527	URETHRAL CARUNCLE, excision of (Anaes.) **Fee:** $148.35 **Benefit:** 75% = $111.30 85% = $126.10
35530	CLITORIS, amputation of, where medically indicated (Anaes.) (Assist.)

	Fee: $274.15 **Benefit:** 75% = $205.65
35533	Vulvoplasty or labioplasty, for repair of: (a) female genital mutilation; or (b) an anomaly associated with a major congenital anomaly of the uro-gynaecological tract other than a service associated with a service to which item 35536, 37836, 37050, 37842, 37851 or 43882 applies (Anaes.) (See para TN.8.123 of explanatory notes to this Category) **Fee:** $355.45 **Benefit:** 75% = $266.60
35534	Vulvoplasty or labioplasty, in a patient aged 18 years or more, performed by a specialist in the practice of the specialist's specialty, for a structural abnormality that is causing significant functional impairment, if the patient's labium extends more than 8 cm below the vaginal introitus while the patient is in a standing resting position (Anaes.) (See para TN.8.123 of explanatory notes to this Category) **Fee:** $355.45 **Benefit:** 75% = $266.60
35536	VULVA, wide local excision of suspected malignancy or hemivulvectomy, 1 or both procedures (Anaes.) (Assist.) **Fee:** $354.05 **Benefit:** 75% = $265.55 85% = $300.95
35539	COLPOSCOPICALLY DIRECTED CO^2 LASER THERAPY for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 1 anatomical site (Anaes.) **Fee:** $277.30 **Benefit:** 75% = $208.00 85% = $235.75
35542	COLPOSCOPICALLY DIRECTED CO^2 LASER THERAPY for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 2 or more anatomical sites (Anaes.) (Assist.) **Fee:** $324.70 **Benefit:** 75% = $243.55 85% = $276.00
35545	COLPOSCOPICALLY DIRECTED CO^2 LASER THERAPY for condylomata, unsuccessfully treated by other methods (Anaes.) **Fee:** $186.55 **Benefit:** 75% = $139.95 85% = $158.60
35548	VULVECTOMY, radical, for malignancy (Anaes.) (Assist.) **Fee:** $847.40 **Benefit:** 75% = $635.55
Amend 35551	PELVIC LYMPH NODES, excision of (radical) (Anaes.) (Assist.) **Fee:** $694.85 **Benefit:** 75% = $521.15
35554	VAGINA, DILATATION OF, as an independent procedure including any associated consultation (Anaes.) **Fee:** $44.20 **Benefit:** 75% = $33.15 85% = $37.60
35557	VAGINA, removal of simple tumour (including Gartner duct cyst) (Anaes.) **Fee:** $217.95 **Benefit:** 75% = $163.50 85% = $185.30
35560	VAGINA, partial or complete removal of (Anaes.) (Assist.)

	Fee: $694.85 **Benefit:** 75% = $521.15
35561	VAGINECTOMY, radical, for proven invasive malignancy - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,401.55 **Benefit:** 75% = $1051.20
35562	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - abdominal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,150.70 **Benefit:** 75% = $863.05
35564	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - perineal surgeon (Assist.) **Fee:** $531.20 **Benefit:** 75% = $398.40
35565	VAGINAL RECONSTRUCTION for congenital absence, gynatresia or urogenital sinus (Anaes.) (Assist.) **Fee:** $694.85 **Benefit:** 75% = $521.15
35566	VAGINAL SEPTUM, excision of, for correction of double vagina (Anaes.) (Assist.) **Fee:** $403.60 **Benefit:** 75% = $302.70
35568	SACROSPINOUS COLPOPEXY FOR MANAGEMENT OF UPPER VAGINAL PROLAPSE (Anaes.) (Assist.) **Fee:** $634.60 **Benefit:** 75% = $475.95
35569	PLASTIC REPAIR TO ENLARGE VAGINAL ORIFICE (Anaes.) **Fee:** $163.40 **Benefit:** 75% = $122.55
35570	Anterior vaginal compartment repair by vaginal approach for pelvic organ prolapse (involving repair of urethrocele and cystocele), using native tissue without graft, other than a service associated with a service to which item 35573, 35577 or 35578 applies. (Anaes.) (Assist.) **Fee:** $562.70 **Benefit:** 75% = $422.05
35571	Posterior vaginal compartment repair by vaginal approach for pelvic organ prolapse involving repair of one or more of the following: (a) perineum; (b) rectocoele; (c) enterocoele; using native tissue without graft, other than a service associated with a service to which item 35573, 35577 or 35578 applies. (Anaes.) (Assist.) **Fee:** $562.70 **Benefit:** 75% = $422.05
35572	COLPOTOMY not being a service to which another item in this Group applies (Anaes.) **Fee:** $125.80 **Benefit:** 75% = $94.35
35573	Anterior and posterior vaginal compartment repair by vaginal approach for pelvic organ prolapse (involving anterior and posterior compartment defects), using native tissue without graft, other than a

	service associated with a service to which item 35577 or 35578 applies. (Anaes.) (Assist.) **Fee:** $844.20 **Benefit:** 75% = $633.15
35577	Manchester (Donald Fothergill) operation for pelvic organ prolapse (includes cervical amputation, anterior and posterior native tissue vaginal wall repairs without graft). (Anaes.) (Assist.) **Fee:** $685.30 **Benefit:** 75% = $514.00
35578	LE FORT OPERATION for genital prolapse, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $685.30 **Benefit:** 75% = $514.00
35581	Vaginal procedure for excision of graft material in symptomatic patients with graft related complications, including graft related pain or discharge and bleeding related to graft exposure, less than $2cm^2$ in its maximum area, either singly or in multiple pieces, other than a service associated with a service to which item 35582 or 35585 applies. (Anaes.) (Assist.) (See para TN.8.140 of explanatory notes to this Category) **Fee:** $562.70 **Benefit:** 75% = $422.05
35582	Vaginal procedure for excision of graft material in symptomatic patients with graft related complications, including graft related pain or discharge and bleeding related to graft exposure, more than $2cm^2$ in its maximum area, either singly or in multiple pieces, other than a service associated with a service to which item 35581 or 35585 applies. (Anaes.) (Assist.) (See para TN.8.140 of explanatory notes to this Category) **Fee:** $844.20 **Benefit:** 75% = $633.15
35585	Abdominal procedure either open, laparoscopic or robotic, for removal of graft material in patients symptomatic with graft related complications, including graft related pain or discharge and bleeding related to graft exposure or where the graft has penetrated adjacent organs such as the bladder (including urethra) or bowel, including retroperitoneal dissection and mobilisation of bladder and/or bowel, other than a service associated with a service to which item 35581 or 35582 applies. (Anaes.) (Assist.) **Fee:** $1,496.75 **Benefit:** 75% = $1122.60
35595	LAPAROSCOPIC OR ABDOMINAL PELVIC FLOOR REPAIR INCORPORATING THE FIXATION OF THE UTEROSACRAL AND CARDINAL LIGAMENTS TO RECTOVAGINAL AND PUBOCERVICAL FASCIA for symptomatic upper vaginal vault prolapse (Anaes.) (Assist.) **Fee:** $1,173.50 **Benefit:** 75% = $880.15
35596	FISTULA BETWEEN GENITAL AND URINARY OR ALIMENTARY TRACTS, repair of, not being

	a service to which item 37029, 37333 or 37336 applies (Anaes.) (Assist.) **Fee:** $694.85 **Benefit:** 75% = $521.15
35597	SACRAL COLPOPEXY, laparoscopic or open procedure where graft or mesh secured to vault, anterior and posterior compartment and to sacrum for correction of symptomatic upper vaginal vault prolapse (Anaes.) (Assist.) **Fee:** $1,496.75 **Benefit:** 75% = $1122.60
35599	STRESS INCONTINENCE, sling operation for, with or without mesh or tape, not being a service associated with a service to which item 30405 applies (Anaes.) (Assist.) **Fee:** $685.30 **Benefit:** 75% = $514.00
35602	STRESS INCONTINENCE, combined synchronous ABDOMINOVAGINAL operation for; abdominal procedure, with or without mesh, (including aftercare), not being a service associated with a service to which item 30405 applies (Anaes.) (Assist.) **Fee:** $685.30 **Benefit:** 75% = $514.00
35605	STRESS INCONTINENCE, combined synchronous ABDOMINOVAGINAL operation for; vaginal procedure, with or without mesh, (including aftercare), not being a service associated with a service to which item 30405 applies (Assist.) **Fee:** $371.80 **Benefit:** 75% = $278.85 85% = $316.05
35608	CERVIX, cauterisation (other than by chemical means), ionisation, diathermy or biopsy of, with or without dilatation of cervix (Anaes.) **Fee:** $65.00 **Benefit:** 75% = $48.75 85% = $55.25
35611	CERVIX, removal of polyp or polypi, with or without dilatation of cervix, not being a service associated with a service to which item 35608 applies (Anaes.) **Fee:** $65.00 **Benefit:** 75% = $48.75 85% = $55.25
35612	CERVIX, RESIDUAL STUMP, removal of, by abdominal approach (Anaes.) (Assist.) **Fee:** $514.10 **Benefit:** 75% = $385.60 85% = $437.00
35613	CERVIX, RESIDUAL STUMP, removal of, by vaginal approach (Anaes.) (Assist.) **Fee:** $411.30 **Benefit:** 75% = $308.50
35614	EXAMINATION OF LOWER TRACT by a Hinselmanntype colposcope in a patient with a previous abnormal cervical smear screen result or a history of maternal ingestion of oestrogen or where a patient, because of suspicious signs of cancer, has been referred by another medical practitioner (Anaes.) (See para TN.8.42 of explanatory notes to this Category) **Fee:** $64.90 **Benefit:** 75% = $48.70 85% = $55.20
35615	VULVA, biopsy of, when performed in conjunction with a service to which item 35614 applies **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
35616	ENDOMETRIUM, endoscopic examination of and ablation of, by microwave or thermal balloon or radiofrequency electrosurgery, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage (Anaes.) **Fee:** $456.80 **Benefit:** 75% = $342.60
35618	CERVIX, cone biopsy, amputation or repair of, other than a service to which item 35577 or 35578

	applies (Anaes.) **Fee:** $221.50 **Benefit:** 75% = $166.15 85% = $188.30
35620	ENDOMETRIAL BIOPSY where malignancy is suspected in patients with abnormal uterine bleeding or post menopausal bleeding (Anaes.) **Fee:** $54.20 **Benefit:** 75% = $40.65 85% = $46.10
35622	ENDOMETRIUM, endoscopic ablation of, by laser or diathermy, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage, not being a service associated with a service to which item 30390 applies (Anaes.) **Fee:** $612.10 **Benefit:** 75% = $459.10
35623	HYSTEROSCOPIC RESECTION of myoma, or myoma and uterine septum resection (where both are performed), followed by endometrial ablation by laser or diathermy (Anaes.) **Fee:** $832.35 **Benefit:** 75% = $624.30
35626	HYSTEROSCOPY, including biopsy, performed by a specialist in the practice of his or her specialty where the patient is referred to him or her for the investigation of suspected intrauterine pathology (with or without local anaesthetic), not being a service associated with a service to which item 35627 or 35630 applies (See para TN.8.43 of explanatory notes to this Category) **Fee:** $84.10 **Benefit:** 75% = $63.10 85% = $71.50
35627	HYSTEROSCOPY with dilatation of the cervix performed in the operating theatre of a hospital - not being a service associated with a service to which item 35626 or 35630 applies (Anaes.) **Fee:** $108.85 **Benefit:** 75% = $81.65
35630	HYSTEROSCOPY, with endometrial biopsy, performed in the operating theatre of a hospital - not being a service associated with a service to which item 35626 or 35627 applies (Anaes.) **Fee:** $185.95 **Benefit:** 75% = $139.50
35633	HYSTEROSCOPY with uterine adhesiolysis or polypectomy or tubal catheterisation (including for insertion of device for sterilisation) or removal of IUD which cannot be removed by other means, 1 or more of (Anaes.) **Fee:** $221.50 **Benefit:** 75% = $166.15 85% = $188.30
35634	HYSTEROSCOPIC RESECTION of uterine septum followed by endometrial ablation by laser or diathermy (Anaes.) **Fee:** $696.65 **Benefit:** 75% = $522.50 85% = $611.95
35635	HYSTEROSCOPY involving resection of the uterine septum (Anaes.) **Fee:** $304.25 **Benefit:** 75% = $228.20
35636	HYSTEROSCOPY, involving resection of myoma, or resection of myoma and uterine septum (where both are performed) (Anaes.) **Fee:** $439.95 **Benefit:** 75% = $330.00
35637	LAPAROSCOPY, involving puncture of cysts, diathermy of endometriosis, ventrosuspension, division of adhesions or similar procedure - 1 or more procedures with or without biopsy - not being a service associated with any other laparoscopic procedure or hysterectomy (Anaes.) (Assist.)

	(See para TN.1.4 of explanatory notes to this Category) **Fee:** $413.15 **Benefit:** 75% = $309.90
35638	COMPLICATED OPERATIVE LAPAROSCOPY, including use of laser when required, for 1 or more of the following procedures; oophorectomy, ovarian cystectomy, myomectomy, salpingectomy or salpingostomy, ablation of moderate or severe endometriosis requiring more than 1 hours operating time, or division of utero-sacral ligaments for significant dysmenorrhoea - not being a service associated with any other intraperitoneal or retroperitoneal procedure except item 30393 (Anaes.) (Assist.) **Fee:** $722.90 **Benefit:** 75% = $542.20
35640	UTERUS, CURETTAGE OF, with or without dilatation (including curettage for incomplete miscarriage) under general anaesthesia, or under epidural or spinal (intrathecal) nerve block, including procedures to which item 35626, 35627 or 35630 applies, if performed (Anaes.) (See para TN.8.44 of explanatory notes to this Category) **Fee:** $185.95 **Benefit:** 75% = $139.50
35641	ENDOMETRIOSIS LEVEL 4 OR 5, LAPAROSCOPIC RESECTION OF, involving any two of the following procedures, resection of the pelvic side wall including dissection of endometriosis or scar tissue from the ureter, resection of the Pouch of Douglas, resection of an ovarian endometrioma greater than 2 cms in diameter, dissection of bowel from uterus from the level of the endocervical junction or above: where the operating time exceeds 90 minutes (Anaes.) (Assist.) **Fee:** $1,262.55 **Benefit:** 75% = $946.95
35643	EVACUATION OF THE CONTENTS OF THE GRAVID UTERUS BY CURETTAGE OR SUCTION CURETTAGE other than a service to which item 35640 applies, including procedures to which item 35626, 35627 or 35630 applies, if performed (Anaes.) **Fee:** $221.50 **Benefit:** 75% = $166.15 85% = $188.30
35644	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, other than a service associated with a service to which item 35640 or 35647 applies (Anaes.) (See para TN.8.45 of explanatory notes to this Category) **Fee:** $206.90 **Benefit:** 75% = $155.20 85% = $175.90
35645	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative therapy of additional areas of intraepithelial change in 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35648 applies (Anaes.) (See para TN.8.45 of explanatory notes to this Category) **Fee:** $323.80 **Benefit:** 75% = $242.85 85% = $275.25
35646	CERVIX, colposcopy with radical diathermy of, with or without cervical biopsy, for previously confirmed intraepithelial neoplastic changes of the cervix (Anaes.) (See para TN.8.45 of explanatory notes to this Category) **Fee:** $206.90 **Benefit:** 75% = $155.20 85% = $175.90
35647	CERVIX, large loop excision of transformation zone together with colposcopy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35644 applies (Anaes.) (See para TN.8.45 of explanatory notes to this Category) **Fee:** $206.90 **Benefit:** 75% = $155.20 85% = $175.90
35648	CERVIX, large loop excision diathermy for previously confirmed intraepithelial neoplastic changes of

	the cervix, including any local anaesthesia and biopsies, in conjunction with ablative treatment of additional areas of intraepithelial change of 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35645 applies (Anaes.) (See para TN.8.45 of explanatory notes to this Category) **Fee:** $323.80 **Benefit:** 75% = $242.85 85% = $275.25
35649	HYSTEROTOMY or UTERINE MYOMECTOMY, abdominal (Anaes.) (Assist.) **Fee:** $544.60 **Benefit:** 75% = $408.45
35653	HYSTERECTOMY, ABDOMINAL, SUBTOTAL or TOTAL, with or without removal of uterine adnexae (Anaes.) (Assist.) **Fee:** $685.50 **Benefit:** 75% = $514.15
35657	HYSTERECTOMY, VAGINAL, with or without uterine curettage, not being a service to which item 35673 applies NOTE: *Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim.* (Anaes.) (Assist.) (See para TN.8.46 of explanatory notes to this Category) **Fee:** $685.50 **Benefit:** 75% = $514.15
35658	UTERUS (at least equivalent in size to a 10 week gravid uterus), debulking of, prior to vaginal removal at hysterectomy (Anaes.) (Assist.) (See para TN.8.47 of explanatory notes to this Category) **Fee:** $422.70 **Benefit:** 75% = $317.05
35661	HYSTERECTOMY, ABDOMINAL, requiring extensive retroperitoneal dissection, with or without exposure of 1 or both ureters, for the management of severe endometriosis, pelvic inflammatory disease or benign pelvic tumours, with or without conservation of the ovaries (Anaes.) (Assist.) **Fee:** $885.25 **Benefit:** 75% = $663.95
Amend 35664	RADICAL HYSTERECTOMY with radical excision of pelvic lymph nodes (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes.) (Assist.) **Fee:** $1,475.45 **Benefit:** 75% = $1106.60
35667	RADICAL HYSTERECTOMY without gland dissection (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes.) (Assist.) **Fee:** $1,254.00 **Benefit:** 75% = $940.50
Amend 35670	HYSTERECTOMY, abdominal, with radical excision of pelvic lymph nodes, with or without removal of uterine adnexae (Anaes.) (Assist.) **Fee:** $1,032.55 **Benefit:** 75% = $774.45
35673	HYSTERECTOMY, VAGINAL (with or without uterine curettage) with salpingectomy, oophorectomy or excision of ovarian cyst, 1 or more, 1 or both sides (Anaes.) (Assist.)

	Fee: $769.90 **Benefit:** 75% = $577.45
35674	ULTRASOUND GUIDED NEEDLING and injection of ectopic pregnancy (See para TN.4.11 of explanatory notes to this Category) **Fee:** $211.20 **Benefit:** 75% = $158.40 85% = $179.55
35677	ECTOPIC PREGNANCY, removal of (Anaes.) (Assist.) **Fee:** $544.60 **Benefit:** 75% = $408.45
35678	ECTOPIC PREGNANCY, laparoscopic removal of (Anaes.) (Assist.) **Fee:** $656.60 **Benefit:** 75% = $492.45
35680	BICORNUATE UTERUS, plastic reconstruction for (Anaes.) (Assist.) **Fee:** $591.35 **Benefit:** 75% = $443.55 85% = $506.65
35684	UTERUS, SUSPENSION OR FIXATION OF, as an independent procedure (Anaes.) (Assist.) **Fee:** $478.70 **Benefit:** 75% = $359.05
35688	STERILISATION BY TRANSECTION OR RESECTION OF FALLOPIAN TUBES, via abdominal or vaginal routes or via laparoscopy using diathermy or any other method NOTE: *Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim.* (Anaes.) (Assist.) (See para TN.8.46 of explanatory notes to this Category) **Fee:** $403.60 **Benefit:** 75% = $302.70
35691	STERILISATION BY INTERRUPTION OF FALLOPIAN TUBES, when performed in conjunction with Caesarean section NOTE: *Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explantory note before submitting a claim.* (Anaes.) (Assist.) (See para TN.8.46 of explanatory notes to this Category) **Fee:** $161.25 **Benefit:** 75% = $120.95
35694	TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.) **Fee:** $647.90 **Benefit:** 75% = $485.95
35697	MICROSURGICAL TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.) **Fee:** $961.35 **Benefit:** 75% = $721.05
35700	FALLOPIAN TUBES, unilateral microsurgical anastomosis of, using operating microscope (Anaes.) (Assist.) **Fee:** $741.75 **Benefit:** 75% = $556.35

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.) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
35706	RUBIN TEST FOR PATENCY OF FALLOPIAN TUBES (Anaes.) **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35
35709	FALLOPIAN TUBES, hydrotubation of, as a repetitive postoperative procedure (Anaes.) **Fee:** $44.20 **Benefit:** 75% = $33.15 85% = $37.60
35710	FALLOPOSCOPY, unilateral or bilateral, including hysteroscopy and tubal catheterization (Anaes.) (Assist.) **Fee:** $470.70 **Benefit:** 75% = $353.05
35713	LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGO-OOPHORECTOMY, removal of OVARIAN, PARAOVARIAN, FIMBRIAL or BROAD LIGAMENT CYST - one such procedure, other than a service associated with hysterectomy (Anaes.) (Assist.) **Fee:** $460.10 **Benefit:** 75% = $345.10
35717	LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGO-OOPHORECTOMY, removal of OVARIAN, PARAOVARIAN, FIMBRIAL or BROAD LIGAMENT CYST - 2 or more such procedures, unilateral or bilateral, other than a service associated with hysterectomy (Anaes.) (Assist.) **Fee:** $554.00 **Benefit:** 75% = $415.50
35720	RADICAL OR DEBULKING OPERATION for advanced gynaecological malignancy, with or without omentectomy (Anaes.) (Assist.) (See para TN.8.57 of explanatory notes to this Category) **Fee:** $685.30 **Benefit:** 75% = $514.00
35723	RETROPERITONEAL LYMPH NODE BIOPSIES from above the level of the aortic bifurcation, for staging or restaging of gynaecological malignancy (Anaes.) (Assist.) **Fee:** $490.85 **Benefit:** 75% = $368.15
35726	INFRACOLIC OMENTECTOMY with multiple peritoneal biopsies for staging or restaging of gynaecological malignancy (Anaes.) (Assist.) **Fee:** $490.85 **Benefit:** 75% = $368.15
35729	OVARIAN TRANSPOSITION out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy (Anaes.) **Fee:** $221.30 **Benefit:** 75% = $166.00
35730	Ovarian repositioning for one or both ovaries to preserve ovarian function, prior to gonadotoxic radiotherapy when the treatment volume and dose of radiation have a high probability of causing infertility (Anaes.) **Fee:** $221.30 **Benefit:** 75% = $166.00
35750	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, including any associated laparoscopy (Anaes.) (Assist.) **Fee:** $797.15 **Benefit:** 75% = $597.90

T8. SURGICAL OPERATIONS	4. GYNAECOLOGICAL
35753	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst or treatment of moderate endometriosis, one or both sides, including any associated laparoscopy (Anaes.) (Assist.) **Fee:** $881.50 **Benefit:** 75% = $661.15
35754	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY which requires dissection of endometriosis, or other pathology, from the ureter, one or both sides, including any associated laparoscopy, including when performed with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst, or treatment of endometriosis, not being a service to which item 35641 applies (Anaes.) (Assist.) **Fee:** $1,109.35 **Benefit:** 75% = $832.05
35756	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, when procedure is completed by open hysterectomy, including any associated laparoscopy (Anaes.) (Assist.) **Fee:** $797.15 **Benefit:** 75% = $597.90
35759	Procedure for the control of POST OPERATIVE HAEMORRHAGE following gynaecological surgery, under general anaesthesia, utilising a vaginal or abdominal and vaginal approach where no other procedure is performed (Anaes.) (Assist.) **Fee:** $572.30 **Benefit:** 75% = $429.25

T8. SURGICAL OPERATIONS	5. UROLOGICAL
	Group T8. Surgical Operations
	Subgroup 5. Urological
	GENERAL
36502	PELVIC LYMPHADENECTOMY, open or laparoscopic, or both, unilateral or bilateral (Anaes.) (Assist.) **Fee:** $694.85 **Benefit:** 75% = $521.15
36503	RENAL TRANSPLANT (not being a service to which item 36506 or 36509 applies) (Anaes.) (Assist.) **Fee:** $1,413.40 **Benefit:** 75% = $1060.05
36506	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together vascular anastomosis including aftercare (Anaes.) (Assist.) **Fee:** $939.50 **Benefit:** 75% = $704.65
36509	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together ureterovesical anastomosis including aftercare (Assist.) **Fee:** $795.50 **Benefit:** 75% = $596.65
36516	NEPHRECTOMY, complete (Anaes.) (Assist.) **Fee:** $939.50 **Benefit:** 75% = $704.65
36519	NEPHRECTOMY, complete, complicated by previous surgery on the same kidney (Anaes.) (Assist.) **Fee:** $1,311.75 **Benefit:** 75% = $983.85

36522	NEPHRECTOMY, partial (Anaes.) (Assist.) **Fee:** $1,125.70 **Benefit:** 75% = $844.30
36525	NEPHRECTOMY, partial, complicated by previous surgery on the same kidney (Anaes.) (Assist.) **Fee:** $1,599.65 **Benefit:** 75% = $1199.75
36526	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10cms in diameter, where performed if malignancy is clinically suspected but not confirmed by histopathological examination (Anaes.) (Assist.) (See para TN.8.48 of explanatory notes to this Category) **Fee:** $1,311.75 **Benefit:** 75% = $983.85 85% = $1227.05
36527	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour 10cms or more in diameter, or complicated by previous open or laparoscopic surgery on the same kidney, where performed if malignancy is clinically suspected but not confirmed by histopathological examination (Anaes.) (Assist.) (See para TN.8.48 of explanatory notes to this Category) **Fee:** $1,618.90 **Benefit:** 75% = $1214.20 85% = $1534.20
36528	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10 cms in diameter (Anaes.) (Assist.) **Fee:** $1,311.75 **Benefit:** 75% = $983.85
36529	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour 10 cms or more in diameter, or complicated by previous open or laparoscopic surgery on the same kidney (Anaes.) (Assist.) **Fee:** $1,618.90 **Benefit:** 75% = $1214.20
36531	NEPHROURETERECTOMY, complete, including associated bladder repair and any associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $1,176.40 **Benefit:** 75% = $882.30
36532	NEPHRO-URETERECTOMY, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $1,688.45 **Benefit:** 75% = $1266.35
36533	NEPHRO-URETERECTOMY, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures, complicated by previous open or laparoscopic surgery on the same kidney or ureter (Anaes.) (Assist.) **Fee:** $1,995.60 **Benefit:** 75% = $1496.70
36537	KIDNEY OR PERINEPHRIC AREA, EXPLORATION OF, with or without drainage of, by open exposure, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $702.45 **Benefit:** 75% = $526.85
36540	NEPHROLITHOTOMY OR PYELOLITHOTOMY, or both, through the same skin incision, for 1 or 2 stones (Anaes.) (Assist.) **Fee:** $1,125.70 **Benefit:** 75% = $844.30 85% = $1041.00
36543	NEPHROLITHOTOMY OR PYELOLITHOTOMY, or both, extended, for staghorn stone or 3 or more stones, including 1 or more of the following: nephrostomy, pyelostomy, pedicle control with or without

	freezing, calyorrhaphy or pyeloplasty (Anaes.) (Assist.) **Fee:** $1,311.75 **Benefit:** 75% = $983.85 85% = $1227.05
36546	EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY (ESWL) to urinary tract and posttreatment care for 3 days, including pretreatment consultation, unilateral (Anaes.) **Fee:** $702.45 **Benefit:** 75% = $526.85 85% = $617.75
36549	URETEROLITHOTOMY (Anaes.) (Assist.) **Fee:** $846.45 **Benefit:** 75% = $634.85
36552	NEPHROSTOMY or pyelostomy, open, as an independent procedure (Anaes.) (Assist.) **Fee:** $753.35 **Benefit:** 75% = $565.05
36558	RENAL CYST OR CYSTS, excision or unroofing of (Anaes.) (Assist.) **Fee:** $660.20 **Benefit:** 75% = $495.15 85% = $575.50
36561	RENAL BIOPSY (closed) (Anaes.) **Fee:** $175.25 **Benefit:** 75% = $131.45 85% = $149.00
36564	PYELOPLASTY, (plastic reconstruction of the pelvi-ureteric junction) by open exposure, laparoscopy or laparoscopic assisted techniques (Anaes.) (Assist.) **Fee:** $939.50 **Benefit:** 75% = $704.65
36567	PYELOPLASTY in a kidney that is congenitally abnormal in addition to the presence of PUJ obstruction, or in a solitary kidney, by open exposure (Anaes.) (Assist.) **Fee:** $1,032.55 **Benefit:** 75% = $774.45
36570	PYELOPLASTY, complicated by previous surgery on the same kidney, by open exposure (Anaes.) (Assist.) **Fee:** $1,311.75 **Benefit:** 75% = $983.85
36573	DIVIDED URETER, repair of (Anaes.) (Assist.) **Fee:** $939.50 **Benefit:** 75% = $704.65
36576	KIDNEY, exposure and exploration of, including repair or nephrectomy, for trauma, not being a service associated with any other procedure performed on the kidney, renal pelvis or renal pedicle (Anaes.) (Assist.) **Fee:** $1,176.40 **Benefit:** 75% = $882.30
36579	URETERECTOMY, COMPLETE OR PARTIAL, with or without associated bladder repair, not being a service associated with a service to which item 37000 applies (Anaes.) (Assist.) **Fee:** $753.35 **Benefit:** 75% = $565.05
36585	URETER, transplantation of, into skin (Anaes.) (Assist.) **Fee:** $753.35 **Benefit:** 75% = $565.05
36588	URETER, reimplantation into bladder (Anaes.) (Assist.) **Fee:** $939.50 **Benefit:** 75% = $704.65

36591	URETER, reimplantation into bladder with psoas hitch or Boari flap or both (Anaes.) (Assist.) **Fee:** $1,125.70 **Benefit:** 75% = $844.30
36594	URETER, transplantation of, into intestine (Anaes.) (Assist.) **Fee:** $939.50 **Benefit:** 75% = $704.65
36597	URETER, transplantation of, into another ureter (Anaes.) (Assist.) **Fee:** $939.50 **Benefit:** 75% = $704.65
36600	URETER, transplantation of, into isolated intestinal segment, unilateral (Anaes.) (Assist.) **Fee:** $1,125.70 **Benefit:** 75% = $844.30 85% = $1041.00
36603	URETERS, transplantation of, into isolated intestinal segment, bilateral (Anaes.) (Assist.) **Fee:** $1,311.75 **Benefit:** 75% = $983.85
36604	URETERIC STENT, passage of through percutaneous nephrostomy tube, using interventional imaging techniques (Anaes.) **Fee:** $271.95 **Benefit:** 75% = $204.00 85% = $231.20
36605	URETERIC STENT, insertion of, with removal of calculus from: (a) the pelvicalyceal system; or (b) ureter; or (c) the pelvicalyceal system and ureter; through a nephrostomy tube using interventional imaging techniques (Anaes.) **Fee:** $701.75 **Benefit:** 75% = $526.35
36606	INTESTINAL URINARY RESERVOIR, continent, formation of, including formation of nonreturn valves and implantation of ureters (1 or both) into reservoir (Anaes.) (Assist.) **Fee:** $2,352.85 **Benefit:** 75% = $1764.65
36607	URETERIC STENT insertion of, with baloon dilatation of: (a) the pelvicalyceal system; or (b) ureter; or (c) the pelvicalyceal system and ureter; through a nephrostomy tube using interventional imaging techniques (Anaes.) **Fee:** $701.75 **Benefit:** 75% = $526.35
36608	URETERIC STENT, exchange of, percutaneously through either the ileal conduit or bladder, using interventional imaging techniques, not being a service associated with a service to which items 36811 to 36854 apply (Anaes.) **Fee:** $271.95 **Benefit:** 75% = $204.00
36609	INTESTINAL URINARY CONDUIT OR URETEROSTOMY, revision of (Anaes.) (Assist.)

	Fee: $753.35 **Benefit:** 75% = $565.05
36612	URETER, exploration of, with or without drainage of, as an independent procedure (Anaes.) (Assist.) **Fee:** $660.20 **Benefit:** 75% = $495.15
36615	URETEROLYSIS, with or without repositioning of the ureter, for obstruction of the ureter, evident either radiologically or by proximal ureteric dilatation at operation, secondary to retroperitoneal fibrosis, or similar condition (Anaes.) (Assist.) **Fee:** $753.35 **Benefit:** 75% = $565.05
36618	REDUCTION URETEROPLASTY (Anaes.) (Assist.) **Fee:** $660.20 **Benefit:** 75% = $495.15
36621	CLOSURE OF CUTANEOUS URETEROSTOMY (Anaes.) (Assist.) **Fee:** $471.95 **Benefit:** 75% = $354.00
36624	NEPHROSTOMY, percutaneous, using interventional imaging techniques (Anaes.) (Assist.) **Fee:** $567.05 **Benefit:** 75% = $425.30 85% = $482.35
36627	NEPHROSCOPY, percutaneous, with or without any 1 or more of; stone extraction, biopsy or diathermy, not being a service to which item 36639, 36642, 36645 or 36648 applies (Anaes.) **Fee:** $702.45 **Benefit:** 75% = $526.85
36630	NEPHROSCOPY, BEING A SERVICE TO WHICH ITEM 36627 APPLIES, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION DUE TO BLEEDING (Anaes.) (Assist.) **Fee:** $346.95 **Benefit:** 75% = $260.25
36633	NEPHROSCOPY, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, not being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (Anaes.) (Assist.) **Fee:** $753.35 **Benefit:** 75% = $565.05 85% = $668.65
36636	NEPHROSCOPY, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (Anaes.) (Assist.) **Fee:** $406.30 **Benefit:** 75% = $304.75
36639	NEPHROSCOPY, percutaneous, with destruction and extraction of 1 or 2 stones using ultrasound or electrohydraulic shock waves or lasers (not being a service to which item 36645 or 36648 applies) (Anaes.) **Fee:** $846.45 **Benefit:** 75% = $634.85
36642	NEPHROSCOPY, BEING A SERVICE TO WHICH ITEM 36639 APPLIES, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION DUE TO BLEEDING (Anaes.) (Assist.) **Fee:** $423.10 **Benefit:** 75% = $317.35
36645	NEPHROSCOPY, percutaneous, with removal or destruction of a stone greater than 3 cm in any dimension, or for 3 or more stones (Anaes.) (Assist.) **Fee:** $1,083.35 **Benefit:** 75% = $812.55

36648	NEPHROSCOPY, being a service to which item 36645 applies, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION (Anaes.) (Assist.) **Fee:** $964.80 **Benefit:** 75% = $723.60
36649	NEPHROSTOMY DRAINAGE TUBE, exchange of - but not including imaging (Anaes.) (Assist.) **Fee:** $271.95 **Benefit:** 75% = $204.00 85% = $231.20
36650	NEPHROSTOMY TUBE, removal of, if the ureter has been stented with a double J ureteric stent and that stent is left in place, using interventional imaging techniques (Anaes.) **Fee:** $152.10 **Benefit:** 75% = $114.10
36652	PYELOSCOPY, retrograde, of one collecting system, with or without any one or more of, cystoscopy, ureteric meatotomy, ureteric dilatation, not being a service associated with a service to which item 36803, 36812 or 36824 applies (Anaes.) (Assist.) **Fee:** $660.20 **Benefit:** 75% = $495.15
36654	PYELOSCOPY, retrograde, of one collecting system, being a service to which item 36652 applies, plus 1 or more of extraction of stone from the renal pelvis or calyces, or biopsy or diathermy of the renal pelvis or calyces, not being a service associated with a service to which item 36656 applies to a procedure performed in the same collecting system (Anaes.) (Assist.) **Fee:** $846.45 **Benefit:** 75% = $634.85
36656	PYELOSCOPY, retrograde, of one collecting system, being a service to which item 36652 applies, plus extraction of 2 or more stones in the renal pelvis or calyces or destruction of stone with ultrasound, electrohydraulic or kinetic lithotripsy, or laser in the renal pelvis or calyces, with or without extraction of fragments, not being a service associated with a service to which item 36654 applies to a procedure performed in the same collecting system (Anaes.) (Assist.) **Fee:** $1,083.35 **Benefit:** 75% = $812.55
	OPERATIONS ON BLADDER
36504	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with biopsy of bladder, not being a service associated with a service to which item 36505, 36507, 36508, 36812, 36830, 36836, 36840, 36845, 36848, 36854, 37203, 37206, 37215, 37230 or 37233 applies. (Anaes.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $299.55 **Benefit:** 75% = $224.70 85% = $254.65
36505	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, 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.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $235.40 **Benefit:** 75% = $176.55 85% = $200.10

36507	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with resection, diathermy or visual laser destruction of bladder tumour or other lesion of the bladder, not being a service to which item 36840 or 36845 applies. (Anaes.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $394.40 **Benefit:** 75% = $295.80 85% = $335.25
36508	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, 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, not being a service to which item 36845 applies. (Anaes.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $768.50 **Benefit:** 75% = $576.40 85% = $683.80
36663	Both: (a) percutaneous placement of sacral nerve lead or leads using fluoroscopic guidance, or open placement of sacral nerve lead or leads; and (b) intra-operative test stimulation, to manage: (i) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or (ii) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment (Anaes.) **Fee:** $671.55 **Benefit:** 75% = $503.70 85% = $586.85
36664	Both: (a) percutaneous repositioning of sacral nerve lead or leads using fluoroscopic guidance, or open repositioning of sacral nerve lead or leads; and (b) intra-operative test stimulation, to correct displacement or unsatisfactory positioning, if inserted for the management of: (i) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or (ii) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment —other than a service to which item 36663 applies (Anaes.) **Fee:** $603.05 **Benefit:** 75% = $452.30 85% = $518.35
36665	Sacral nerve electrode or electrodes, management and adjustment of the pulse generator by a medical practitioner, to manage detrusor overactivity or non obstructive urinary retention - each day **Fee:** $127.40 **Benefit:** 75% = $95.55 85% = $108.30

36666	Pulse generator, subcutaneous placement of, and placement and connection of extension wire or wires to sacral nerve electrode or electrodes, for the management of: (a) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or (b) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment (Anaes.) **Fee:** $339.35 **Benefit:** 75% = $254.55 85% = $288.45
36667	Sacral nerve lead or leads, removal of, if the lead was inserted to manage: (a) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or (b) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment (Anaes.) **Fee:** $158.80 **Benefit:** 75% = $119.10 85% = $135.00
36668	Pulse generator, removal of, if the pulse generator was inserted to manage: (a) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or (b) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment (Anaes.) **Fee:** $158.80 **Benefit:** 75% = $119.10 85% = $135.00
36671	Percutaneous tibial nerve stimulation, initial treatment protocol, for the treatment of overactive bladder, by a specialist urologist, gynaecologist or urogynaecologist, if: (a) the patient has been diagnosed with idiopathic overactive bladder; and (b) the patient has been refractory to, is contraindicated or otherwise not suitable for conservative treatments (including anti-cholinergic agents); and (c) the patient is contraindicated or otherwise not a suitable candidate for botulinum toxin type A therapy; and (d) the patient is contraindicated or otherwise not a suitable candidate for sacral nerve stimulation; and (e) the patient is willing and able to comply with the treatment protocol; and (f) the initial treatment protocol comprises 12 sessions, delivered over a 3 month period; and (g) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts for 30 minutes. For each patient—applicable only once, unless the patient achieves at least a 50% reduction in

	overactive bladder symptoms from baseline at any time during the 3 month treatment period. Not applicable for a service associated with a service to which item 36672 or 36673 applies **Fee:** $203.20 **Benefit:** 75% = $152.40 85% = $172.75
36672	Percutaneous tibial nerve stimulation, tapering treatment protocol, for the treatment of overactive bladder, including any associated consultation at the time the percutaneous tibial nerve stimulation treatment is administered, if: (a) the patient responded to the percutaneous tibial nerve stimulation initial treatment protocol and has achieved at least a 50% reduction in overactive bladder symptoms from baseline at any time during the treatment period for the initial treatment protocol; and (b) the tapering treatment protocol comprises no more than 5 sessions, delivered over a 3 month period, and the interval between sessions is adjusted with the aim of sustaining therapeutic benefit of the treatment; and (c) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts for 30 minutes. Not applicable for a service associated with a service to which item 36671 or 36673 applies **Fee:** $203.20 **Benefit:** 75% = $152.40 85% = $172.75
36673	Percutaneous tibial nerve stimulation, maintenance treatment protocol, for the treatment of overactive bladder, including any associated consultation at the time the percutaneous tibial nerve stimulation treatment is administered, if: (a) the patient responded to the percutaneous tibial nerve stimulation initial treatment protocol and to the tapering treatment protocol, and has achieved at least a 50% reduction in overactive bladder symptoms from baseline at any time during the treatment period for the initial treatment protocol; and (b) the maintenance treatment protocol comprises no more than 12 sessions, delivered over a 12 month period, and the interval between sessions is adjusted with the aim of sustaining therapeutic benefit of the treatment; and (c) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts for 30 minutes. Not applicable for service associated with a service to which item 36671 or 36672 applies **Fee:** $203.20 **Benefit:** 75% = $152.40 85% = $172.75
36800	BLADDER, catheterisation of, where no other procedure is performed (Anaes.) **Fee:** $28.05 **Benefit:** 75% = $21.05 85% = $23.85
36803	URETEROSCOPY, of one ureter, with or without any one or more of; cystoscopy, ureteric meatotomy or ureteric dilatation, not being a service associated with a service to which item 36652, 36654, 36656, 36806, 36809, 36812, 36824, 36848 or 36857 applies (Anaes.) (Assist.) (See para TN.8.51 of explanatory notes to this Category) **Fee:** $473.80 **Benefit:** 75% = $355.35 85% = $402.75

36806	URETEROSCOPY, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, plus one or more of extraction of stone from the ureter, or biopsy or diathermy of the ureter, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36809, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (Anaes.) (Assist.) **Fee:** $660.20 **Benefit:** 75% = $495.15
36809	URETEROSCOPY, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, PLUS destruction of stone in the ureter with ultrasound, electrohydraulic or kinetic lithotripsy, or laser, with or without extraction of fragments, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36806, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (Anaes.) (Assist.) **Fee:** $846.45 **Benefit:** 75% = $634.85
36811	CYSTOSCOPY with insertion of urethral prosthesis (Anaes.) **Fee:** $328.55 **Benefit:** 75% = $246.45 85% = $279.30
36812	CYSTOSCOPY with urethroscopy with or without urethral dilatation, not being a service associated with any other urological endoscopic procedure on the lower urinary tract except a service to which item 37327 applies (Anaes.) **Fee:** $169.35 **Benefit:** 75% = $127.05 85% = $143.95
36815	CYSTOSCOPY, with or without urethroscopy, for the treatment of penile warts or uretheral warts, not being a service associated with a service to which item 30189 applies (Anaes.) (See para TN.8.9 of explanatory notes to this Category) **Fee:** $241.70 **Benefit:** 75% = $181.30 85% = $205.45
36818	CYSTOSCOPY with ureteric catheterisation including fluoroscopic imaging of the upper urinary tract, unilateral or bilateral, not being a service associated with a service to which item 36824 or 36830 applies (Anaes.) (Assist.) **Fee:** $281.05 **Benefit:** 75% = $210.80 85% = $238.90
36821	CYSTOSCOPY with 1 or more of; ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or renal pelvis, unilateral, not being a service associated with a service to which item 36824 or 36830 applies (Anaes.) (Assist.) **Fee:** $328.35 **Benefit:** 75% = $246.30 85% = $279.10
36824	CYSTOSCOPY, with ureteric catheterisation, unilateral or bilateral, not being a service associated with a service to which item 36818 or 36821 applies (Anaes.) **Fee:** $216.55 **Benefit:** 75% = $162.45 85% = $184.10
36825	CYSTOSCOPY, with endoscopic incision of pelviureteric junction or ureteric stricture, including removal or replacement of ureteric stent, not being a service associated with a service to which item 36818, 36821, 36824, 36830 or 36833 applies (Anaes.) (Assist.) **Fee:** $590.60 **Benefit:** 75% = $442.95
36827	CYSTOSCOPY, with controlled hydrodilatation of the bladder (Anaes.) **Fee:** $233.55 **Benefit:** 75% = $175.20 85% = $198.55
36830	CYSTOSCOPY, with ureteric meatotomy (Anaes.)

	Fee: $206.50 **Benefit:** 75% = $154.90
36833	CYSTOSCOPY, with removal of ureteric stent or other foreign body (Anaes.) (Assist.) **Fee:** $281.05 **Benefit:** 75% = $210.80 85% = $238.90
36836	CYSTOSCOPY, with biopsy of bladder, not being a service associated with a service to which item 36812, 36830, 36840, 36845, 36848, 36854, 37203, 37206, 37215, 37230 or 37233 applies (Anaes.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $233.55 **Benefit:** 75% = $175.20 85% = $198.55
36840	CYSTOSCOPY, with resection, diathermy or visual laser destruction of bladder tumour or other lesion of the bladder, not being a service to which item 36845 applies (Anaes.) **Fee:** $328.35 **Benefit:** 75% = $246.30 85% = $279.10
36842	CYSTOSCOPY, with lavage of blood clots from bladder including any associated diathermy of prostate or bladder and not being a service associated with a service to which item 36812, 36827 to 36863, 37203 or 37206 apply (Anaes.) (Assist.) **Fee:** $330.40 **Benefit:** 75% = $247.80
36845	CYSTOSCOPY, with diathermy, resection or visual laser destruction of multiple tumours in more than 2 quadrants of the bladder or solitary tumour greater than 2cm in diameter (Anaes.) **Fee:** $702.45 **Benefit:** 75% = $526.85 85% = $617.75
36848	CYSTOSCOPY, with resection of ureterocele (Anaes.) **Fee:** $233.55 **Benefit:** 75% = $175.20
36851	Cystoscopy, with injection into bladder wall, other than a service associated with a service to which item 18375 or 18379 applies (H) (Anaes.) **Fee:** $233.55 **Benefit:** 75% = $175.20
36854	CYSTOSCOPY, with endoscopic incision or resection of external sphincter, bladder neck or both (Anaes.) **Fee:** $473.80 **Benefit:** 75% = $355.35
36857	ENDOSCOPIC MANIPULATION OR EXTRACTION of ureteric calculus (Anaes.) **Fee:** $372.30 **Benefit:** 75% = $279.25
36860	ENDOSCOPIC EXAMINATION of intestinal conduit or reservoir (Anaes.) **Fee:** $169.35 **Benefit:** 75% = $127.05 85% = $143.95
36863	LITHOLAPAXY, with or without cystoscopy (Anaes.) (Assist.) **Fee:** $473.80 **Benefit:** 75% = $355.35
37000	BLADDER, partial excision of (Anaes.) (Assist.) **Fee:** $753.35 **Benefit:** 75% = $565.05
37004	BLADDER, repair of rupture (Anaes.) (Assist.) **Fee:** $660.20 **Benefit:** 75% = $495.15
37008	CYSTOSTOMY OR CYSTOTOMY, suprapubic, not being a service to which item 37011 applies and

	not being a service associated with other open bladder procedure (Anaes.) **Fee:** $423.10 **Benefit:** 75% = $317.35 85% = $359.65
37011	SUPRAPUBIC STAB CYSTOTOMY, not being a service associated with a service to which items 37200 to 37221 apply (Anaes.) **Fee:** $94.85 **Benefit:** 75% = $71.15 85% = $80.65
37014	BLADDER, total excision of (Anaes.) (Assist.) **Fee:** $1,083.35 **Benefit:** 75% = $812.55
37020	BLADDER DIVERTICULUM, excision or obliteration of (Anaes.) (Assist.) **Fee:** $753.35 **Benefit:** 75% = $565.05
37023	VESICAL FISTULA, cutaneous, operation for (Anaes.) **Fee:** $423.10 **Benefit:** 75% = $317.35
37026	CUTANEOUS VESICOSTOMY, establishment of (Anaes.) (Assist.) **Fee:** $423.10 **Benefit:** 75% = $317.35
37029	VESICOVAGINAL FISTULA, closure of, by abdominal approach (Anaes.) (Assist.) **Fee:** $939.50 **Benefit:** 75% = $704.65
37038	VESICOINTESTINAL FISTULA, closure of, excluding bowel resection (Anaes.) (Assist.) **Fee:** $702.80 **Benefit:** 75% = $527.10
37040	Bladder stress incontinence, sling procedure for, using a non-adjustable synthetic male sling system, with or without mesh, other than a service associated with a service to which item 30405, 35599 or 37042 applies (Anaes.) (Assist.) **Fee:** $925.90 **Benefit:** 75% = $694.45
37041	BLADDER ASPIRATION by needle **Fee:** $47.35 **Benefit:** 75% = $35.55 85% = $40.25
37042	BLADDER STRESS INCONTINENCE, sling procedure for, using autologous fascial sling, including harvesting of sling, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.) **Fee:** $925.90 **Benefit:** 75% = $694.45
37043	BLADDER STRESS INCONTINENCE, Stamey or similar type needle colposuspension, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.) **Fee:** $685.30 **Benefit:** 75% = $514.00
37044	BLADDER STRESS INCONTINENCE, suprapubic procedure for, eg Burch colposuspension, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.) **Fee:** $702.80 **Benefit:** 75% = $527.10
37045	CONTINENT CATHETERISATION BLADDER STOMAS (eg. Mitrofanoff), formation of (Anaes.) (Assist.)

	Fee: $1,451.60 **Benefit:** 75% = $1088.70
37047	BLADDER ENLARGEMENT using intestine (Anaes.) (Assist.) **Fee:** $1,692.70 **Benefit:** 75% = $1269.55
37050	BLADDER EXSTROPHY CLOSURE, not involving sphincter reconstruction (Anaes.) (Assist.) **Fee:** $753.35 **Benefit:** 75% = $565.05
37053	BLADDER TRANSECTION AND RE-ANASTOMOSIS TO TRIGONE (Anaes.) (Assist.) **Fee:** $870.40 **Benefit:** 75% = $652.80
	OPERATIONS ON PROSTATE
37200	PROSTATECTOMY, open (Anaes.) (Assist.) **Fee:** $1,032.55 **Benefit:** 75% = $774.45
37201	PROSTATE, transurethral radio-frequency needle ablation of, with or without cystoscopy and with or without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is, prostatectomy using diathermy or cold punch) and including services to which item 36854, 37203, 37206, 37207, 37208, 37245, 37303, 37321 or 37324 applies (Anaes.) (See para TN.8.53 of explanatory notes to this Category) **Fee:** $842.10 **Benefit:** 75% = $631.60
37202	PROSTATE, transurethral radio-frequency needle ablation of, with or without cystoscopy and with or without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is prostatectomy using diathermy or cold punch) and including services to which item 36854, 37245, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203 or 37207 which had to be discontinued for medical reasons (Anaes.) (See para TN.8.53 of explanatory notes to this Category) **Fee:** $422.70 **Benefit:** 75% = $317.05 85% = $359.30
37203	PROSTATECTOMY (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37201, 37202, 37207, 37208, 37245, 37303, 37321 or 37324 applies (Anaes.) **Fee:** $1,058.80 **Benefit:** 75% = $794.10
37206	PROSTATECTOMY (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203, 37207 or 37245 which had to be discontinued for medical reasons (Anaes.) **Fee:** $567.05 **Benefit:** 75% = $425.30
37207	PROSTATE, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which items 36854, 37201, 37202, 37203, 37206, 37245, 37321 or 37324 applies (Anaes.) **Fee:** $880.30 **Benefit:** 75% = $660.25
37208	PROSTATE, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by items 37201, 37203, 37207 or

	37245 which had to be discontinued for medical reasons (Anaes.) **Fee:** $422.70 **Benefit:** 75% = $317.05
37209	PROSTATE, and/or SEMINAL VESICLE/AMPULLA OF VAS, unilateral or bilateral, total excision of, not being a service associated with a service to which item number 37210 or 37211 applies (Anaes.) (Assist.) **Fee:** $1,311.75 **Benefit:** 75% = $983.85
37210	PROSTATECTOMY, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, not being a service associated with a service to which item 35551, 36502 or 37375 applies (Anaes.) (Assist.) **Fee:** $1,618.90 **Benefit:** 75% = $1214.20
37211	PROSTATECTOMY, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, *with pelvic lymphadenectomy*, not being a service associated with a service to which item 35551, 36502 or 37375 applies (Anaes.) (Assist.) **Fee:** $1,966.15 **Benefit:** 75% = $1474.65
37212	PROSTATE, open perineal biopsy or open drainage of abscess (Anaes.) (Assist.) **Fee:** $281.05 **Benefit:** 75% = $210.80
37215	PROSTATE, biopsy of, endoscopic, with or without cystoscopy (Anaes.) (Assist.) **Fee:** $423.10 **Benefit:** 75% = $317.35 85% = $359.65
37217	Prostate, implantation of radio-opaque fiducial markers into the prostate gland or prostate surgical bed (Anaes.) (See para TN.8.54 of explanatory notes to this Category) **Fee:** $140.50 **Benefit:** 75% = $105.40 85% = $119.45
37218	PROSTATE, needle biopsy of, or injection into, excluding for insertion of radiopaque markers (Anaes.) **Fee:** $140.50 **Benefit:** 75% = $105.40 85% = $119.45
37219	PROSTATE, needle biopsy of, using prostatic ultrasound techniques and obtaining 1 or more prostatic specimens, being a service associated with a service to which item 55600 or 55603 applies (Anaes.) (Assist.) **Fee:** $285.35 **Benefit:** 75% = $214.05 85% = $242.55
37220	PROSTATE, radioactive seed implantation of, urological component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate), with a Gleason score of less than or equal to 7 and a prostate specific antigen (PSA) of less than or equal to 10ng/ml at the time of diagnosis. The procedure must be performed by a urologist at an approved site in association with a radiation oncologist, and be associated with a service to which item 55603 applies. (Anaes.) (See para TN.8.55 of explanatory notes to this Category) **Fee:** $1,060.90 **Benefit:** 75% = $795.70
37221	PROSTATIC ABSCESS, endoscopic drainage of (Anaes.) (Assist.) **Fee:** $473.80 **Benefit:** 75% = $355.35
37223	PROSTATIC COIL, insertion of, under ultrasound control (Anaes.)

	Fee: $209.55 **Benefit:** 75% = $157.20
37224	PROSTATE, diathermy or visual laser destruction of lesion of, not being a service associated with a service to which item 37201, 37202, 37203, 37206, 37207, 37208 or 37215 applies (Anaes.) **Fee:** $328.35 **Benefit:** 75% = $246.30 85% = $279.10
37227	PROSTATE, transperineal insertion of catheters into, for high dose rate brachytherapy using ultrasound guidance including any associated cystoscopy. The procedure must be performed at an approved site in association with a radiation oncologist, and be associated with a service to which item 15331 or 15332 applies. (Anaes.) (See para TN.8.56 of explanatory notes to this Category) **Fee:** $574.90 **Benefit:** 75% = $431.20 85% = $490.20
37230	PROSTATE, high-energy transurethral microwave thermotherapy of, with or without cystoscopy and with or without urethroscopy and including services to which item 36854, 37203, 37206, 37207, 37208, 37303, 37321 or 37324 applies (Anaes.) **Fee:** $1,058.80 **Benefit:** 75% = $794.10 85% = $974.10
37233	PROSTATE, high-energy transurethral microwave thermotherapy of, with or without cystoscopy and with or without urethroscopy and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203, 37207, 37230 which had to be discontinued for medical reasons (Anaes.) **Fee:** $567.05 **Benefit:** 75% = $425.30 85% = $482.35
37245	Prostate, endoscopic enucleation of, using high powered Holmium:YAG laser and an end-firing, non-contact fibre, with or without tissue morcellation, cystoscopy or urethroscopy, for the treatment of benign prostatic hyperplasia, and other than a service associated with a service to which item 36854, 37201, 37202, 37203, 37206, 37207, 37208, 37303, 37321, or 37324 applies. (Anaes.) **Fee:** $1,282.35 **Benefit:** 75% = $961.80
	OPERATIONS ON URETHRA, PENIS OR SCROTUM
37300	URETHRAL SOUNDS, passage of, as an independent procedure (Anaes.) **Fee:** $47.35 **Benefit:** 75% = $35.55 85% = $40.25
37303	URETHRAL STRICTURE, dilatation of (Anaes.) **Fee:** $75.25 **Benefit:** 75% = $56.45 85% = $64.00
37306	URETHRA, repair of rupture of distal section (Anaes.) (Assist.) **Fee:** $660.20 **Benefit:** 75% = $495.15
37309	URETHRA, repair of rupture of prostatic or membranous segment (Anaes.) (Assist.) **Fee:** $939.50 **Benefit:** 75% = $704.65
37315	URETHROSCOPY, as an independent procedure (Anaes.) **Fee:** $140.50 **Benefit:** 75% = $105.40 85% = $119.45
37318	URETHROSCOPY with any 1 or more of - biopsy, diathermy, visual laser destruction of stone or removal of foreign body or stone (Anaes.) (Assist.) **Fee:** $281.05 **Benefit:** 75% = $210.80 85% = $238.90
37321	URETHRAL MEATOTOMY, EXTERNAL (Anaes.)

	Fee: $94.85 **Benefit:** 75% = $71.15 85% = $80.65
37324	URETHROTOMY OR URETHROSTOMY, internal or external (Anaes.) **Fee:** $233.55 **Benefit:** 75% = $175.20
37327	URETHROTOMY, optical, for urethral stricture (Anaes.) (Assist.) **Fee:** $328.35 **Benefit:** 75% = $246.30
37330	URETHRECTOMY, partial or complete, for removal of tumour (Anaes.) (Assist.) **Fee:** $660.20 **Benefit:** 75% = $495.15
37333	URETHROVAGINAL FISTULA, closure of (Anaes.) (Assist.) **Fee:** $567.05 **Benefit:** 75% = $425.30
37336	URETHRORECTAL FISTULA, closure of (Anaes.) (Assist.) **Fee:** $753.35 **Benefit:** 75% = $565.05
37338	Urethral synthetic male sling system, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, other than a service associated with a service to which item 37340 or 37341 applies (Anaes.) (Assist.) **Fee:** $925.90 **Benefit:** 75% = $694.45
37339	Periurethral or transurethral injection of materials for the treatment of urinary incontinence, including cystoscopy and urethroscopy, other than a service associated with a service to which item 18375 or 18379 applies (Anaes.) **Fee:** $243.70 **Benefit:** 75% = $182.80 85% = $207.15
37340	URETHRAL SLING, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, vaginal approach, not being a service associated with a service to which item number 37341 applies (Anaes.) (Assist.) **Fee:** $431.80 **Benefit:** 75% = $323.85
37341	URETHRAL SLING, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, suprapubic or combined suprapubic/vaginal approach, not being a service associated with a service to which item number 37340 applies (Anaes.) (Assist.) **Fee:** $925.90 **Benefit:** 75% = $694.45
37342	URETHROPLASTY single stage operation (Anaes.) (Assist.) **Fee:** $846.45 **Benefit:** 75% = $634.85
37343	URETHROPLASTY, single stage operation, transpubic approach via separate incisions above and below the symphysis pubis, excluding laparotomy, symphysectomy and suprapubic cystotomy, with or without re-routing of the urethra around the crura (Anaes.) (Assist.) **Fee:** $1,413.40 **Benefit:** 75% = $1060.05
37345	URETHROPLASTY 2 stage operation first stage (Anaes.) (Assist.) **Fee:** $702.45 **Benefit:** 75% = $526.85
37348	URETHROPLASTY 2 stage operation second stage (Anaes.) (Assist.) **Fee:** $702.45 **Benefit:** 75% = $526.85

37351	URETHROPLASTY, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $281.05 **Benefit:** 75% = $210.80
37354	HYPOSPADIAS, meatotomy and hemicircumcision (Anaes.) (Assist.) **Fee:** $328.35 **Benefit:** 75% = $246.30
37369	URETHRA, excision of prolapse of (Anaes.) **Fee:** $189.60 **Benefit:** 75% = $142.20
37372	URETHRAL DIVERTICULUM, excision of (Anaes.) (Assist.) **Fee:** $473.80 **Benefit:** 75% = $355.35
37375	URETHRAL SPHINCTER, reconstruction by bladder tubularisation technique or similar procedure (Anaes.) (Assist.) **Fee:** $1,176.40 **Benefit:** 75% = $882.30
37381	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, perineal approach (Anaes.) (Assist.) **Fee:** $753.35 **Benefit:** 75% = $565.05
37384	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, abdominal approach (Anaes.) (Assist.) **Fee:** $1,176.40 **Benefit:** 75% = $882.30
37387	ARTIFICIAL URINARY SPHINCTER, insertion of pressure regulating balloon and pump (Anaes.) (Assist.) **Fee:** $328.35 **Benefit:** 75% = $246.30
37390	ARTIFICIAL URINARY SPHINCTER, revision or removal of, with or without replacement (Anaes.) (Assist.) **Fee:** $939.50 **Benefit:** 75% = $704.65
37393	PRIAPISM, decompression by glanular stab cavernosospongiosum shunt or penile aspiration with or without lavage (Anaes.) **Fee:** $233.55 **Benefit:** 75% = $175.20 85% = $198.55
37396	PRIAPISM, shunt operation for, not being a service to which item 37393 applies (Anaes.) (Assist.) **Fee:** $753.35 **Benefit:** 75% = $565.05
37402	PENIS, partial amputation of (Anaes.) (Assist.) **Fee:** $473.80 **Benefit:** 75% = $355.35
37405	PENIS, complete or radical amputation of (Anaes.) (Assist.) **Fee:** $939.50 **Benefit:** 75% = $704.65
37408	PENIS, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.) **Fee:** $473.80 **Benefit:** 75% = $355.35
37411	PENIS, repair of avulsion (Anaes.) (Assist.) **Fee:** $939.50 **Benefit:** 75% = $704.65 85% = $854.80
37415	PENIS, injection of, for the investigation and treatment of impotence - 2 services only in a period of 36

	consecutive months **Fee:** $47.35 **Benefit:** 75% = $35.55 85% = $40.25
37417	PENIS, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting (Anaes.) (Assist.) **Fee:** $567.05 **Benefit:** 75% = $425.30
37418	PENIS, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting, involving mobilization of the urethra (Anaes.) (Assist.) **Fee:** $753.35 **Benefit:** 75% = $565.05 85% = $668.65
37420	PENIS, surgery to inhibit rapid penile drainage causing impotence, by ligation of veins deep to Buck's fascia including 1 or more deep cavernosal veins with or without pharmacological erection test (Anaes.) (Assist.) **Fee:** $372.30 **Benefit:** 75% = $279.25
37423	PENIS, lengthening by translocation of corpora (Anaes.) (Assist.) **Fee:** $939.50 **Benefit:** 75% = $704.65
37426	PENIS, artificial erection device, insertion of, into 1 or both corpora (Anaes.) (Assist.) **Fee:** $990.15 **Benefit:** 75% = $742.65
37429	PENIS, artificial erection device, insertion of pump and pressure regulating reservoir (Anaes.) (Assist.) **Fee:** $328.35 **Benefit:** 75% = $246.30
37432	PENIS, artificial erection device, complete or partial revision or removal of components, with or without replacement (Anaes.) (Assist.) **Fee:** $939.50 **Benefit:** 75% = $704.65
37435	PENIS, frenuloplasty as an independent procedure (Anaes.) **Fee:** $94.85 **Benefit:** 75% = $71.15 85% = $80.65
37438	SCROTUM, partial excision of (Anaes.) (Assist.) **Fee:** $281.05 **Benefit:** 75% = $210.80 85% = $238.90
37444	URETEROLITHOTOMY COMPLICATED BY PREVIOUS SURGERY at the same site of the same ureter (Anaes.) (Assist.) **Fee:** $1,015.65 **Benefit:** 75% = $761.75 85% = $930.95
	OPERATIONS ON TESTES, VASA OR SEMINAL VESICLES
37601	SPERMATOCELE OR EPIDIDYMAL CYST, excision of, 1 or more of, on 1 side (Anaes.) **Fee:** $281.05 **Benefit:** 75% = $210.80 85% = $238.90
37604	EXPLORATION OF SCROTAL CONTENTS, with or without fixation and with or without biopsy, unilateral, not being a service associated with sperm harvesting for IVF (Anaes.) **Fee:** $281.05 **Benefit:** 75% = $210.80 85% = $238.90
37605	Transcutaneous sperm retrieval, unilateral, from either the testis or the epididymis, for the purposes of intracytoplasmic sperm injection, for male factor infertility, excluding a service to which item 13218

	applies. (Anaes.) (See para TN.8.58, TN.1.5 of explanatory notes to this Category) **Fee:** $379.45 **Benefit:** 75% = $284.60 85% = $322.55
37606	Open surgical sperm retrieval, unilateral, including the exploration of scrotal contents, with our without biopsy, for the purposes of intracytoplasmic sperm injection, for male factor infertility, performed in a hospital, excluding a service to which item 13218 or 37604 applies. (Anaes.) (See para TN.1.5, TN.8.59 of explanatory notes to this Category) **Fee:** $563.40 **Benefit:** 75% = $422.55 85% = $478.90
37607	RETROPERITONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a service to which item 36528 applies (Anaes.) (Assist.) **Fee:** $939.50 **Benefit:** 75% = $704.65
37610	RETROPERITONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a service to which item 36528 applies, following previous similar retroperitoneal dissection, retroperitoneal irradiation or chemotherapy (Anaes.) (Assist.) **Fee:** $1,413.40 **Benefit:** 75% = $1060.05
37613	EPIDIDYMECTOMY (Anaes.) **Fee:** $281.05 **Benefit:** 75% = $210.80 85% = $238.90
37616	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, using operating microscope, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.) **Fee:** $702.45 **Benefit:** 75% = $526.85
37619	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.) **Fee:** $281.05 **Benefit:** 75% = $210.80 85% = $238.90 **Extended Medicare Safety Net Cap:** $224.85
37623	VASOTOMY OR VASECTOMY, unilateral or bilateral NOTE: *Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim.* (Anaes.) (See para TN.8.46 of explanatory notes to this Category) **Fee:** $233.55 **Benefit:** 75% = $175.20 85% = $198.55
	PAEDIATRIC GENITURINARY SURGERY
37800	PATENT URACHUS, excision of, on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $529.60 **Benefit:** 75% = $397.20
37801	PATENT URACHUS, excision of, when performed on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $688.50 **Benefit:** 75% = $516.40
37803	UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37806 applies, on a person 10 years of age or over. (Anaes.) (Assist.)

	Fee: $529.60 **Benefit:** 75% = $397.20
37804	UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37807 applies, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $688.50 **Benefit:** 75% = $516.40
37806	UNDESCENDED TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $611.90 **Benefit:** 75% = $458.95 85% = $527.20
37807	UNDESCENDED TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $795.50 **Benefit:** 75% = $596.65 85% = $710.80
37809	UNDESCENDED TESTIS, revision orchidopexy for, on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $611.90 **Benefit:** 75% = $458.95
37810	UNDESCENDED TESTIS, revision orchidopexy for, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $795.50 **Benefit:** 75% = $596.65
37812	IMPALPABLE TESTIS, exploration of groin for, not being a service associated with a service to which items 37803, 37806 and 37809 applies, on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $564.90 **Benefit:** 75% = $423.70
37813	IMPALPABLE TESTIS, exploration of groin for, not being a service associated with a service to which items 37804, 37807 and 37810 applies, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $734.35 **Benefit:** 75% = $550.80
37815	HYPOSPADIAS, examination under anaesthesia with erection test on a person 10 years of age or over. (Anaes.) **Fee:** $94.25 **Benefit:** 75% = $70.70
37816	HYPOSPADIAS, examination under anaesthesia with erection test, on a person under 10 years of age (Anaes.) **Fee:** $122.55 **Benefit:** 75% = $91.95
37818	HYPOSPADIAS, glanuloplasty incorporating meatal advancement, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $499.30 **Benefit:** 75% = $374.50 85% = $424.45
37819	HYPOSPADIAS, glanuloplasty incorporating meatal advancement, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $649.10 **Benefit:** 75% = $486.85 85% = $564.40
37821	HYPOSPADIAS, distal, 1 stage repair, on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $846.45 **Benefit:** 75% = $634.85
37822	HYPOSPADIAS, distal, 1 stage repair, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $1,100.40 **Benefit:** 75% = $825.30

37824	HYPOSPADIAS, proximal, 1 stage repair on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $1,176.85 **Benefit:** 75% = $882.65
37825	HYPOSPADIAS, proximal, 1 stage repair, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $1,529.90 **Benefit:** 75% = $1147.45
37827	HYPOSPADIAS, staged repair, first stage, on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $542.15 **Benefit:** 75% = $406.65
37828	HYPOSPADIAS, staged repair, first stage, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $704.80 **Benefit:** 75% = $528.60
37830	HYPOSPADIAS, staged repair, second stage, on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $702.45 **Benefit:** 75% = $526.85 85% = $617.75
37831	HYPOSPADIAS, staged repair, second stage, on a person under 10 years of age. (Anaes.) (Assist.) **Fee:** $913.30 **Benefit:** 75% = $685.00 85% = $828.60
37833	HYPOSPADIAS, repair of post-operative urethral fistula, on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $335.25 **Benefit:** 75% = $251.45
37834	HYPOSPADIAS, repair of post-operative urethral fistula, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $435.80 **Benefit:** 75% = $326.85
37836	EPISPADIAS, staged repair, first stage (Anaes.) (Assist.) **Fee:** $706.10 **Benefit:** 75% = $529.60
37839	EPISPADIAS, staged repair, second stage (Anaes.) (Assist.) **Fee:** $800.20 **Benefit:** 75% = $600.15
37842	EXSTROPHY OF BLADDER OR EPISPADIAS, secondary repair with bladder neck tightening, with or without ureteric reimplantation (Anaes.) (Assist.) **Fee:** $1,553.55 **Benefit:** 75% = $1165.20
37845	AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty, with or without endoscopy (Anaes.) (Assist.) **Fee:** $706.10 **Benefit:** 75% = $529.60
37848	AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty with endoscopy and vaginoplasty (Anaes.) (Assist.) **Fee:** $1,271.05 **Benefit:** 75% = $953.30
37851	CONGENITAL ADRENAL HYPERPLASIA, mixed gonadal dysgenesis or similar condition, vaginoplasty for, with or without endoscopy (Anaes.) (Assist.) **Fee:** $941.65 **Benefit:** 75% = $706.25
37854	URETHRAL VALVE, destruction of, including cystoscopy and urethroscopy (Anaes.) (Assist.)

T8. SURGICAL OPERATIONS	5. UROLOGICAL
	Fee: $372.30 **Benefit:** 75% = $279.25

T8. SURGICAL OPERATIONS	6. CARDIO-THORACIC
	Group T8. Surgical Operations
	Subgroup 6. Cardio-Thoracic
	CARDIOLOGY PROCEDURES
38200	RIGHT HEART CATHETERISATION, with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurement by any method, shunt detection or exercise stress test (Anaes.) **Fee:** $452.55 **Benefit:** 75% = $339.45 85% = $384.70
38203	LEFT HEART CATHETERISATION by percutaneous arterial puncture, arteriotomy or percutaneous left ventricular puncture with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection or exercise stress test (Anaes.) **Fee:** $540.05 **Benefit:** 75% = $405.05 85% = $459.05
38206	RIGHT HEART CATHETERISATION WITH LEFT HEART CATHETERISATION via the right heart or by any other procedure with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection or exercise stress test (Anaes.) **Fee:** $652.95 **Benefit:** 75% = $489.75 85% = $568.25
38209	CARDIAC ELECTROPHYSIOLOGICAL STUDY up to and including 3 catheter investigation of any 1 or more of syncope, atrioventricular conduction, sinus node function or simple ventricular tachycardia studies, not being a service associated with a service to which item 38212 or 38213 applies (Anaes.) (See para TN.8.60 of explanatory notes to this Category) **Fee:** $838.35 **Benefit:** 75% = $628.80 85% = $753.65
38212	CARDIAC ELECTROPHYSIOLOGICAL STUDY 4 or more catheter supraventricular tachycardia investigation; or complex tachycardia inductions, or multiple catheter mapping, or acute intravenous antiarrhythmic drug testing with pre and post drug inductions; or catheter ablation to intentionally induce complete AV block; or intraoperative mapping; or electrophysiological services during defibrillator implantation not being a service associated with a service to which item 38209 or 38213 applies (Anaes.) (See para TN.8.60 of explanatory notes to this Category) **Fee:** $1,394.40 **Benefit:** 75% = $1045.80 85% = $1309.70
38213	CARDIAC ELECTROPHYSIOLOGICAL STUDY, for follow-up testing of implanted defibrillator - not being a service associated with a service to which item 38209 or 38212 applies (Anaes.) **Fee:** $415.25 **Benefit:** 75% = $311.45 85% = $353.00
38215	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries, not being a service associated with a service to which item 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $360.60 **Benefit:** 75% = $270.45 85% = $306.55
38218	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography, not being a service associated with a service to which item 38215, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246

	applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $540.75 **Benefit:** 75% = $405.60 85% = $459.65
38220	SELECTIVE CORONARY GRAFT ANGIOGRAPHY placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25
38222	SELECTIVE CORONARY GRAFT ANGIOGRAPHY, placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $360.60 **Benefit:** 75% = $270.45 85% = $306.55
38225	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $540.85 **Benefit:** 75% = $405.65 85% = $459.75
38228	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $721.25 **Benefit:** 75% = $540.95 85% = $636.55
38231	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into the free coronary graft(s) attached to the aorta (irrespective of the number of grafts), and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $901.45 **Benefit:** 75% = $676.10 85% = $816.75
38234	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38237, 38240 or 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $721.10 **Benefit:** 75% = $540.85 85% = $636.40
38237	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection

	of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38240 or 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $901.40 **Benefit:** 75% = $676.05 85% = $816.70
38240	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts) and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237 or 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $1,081.65 **Benefit:** 75% = $811.25 85% = $996.95
38241	USE OF A CORONARY PRESSURE WIRE during selective coronary angiography to measure fractional flow reserve (FFR) and coronary flow reserve (CFR) in one or more intermediate coronary artery or graft lesions (stenosis of 30-70%), to determine whether revascularisation should be performed where previous stress testing has either not been performed or the results are inconclusive (Anaes.) **Fee:** $477.20 **Benefit:** 75% = $357.90 85% = $405.65
38243	PLACEMENT OF CATHETER(S) and injection of opaque material into any coronary vessel(s) or graft(s) prior to any coronary interventional procedure, not being a service associated with a service to which item 38246 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $450.70 **Benefit:** 75% = $338.05 85% = $383.10
38246	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography followed by placement of catheters prior to any coronary interventional procedure, not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38243 applies (Anaes.) (See para TN.8.52 of explanatory notes to this Category) **Fee:** $901.40 **Benefit:** 75% = $676.05 85% = $816.70
38256	TEMPORARY TRANSVENOUS PACEMAKING ELECTRODE, insertion of (Anaes.) **Fee:** $271.55 **Benefit:** 75% = $203.70 85% = $230.85
38270	BALLOON VALVULOPLASTY OR ISOLATED ATRIAL SEPTOSTOMY, including cardiac catheterisations before and after balloon dilatation (Anaes.) (Assist.) **Fee:** $926.90 **Benefit:** 75% = $695.20 85% = $842.20
38272	ATRIAL SEPTAL DEFECT closure, with septal occluder or other similar device, by transcatheter approach (Anaes.) (Assist.) **Fee:** $926.90 **Benefit:** 75% = $695.20 85% = $842.20
38273	Patent ductus arteriosus, transcatheter closure of, including cardiac catheterisation and any imaging associated with the service (Anaes.) (Assist.) **Fee:** $926.90 **Benefit:** 75% = $695.20
38274	Ventricular septal defect, transcatheter closure of, with imaging and cardiac catheterisation (Anaes.)

	(Assist.) **Fee:** $926.90 **Benefit:** 75% = $695.20
38275	MYOCARDIAL BIOPSY, by cardiac catheterisation (Anaes.) **Fee:** $302.95 **Benefit:** 75% = $227.25 85% = $257.55
38276	Transcatheter occlusion of left atrial appendage, and cardiac catheterisation performed by the same practitioner, for stroke prevention in a patient who has non-valvular atrial fibrillation and a contraindication to life-long oral anticoagulation therapy, and is at increased risk of thromboembolism demonstrated by: (a) a prior stroke (whether of an ischaemic or unknown type), transient ischaemic attack or non-central nervous system systemic embolism; or (b) at least 2 of the following risk factors: (i) an age of 65 years or more; (ii) hypertension; (iii) diabetes mellitus; (iv) heart failure or left ventricular ejection fraction of 35% or less (or both); (v) vascular disease (prior myocardial infarction, peripheral artery disease or aortic plaque) (Anaes.) (Assist.) (See para TN.8.132 of explanatory notes to this Category) **Fee:** $926.90 **Benefit:** 75% = $695.20
38285	IMPLANTABLE ECG LOOP RECORDER, insertion of, for diagnosis of primary disorder in patients with recurrent unexplained syncope where: - a diagnosis has not been achieved through all other available cardiac investigations; and - a neurogenic cause is not suspected; and - it has been determined that the patient does not have structural heart disease associated with a high risk of sudden cardiac death. including initial programming and testing, as an admitted patient in an approved hospital (Anaes.) (See para TN.8.61 of explanatory notes to this Category) **Fee:** $196.00 **Benefit:** 75% = $147.00 85% = $166.60
38286	IMPLANTABLE ECG LOOP RECORDER, removal of, as an admitted patient in an approved hospital (Anaes.) **Fee:** $176.55 **Benefit:** 75% = $132.45 85% = $150.10
38288	Implantable loop recorder, insertion of, for diagnosis of atrial fibrillation, if: (a) the patient to whom the service is provided has been diagnosed as having had an embolic stroke of undetermined source; and

	(b) the bases of the diagnosis included the following: (i) the medical history of the patient; (ii) physical examination; (iii) brain and carotid imaging; (iv) cardiac imaging; (v) surface ECG testing including 24-hour Holter monitoring; and (c) atrial fibrillation is suspected; and (d) the patient: (i) does not have a permanent indication for oral anticoagulants; or (ii) does not have a permanent oral anticoagulants contraindication; including initial programming and testing (Anaes.) **Fee:** $196.00 **Benefit:** 75% = $147.00 85% = $166.60
	CATHETER BASED ARRHYTHMIA ABLATION
38287	ABLATION OF ARRHYTHMIA CIRCUIT OR FOCUS or isolation procedure involving 1 atrial chamber (Anaes.) (Assist.) **Fee:** $2,132.05 **Benefit:** 75% = $1599.05 85% = $2047.35
38290	ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Anaes.) (Assist.) **Fee:** $2,714.70 **Benefit:** 75% = $2036.05
38293	VENTRICULAR ARRHYTHMIA with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes.) (Assist.) **Fee:** $2,913.95 **Benefit:** 75% = $2185.50 85% = $2829.25
	ENDOVASCULAR INTERVENTIONAL PROCEDURES
38300	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $523.60 **Benefit:** 75% = $392.70 85% = $445.10
38303	TRANSLUMINAL BALLOON ANGIOPLASTY of more than 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation and excluding aftercare (Anaes.) (Assist.) **Fee:** $671.35 **Benefit:** 75% = $503.55 85% = $586.65
38306	Transluminal insertion of stent or stents into one occlusional site, including associated balloon dilatation of coronary artery, percutaneous or by open exposure, excluding associated radiological services,

	radiological preparation and after-care (Anaes.) (Assist.) (See para TN.8.62 of explanatory notes to this Category) **Fee:** $774.55 **Benefit:** 75% = $580.95 85% = $689.85
38309	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of 1 coronary artery, including balloon angioplasty with no stent insertion, where: - no lesion of the coronary artery has been stented; and - each lesion of the coronary artery is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) **Fee:** $899.60 **Benefit:** 75% = $674.70 85% = $814.90
38312	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of 1 coronary artery, including balloon angioplasty with insertion of 1 or more stents, where: - no lesion of the coronary artery has been stented; and - each lesion of the coronary artery is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) **Fee:** $1,150.45 **Benefit:** 75% = $862.85 85% = $1065.75
38315	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty with no stent insertion, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) **Fee:** $1,235.30 **Benefit:** 75% = $926.50 85% = $1150.60
38318	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty, with insertion of 1 or more stents, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category)

	Fee: $1,611.75 **Benefit:** 75% = $1208.85 85% = $1527.05
	MISCELLANEOUS CARDIAC PROCEDURES
38350	SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) **Fee:** $648.85 **Benefit:** 75% = $486.65
38353	PERMANENT CARDIAC PACEMAKER, insertion, removal or replacement of, not for cardiac resynchronisation therapy, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) **Fee:** $259.55 **Benefit:** 75% = $194.70
38356	DUAL CHAMBER PERMANENT TRANSVENOUS ELECTRODES, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) **Fee:** $850.75 **Benefit:** 75% = $638.10
38358	Extraction of chronically implanted transvenous pacing or defibrillator lead or leads, by percutaneous method where the leads have been in situ for greater than six months and require removal with locking stylets, snares and/or extraction sheaths in a facility where cardiac surgery is available, in association with item 61109 or 60509 (Anaes.) (Assist.) (See para TN.8.64 of explanatory notes to this Category) **Fee:** $2,913.95 **Benefit:** 75% = $2185.50
38359	PERICARDIUM, paracentesis of (excluding aftercare) (Anaes.) **Fee:** $135.70 **Benefit:** 75% = $101.80 85% = $115.35
38362	INTRA-AORTIC BALLOON PUMP, percutaneous insertion of (Anaes.) **Fee:** $391.10 **Benefit:** 75% = $293.35 85% = $332.45
38365	Permanent cardiac synchronisation device (including a cardiac synchronisation device that is capable of defibrillation), insertion, removal or replacement of, for a patient who: (a) has: (i) moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 120 ms; or (b) satisfied the requirements mentioned in paragraph (a) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode (Anaes.) (See para TN.8.63 of explanatory notes to this Category) **Fee:** $259.55 **Benefit:** 75% = $194.70
38368	Permanent transvenous left ventricular electrode, insertion, removal or replacement of through the

	coronary sinus, for the purpose of cardiac resynchronisation therapy, including right heart catheterisation and any associated venogram of left ventricular veins, other than a service associated with a service to which item 35200 or 38200 applies, for a patient who: (a) has: (i) moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 120 ms; or (b) has: (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 150 ms; or (c) satisfied the requirements mentioned in paragraph (a) or (b) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode (Anaes.) (See para TN.8.63 of explanatory notes to this Category) **Fee:** $1,244.20 **Benefit:** 75% = $933.15
	Permanent cardiac synchronisation device capable of defibrillation, insertion, removal or replacement of, for a patient who: (a) has: (i) moderate to severe chronic heart failure (New York Heart Association ((NYHA) class III or IV) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 120 ms; or (b) has: (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 150 ms (Anaes.)
38371	(See para TN.8.65 of explanatory notes to this Category)

	Fee: $292.45 **Benefit:** 75% = $219.35
38384	AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for, primary prevention of sudden cardiac death in: - patients with a left ventricular ejection fraction of less than or equal to 30% at least one month after a myocardial infarct when the patient has received optimised medical therapy; or - patients with chronic heart failure associated with mild to moderate symptoms (NYHA II and III) and a left ventricular ejection fraction less than or equal to 35% when the patient has received optimised medical therapy. Not being a service associated with a service to which item 38213 applies (Anaes.) (Assist.) **Fee:** $1,069.50 **Benefit:** 75% = $802.15 85% = $984.80
38387	AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of for, primary prevention of sudden cardiac death in: - patients with a left ventricular ejection fraction of less than or equal to 30% at least one month after a myocardial infarct when the patient has received optimised medical therapy; or - patients with chronic heart failure associated with mild to moderate symptoms (NYHA II and III) and a left ventricular ejection fraction less than or equal to 35% when the patient has received optimised medical therapy. Not being a service associated with a service to which item 38213 applies, not for defibrillators capable of cardiac resynchronisation therapy (Anaes.) (Assist.) **Fee:** $292.45 **Benefit:** 75% = $219.35 85% = $248.60
38390	AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for - not for patients with heart failure or as primary prevention for tachycardia arrhythmias. Not being a service associated with a service to which item 38213 applies (Anaes.) (Assist.) **Fee:** $1,069.50 **Benefit:** 75% = $802.15 85% = $984.80
38393	AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of for - not for patients with heart failure or as primary prevention for tachycardia arrhythmias. Not being a service associated with a service to which item 38213 applies. (Anaes.) (Assist.) **Fee:** $292.45 **Benefit:** 75% = $219.35 85% = $248.60
	THORACIC SURGERY

38415	EMPYEMA, radical operation for, involving resection of rib (Anaes.) (Assist.) **Fee:** $405.75 **Benefit:** 75% = $304.35 85% = $344.90
38418	THORACOTOMY, exploratory, with or without biopsy (Anaes.) (Assist.) **Fee:** $973.75 **Benefit:** 75% = $730.35
38421	THORACOTOMY, with pulmonary decortication (Anaes.) (Assist.) **Fee:** $1,556.50 **Benefit:** 75% = $1167.40
38424	THORACOTOMY, with pleurectomy or pleurodesis, OR ENUCLEATION OF HYDATID cysts (Anaes.) (Assist.) **Fee:** $973.75 **Benefit:** 75% = $730.35
38427	THORACOPLASTY (complete) - 3 or more ribs (Anaes.) (Assist.) **Fee:** $1,202.35 **Benefit:** 75% = $901.80
38430	THORACOPLASTY (in stages) each stage (Anaes.) (Assist.) **Fee:** $619.65 **Benefit:** 75% = $464.75
38436	THORACOSCOPY, with or without division of pleural adhesions, including insertion of intercostal catheter where necessary, with or without biopsy (Anaes.) **Fee:** $253.75 **Benefit:** 75% = $190.35
38438	PNEUMONECTOMY or LOBECTOMY or SEGMENTECTOMY not being a service associated with a service to which Item 38418 applies (Anaes.) (Assist.) **Fee:** $1,556.50 **Benefit:** 75% = $1167.40
38440	LUNG, wedge resection of (Anaes.) (Assist.) **Fee:** $1,165.55 **Benefit:** 75% = $874.20
38441	RADICAL LOBECTOMY or PNEUMONECTOMY including resection of chest wall, diaphragm, pericardium, or formal mediastinal node dissection (Anaes.) (Assist.) **Fee:** $1,844.25 **Benefit:** 75% = $1383.20
38446	THORACOTOMY or STERNOTOMY, for removal of thymus or mediastinal tumour (Anaes.) (Assist.) **Fee:** $1,202.35 **Benefit:** 75% = $901.80
38447	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $1,556.50 **Benefit:** 75% = $1167.40
38448	MEDIASTINUM, cervical exploration of, with or without biopsy (Anaes.) (Assist.) **Fee:** $368.85 **Benefit:** 75% = $276.65
38449	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $2,177.50 **Benefit:** 75% = $1633.15
38450	PERICARDIUM, transthoracic open surgical drainage of (Anaes.) (Assist.)

	Fee: $870.35 **Benefit:** 75% = $652.80
38452	PERICARDIUM, subxiphoid open surgical drainage of (Anaes.) (Assist.) **Fee:** $582.90 **Benefit:** 75% = $437.20
38453	TRACHEAL excision and repair without cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $1,748.45 **Benefit:** 75% = $1311.35
38455	TRACHEAL EXCISION AND REPAIR OF, with cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $2,364.95 **Benefit:** 75% = $1773.75
38456	INTRATHORACIC OPERATION on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than 1 of those organs, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $1,556.50 **Benefit:** 75% = $1167.40
38457	PECTUS EXCAVATUM or PECTUS CARINATUM, repair or radical correction of (Anaes.) (Assist.) **Fee:** $1,453.15 **Benefit:** 75% = $1089.90
38458	PECTUS EXCAVATUM, repair of, with implantation of subcutaneous prosthesis (Anaes.) (Assist.) **Fee:** $774.55 **Benefit:** 75% = $580.95
38460	STERNAL WIRE OR WIRES, removal of (Anaes.) **Fee:** $279.80 **Benefit:** 75% = $209.85
38462	STERNOTOMY WOUND, debridement of, not involving reopening of the mediastinum (Anaes.) **Fee:** $331.65 **Benefit:** 75% = $248.75
38464	STERNOTOMY WOUND, debridement of, involving curettage of infected bone with or without removal of wires but not involving reopening of the mediastinum (Anaes.) **Fee:** $360.50 **Benefit:** 75% = $270.40
38466	STERNUM, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring (Anaes.) (Assist.) **Fee:** $973.35 **Benefit:** 75% = $730.05
38468	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps or greater omentum (Anaes.) (Assist.) **Fee:** $1,499.75 **Benefit:** 75% = $1124.85
38469	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps and greater omentum (Anaes.) (Assist.) **Fee:** $1,748.45 **Benefit:** 75% = $1311.35
	CARDIAC SURGERY PROCEDURES
38470	PERMANENT MYOCARDIAL ELECTRODE, insertion of, by thoracotomy or sternotomy (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $973.75 **Benefit:** 75% = $730.35

38473	PERMANENT PACEMAKER ELECTRODE, insertion by open surgical approach (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $582.90 **Benefit:** 75% = $437.20
	VALVULAR PROCEDURES
38475	VALVE ANNULOPLASTY without insertion of ring, not being a service associated with a service to which item 38480 or 38481 applies (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $845.05 **Benefit:** 75% = $633.80
38477	VALVE ANNULOPLASTY with insertion of ring not being a service to which item 38478 applies (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,035.40 **Benefit:** 75% = $1526.55
38478	VALVE ANNULOPLASTY with insertion of ring performed in conjunction with item 38480 or 38481 (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $985.95 **Benefit:** 75% = $739.50
38480	VALVE REPAIR, 1 leaflet (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,035.40 **Benefit:** 75% = $1526.55
38481	VALVE REPAIR, 2 or more leaflets (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,317.15 **Benefit:** 75% = $1737.90
38483	AORTIC VALVE LEAFLET OR LEAFLETS, decalcification of, not being a service to which item 38475, 38477, 38480, 38481, 38488 or 38489 applies (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,748.45 **Benefit:** 75% = $1311.35
38485	MITRAL ANNULUS, reconstruction of, after decalcification, when performed in association with valve surgery (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $830.15 **Benefit:** 75% = $622.65
38487	MITRAL VALVE, open valvotomy of (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,748.45 **Benefit:** 75% = $1311.35
38488	VALVE REPLACEMENT with BIOPROSTHESIS OR MECHANICAL PROSTHESIS (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,940.15 **Benefit:** 75% = $1455.15
38489	VALVE REPLACEMENT with allograft (subcoronary or cylindrical implant), or unstented xenograft (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,307.40 **Benefit:** 75% = $1730.55

38490	SUB-VALVULAR STRUCTURES, reconstruction and re-implantation of, associated with mitral and tricuspid valve replacement (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $563.40 **Benefit:** 75% = $422.55
38493	OPERATIVE MANAGEMENT of acute infective endocarditis, in association with heart valve surgery (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,988.90 **Benefit:** 75% = $1491.70
38495	TAVI, for the treatment of symptomatic severe aortic stenosis, performed via transfemoral delivery, unless transfemoral delivery is contraindicated or not feasible, in a TAVI Hospital on a TAVI Patient by a TAVI Practitioner – includes all intraoperative diagnostic imaging that the TAVI Practitioner performs upon the TAVI Patient. (Not payable more than once per patient in a five year period.) (Anaes.) (Assist.) (See para AN.33.1, TN.8.135 of explanatory notes to this Category) **Fee:** $1,455.10 **Benefit:** 75% = $1091.35 85% = $1370.40
	SURGERY FOR ISCHAEMIC HEART DISEASE
38496	ARTERY HARVESTING (other than internal mammary), for coronary artery bypass (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $633.95 **Benefit:** 75% = $475.50
38497	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, not being a service asociated with a service to which items 38498, 38500, 38501, 38503 or 38504 apply (Anaes.) (Assist.) (See para TN.8.68, TN.8.67 of explanatory notes to this Category) **Fee:** $2,080.35 **Benefit:** 75% = $1560.30
38498	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38500, 38501, 38503, 38504 or 38600 apply (Anaes.) (Assist.) (See para TN.8.68, TN.8.67 of explanatory notes to this Category) **Fee:** $2,080.35 **Benefit:** 75% = $1560.30
38500	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38501, 38503 or 38504 apply (Anaes.) (Assist.) (See para TN.8.68, TN.8.67 of explanatory notes to this Category) **Fee:** $2,235.20 **Benefit:** 75% = $1676.40
38501	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38498, 38500, 38503, 38504 or 38600 apply (Anaes.) (Assist.) (See para TN.8.68, TN.8.67 of explanatory notes to this Category) **Fee:** $2,235.20 **Benefit:** 75% = $1676.40

38503	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38500, 38501 or 38504 apply (Anaes.) (Assist.) (See para TN.8.68, TN.8.67 of explanatory notes to this Category) **Fee:** $2,426.90 **Benefit:** 75% = $1820.20
38504	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38498, 38500, 38501, 38503 or 38600 apply (Anaes.) (Assist.) (See para TN.8.68, TN.8.67 of explanatory notes to this Category) **Fee:** $2,426.90 **Benefit:** 75% = $1820.20
38505	CORONARY ENDARTERECTOMY, by open operation, including repair with 1 or more patch grafts, each vessel (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $281.70 **Benefit:** 75% = $211.30
38506	LEFT VENTRICULAR ANEURYSM, plication of (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,652.25 **Benefit:** 75% = $1239.20
38507	LEFT VENTRICULAR ANEURYSM resection with primary repair (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,939.75 **Benefit:** 75% = $1454.85
38508	LEFT VENTRICULAR ANEURYSM resection with patch reconstruction of the left ventricle (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,426.90 **Benefit:** 75% = $1820.20
38509	ISCHAEMIC VENTRICULAR SEPTAL RUPTURE, repair of (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,426.90 **Benefit:** 75% = $1820.20
	ARRHYTHMIA SURGERY
38512	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving 1 atrial chamber only (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,132.05 **Benefit:** 75% = $1599.05
38515	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving both atrial chambers and including curative surgery for atrial fibrillation (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,714.70 **Benefit:** 75% = $2036.05
38518	VENTRICULAR ARRHYTHMIA with mapping and muscle ablation, with or without aneurysmeotomy (Anaes.) (Assist.)

	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,913.95 **Benefit:** 75% = $2185.50
	PROCEDURES ON THORACIC AORTA
38550	ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,180.50 **Benefit:** 75% = $1635.40
38553	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,763.25 **Benefit:** 75% = $2072.45
38556	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $3,154.40 **Benefit:** 75% = $2365.80
38559	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,571.50 **Benefit:** 75% = $1928.65
38562	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $3,154.40 **Benefit:** 75% = $2365.80
38565	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $3,537.95 **Benefit:** 75% = $2653.50
38568	DESCENDING THORACIC AORTA, repair or replacement of, without shunt or cardiopulmonary bypass, by open exposure, percutaneous or endovascular means (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,892.75 **Benefit:** 75% = $1419.60
38571	DESCENDING THORACIC AORTA, repair or replacement of, using shunt or cardiopulmonary bypass (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,084.60 **Benefit:** 75% = $1563.45
38572	OPERATIVE MANAGEMENT OF ACUTE RUPTURE OR DISSECTION, in conjunction with procedures on the thoracic aorta (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,018.85 **Benefit:** 75% = $1514.15
38577	CANNULATION FOR, and supervision and monitoring of, the administration of retrograde cerebral perfusion during deep hypothermic arrest (Assist.) (See para TN.8.67 of explanatory notes to this Category)

	Fee: $563.40 **Benefit:** 75% = $422.55
	TECHNIQUES FOR PRESERVATION OF ARRESTED HEART
38588	CANNULATION of the coronary sinus for, and supervision of, the retrograde administration of blood or crystalloid for cardioplegia, including pressure monitoring (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $422.70 **Benefit:** 75% = $317.05
	CIRCULATORY SUPPORT PROCEDURES
38600	CENTRAL CANNULATION for cardiopulmonary bypass excluding post-operative management, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,556.50 **Benefit:** 75% = $1167.40
38603	PERIPHERAL CANNULATION for cardiopulmonary bypass excluding post-operative management (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $973.75 **Benefit:** 75% = $730.35
38609	INTRA-AORTIC BALLOON PUMP, insertion of, by arteriotomy (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $486.80 **Benefit:** 75% = $365.10
38612	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by direct suture (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $545.70 **Benefit:** 75% = $409.30 85% = $463.85
38613	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by patch graft (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $684.85 **Benefit:** 75% = $513.65
38615	Insertion of a left or right ventricular assist device, for use as: (a) a bridge to cardiac transplantation in patients with refractory heart failure who are: (i) currently on a heart transplant waiting list, or (ii) expected to be suitable candidates for cardiac transplantation following a period of support on the ventricular assist device; or (b) acute post cardiotomy support for failure to wean from cardiopulmonary transplantation; or (c) cardio-respiratory support for acute cardiac failure which is likely to recover with short term support of less than 6 weeks; not being a service associated with the use of a ventricular assist device as destination therapy in the management of patients with heart failure who are not expected to be suitable candidates for cardiac

	transplantation (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,556.50 **Benefit:** 75% = $1167.40
38618	Insertion of a left and right ventricular assist device, for use as: (a) a bridge to cardiac transplantation in patients with refractory heart failure who are: (i) currently on a heart transplant waiting list, or (ii) expected to be suitable candidates for cardiac transplantation following a period of support on the ventricular assist device; or (b) acute post cardiotomy support for failure to wean from cardiopulmonary transplantation; or (c) cardio-respiratory support for acute cardiac failure which is likely to recover with short term support of less than 6 weeks; not being a service associated with the use of a ventricular assist device as destination therapy in the management of patients with heart failure who are not expected to be suitable candidates for cardiac transplantation (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,940.15 **Benefit:** 75% = $1455.15
38621	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $774.55 **Benefit:** 75% = $580.95
38624	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $870.35 **Benefit:** 75% = $652.80
38627	EXTRA-CORPOREAL MEMBRANE OXYGENATION, BYPASS OR VENTRICULAR ASSIST DEVICE CANNULAE, adjustment and re-positioning of, by open operation, in patients supported by these devices (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $680.30 **Benefit:** 75% = $510.25
	RE-OPERATION
38637	PATENT DISEASED coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $563.40 **Benefit:** 75% = $422.55
38640	RE-OPERATION via median sternotomy, for any procedure, including any divisions of adhesions where the time taken to divide the adhesions is 45 minutes or less (Anaes.) (Assist.) (See para TN.8.69, TN.8.67 of explanatory notes to this Category)

	Fee: $973.75 **Benefit:** 75% = $730.35
	MISCELLANEOUS CARDIOTHORACIC SURGICAL PROCEDURES
38643	THORACOTOMY OR STERNOTOMY involving division of adhesions where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,084.50 **Benefit:** 75% = $813.40
38647	THORACOTOMY OR STERNOTOMY involving division of extensive adhesions where the time taken to divide the adhesions exceeds 2 hours (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,168.65 **Benefit:** 75% = $1626.50
38650	MYOMECTOMY or MYOTOMY for hypertrophic obstructive cardiomyopathy (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,940.15 **Benefit:** 75% = $1455.15
38653	OPEN HEART SURGERY, not being a service to which another item in this Group applies (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,940.15 **Benefit:** 75% = $1455.15
38654	Permanent left ventricular electrode, insertion, removal or replacement of via open thoracotomy, for the purpose of cardiac resynchronisation therapy, for a patient who: (a) has: (i) moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 120 ms; or (b) has: (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 150 ms; or (c) satisfied the requirements mentioned in paragraph (a) or (b) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode (Anaes.) (Assist.) (See para TN.8.63, TN.8.67 of explanatory notes to this Category) **Fee:** $1,244.20 **Benefit:** 75% = $933.15

38656	THORACOTOMY or median sternotomy for post-operative bleeding (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $973.75 **Benefit:** 75% = $730.35
	CARDIAC TUMOURS
38670	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, without patch or conduit reconstruction (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,939.75 **Benefit:** 75% = $1454.85
38673	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,183.25 **Benefit:** 75% = $1637.45
38677	CARDIAC TUMOUR arising from ventricular myocardium, partial thickness excision of (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,042.50 **Benefit:** 75% = $1531.90
38680	CARDIAC TUMOUR arising from ventricular myocardium, full thickness excision of including repair or reconstruction (Anaes.) (Assist.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $2,422.70 **Benefit:** 75% = $1817.05 85% = $2338.00
	CONGENITAL CARDIAC SURGERY
38700	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,084.50 **Benefit:** 75% = $813.40
38703	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,954.90 **Benefit:** 75% = $1466.20
38706	AORTA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,851.55 **Benefit:** 75% = $1388.70
38709	AORTA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,168.65 **Benefit:** 75% = $1626.50
38712	AORTIC INTERRUPTION, repair of, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,604.15 **Benefit:** 75% = $1953.15
38715	MAIN PULMONARY ARTERY, banding, debanding or repair of, without cardiopulmonary bypass, for

	congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,733.60 **Benefit:** 75% = $1300.20
38718	MAIN PULMONARY ARTERY, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,168.65 **Benefit:** 75% = $1626.50
38721	VENA CAVA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,519.75 **Benefit:** 75% = $1139.85
38724	VENA CAVA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,168.65 **Benefit:** 75% = $1626.50
38727	INTRATHORACIC VESSELS, anastomosis or repair of, without cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,519.75 **Benefit:** 75% = $1139.85
38730	INTRATHORACIC VESSELS, anastomosis or repair of, with cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Anaes.) (Assist.) **Fee:** $2,168.65 **Benefit:** 75% = $1626.50
38733	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,519.75 **Benefit:** 75% = $1139.85
38736	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,168.65 **Benefit:** 75% = $1626.50
38739	ATRIAL SEPTECTOMY, with or without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,954.90 **Benefit:** 75% = $1466.20
38742	ATRIAL SEPTAL DEFECT, closure by open exposure direct suture or patch, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,954.90 **Benefit:** 75% = $1466.20
38745	INTRA-ATRIAL BAFFLE, insertion of, for congenital heart disease (Anaes.) (Assist.)

	(See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,168.65 **Benefit:** 75% = $1626.50
38748	VENTRICULAR SEPTECTOMY, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,168.65 **Benefit:** 75% = $1626.50
38751	Ventricular septal defect, closure by direct suture or patch (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,168.65 **Benefit:** 75% = $1626.50
38754	INTRAVENTRICULAR BAFFLE OR CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,714.70 **Benefit:** 75% = $2036.05
38757	EXTRACARDIAC CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,168.65 **Benefit:** 75% = $1626.50
38760	EXTRACARDIAC CONDUIT, replacement of, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,168.65 **Benefit:** 75% = $1626.50
38763	VENTRICULAR MYECTOMY, for relief of ventricular obstruction, right or left, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,168.65 **Benefit:** 75% = $1626.50
38766	VENTRICULAR AUGMENTATION, right or left, for congenital heart disease (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,168.65 **Benefit:** 75% = $1626.50
	MISCELLANEOUS PROCEDURES ON THE CHEST
38800	THORACIC CAVITY, aspiration of, for diagnostic purposes, not being a service associated with a service to which item 38803 applies **Fee:** $39.10 **Benefit:** 75% = $29.35 85% = $33.25
38803	THORACIC CAVITY, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample **Fee:** $78.15 **Benefit:** 75% = $58.65 85% = $66.45
38806	INTERCOSTAL DRAIN, insertion of, not involving resection of rib (excluding aftercare) (Anaes.) **Fee:** $135.70 **Benefit:** 75% = $101.80 85% = $115.35
38809	INTERCOSTAL DRAIN, insertion of, with pleurodesis and not involving resection of rib (excluding aftercare) (Anaes.) **Fee:** $167.20 **Benefit:** 75% = $125.40 85% = $142.15
38812	PERCUTANEOUS NEEDLE BIOPSY of lung (Anaes.) **Fee:** $212.50 **Benefit:** 75% = $159.40 85% = $180.65

	Group T8. Surgical Operations
	Subgroup 7. Neurosurgical
	GENERAL
39000	LUMBAR PUNCTURE (Anaes.) **Fee:** $76.50 **Benefit:** 75% = $57.40 85% = $65.05
39003	CISTERNAL PUNCTURE (Anaes.) **Fee:** $87.00 **Benefit:** 75% = $65.25 85% = $73.95
39006	VENTRICULAR PUNCTURE (not including burr-hole) (Anaes.) **Fee:** $161.95 **Benefit:** 75% = $121.50 85% = $137.70
39009	SUBDURAL HAEMORRHAGE, tap for, each tap (Anaes.) **Fee:** $60.30 **Benefit:** 75% = $45.25
39012	BURR-HOLE, single, preparatory to ventricular puncture or for inspection purpose - not being a service to which another item applies (Anaes.) **Fee:** $241.40 **Benefit:** 75% = $181.05
39013	INJECTION UNDER IMAGE INTENSIFICATION with 1 or more of contrast media, local anaesthetic or corticosteroid into 1 or more zygo-apophyseal or costo-transverse joints or 1 or more primary posterior rami of spinal nerves (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $110.90 **Benefit:** 75% = $83.20 85% = $94.30
39015	VENTRICULAR RESERVOIR, EXTERNAL VENTRICULAR DRAIN or INTRACRANIAL PRESSURE MONITORING DEVICE, insertion of - including burr-hole (excluding after-care) (Anaes.) (Assist.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $382.00 **Benefit:** 75% = $286.50
39018	CEREBROSPINAL FLUID reservoir, insertion of (Anaes.) (Assist.) **Fee:** $382.00 **Benefit:** 75% = $286.50
	PAIN RELIEF
39100	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $241.40 **Benefit:** 75% = $181.05 85% = $205.20
39106	NEURECTOMY, INTRACRANIAL, for trigeminal neuralgia (Anaes.) (Assist.) **Fee:** $1,207.20 **Benefit:** 75% = $905.40
39109	TRIGEMINAL GANGLIOTOMY by radiofrequency, balloon or glycerol (Anaes.) **Fee:** $450.80 **Benefit:** 75% = $338.10 85% = $383.20
39112	CRANIAL NERVE, intracranial decompression of, using microsurgical techniques (Anaes.) (Assist.)

	Fee: $1,566.15 **Benefit:** 75% = $1174.65
39115	PERCUTANEOUS NEUROTOMY of posterior divisions (or rami) of spinal nerves by any method, including any associated spinal, epidural or regional nerve block (payable once only in a 30 day period) (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $76.50 **Benefit:** 75% = $57.40 85% = $65.05
39118	PERCUTANEOUS NEUROTOMY for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.) (Assist.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $302.60 **Benefit:** 75% = $226.95 85% = $257.25
39121	PERCUTANEOUS CORDOTOMY (Anaes.) (Assist.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $641.85 **Benefit:** 75% = $481.40 85% = $557.15
39124	CORDOTOMY OR MYELOTOMY, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes.) (Assist.) **Fee:** $1,642.65 **Benefit:** 75% = $1232.00
39125	Intrathecal or epidural SPINAL CATHETER insertion or replacement of, and connection to a subcutaneous implanted infusion pump, for the management of chronic intractable pain (Anaes.) (Assist.) **Fee:** $302.80 **Benefit:** 75% = $227.10
39126	INFUSION PUMP, subcutaneous implantation or replacement of, and connection of the pump to an intrathecal or epidural catheter, and filling of reservoir with a therapeutic agent or agents, with or without programming the pump, for the management of chronic intractable pain (Anaes.) (Assist.) **Fee:** $367.70 **Benefit:** 75% = $275.80
39127	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management of chronic intractable pain (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $481.25 **Benefit:** 75% = $360.95
39128	INFUSION PUMP, subcutaneous implantation of, AND intrathecal or epidural SPINAL CATHETER insertion of, and connection of pump to catheter, and filling of reservoir with a therapeutic agent or agents, with or without programming the pump, for the management of chronic intractable pain (Anaes.) (Assist.) **Fee:** $670.50 **Benefit:** 75% = $502.90
39130	EPIDURAL LEAD, percutaneous placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a maximum of 4 leads (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $684.95 **Benefit:** 75% = $513.75
39131	ELECTRODES, epidural or peripheral nerve, management of patient and adjustment or reprogramming of neurostimulator by a medical practitioner, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris - each day **Fee:** $129.85 **Benefit:** 75% = $97.40 85% = $110.40

39133	Removal of subcutaneously IMPLANTED INFUSION PUMP OR removal or repositioning of intrathecal or epidural SPINAL CATHETER, for the management of chronic intractable pain (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $161.95 **Benefit:** 75% = $121.50
39134	NEUROSTIMULATOR or RECEIVER, subcutaneous placement of, including placement and connection of extension wires to epidural or peripheral nerve electrodes, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris (Anaes.) (Assist.) **Fee:** $346.05 **Benefit:** 75% = $259.55
39135	NEUROSTIMULATOR or RECEIVER, that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, removal of, performed in the operating theatre of a hospital (Anaes.) **Fee:** $161.95 **Benefit:** 75% = $121.50
39136	LEAD, epidural or peripheral nerve that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, removal of, performed in the operating theatre of a hospital (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $161.95 **Benefit:** 75% = $121.50
39137	LEAD, epidural or peripheral nerve that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, surgical repositioning to correct displacement or unsatisfactory positioning, including intraoperative test stimulation, not being a service to which item 39130, 39138 or 39139 applies (Anaes.) **Fee:** $615.05 **Benefit:** 75% = $461.30
39138	PERIPHERAL NERVE LEAD, surgical placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a maximum of 4 leads (Anaes.) (Assist.) **Fee:** $684.95 **Benefit:** 75% = $513.75
39139	Epidural lead, surgical placement of one or more by partial or total laminectomy, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris—to a maximum of 4 leads (H) (Anaes.) (Assist.) **Fee:** $919.60 **Benefit:** 75% = $689.70
39140	EPIDURAL CATHETER, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (Anaes.) **Fee:** $297.55 **Benefit:** 75% = $223.20 85% = $252.95
	PERIPHERAL NERVES
39300	CUTANEOUS NERVE (including digital nerve), primary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $359.00 **Benefit:** 75% = $269.25
39303	CUTANEOUS NERVE (including digital nerve), secondary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $473.55 **Benefit:** 75% = $355.20

39306	NERVE TRUNK, primary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $687.65 **Benefit:** 75% = $515.75
39309	NERVE TRUNK, secondary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $725.80 **Benefit:** 75% = $544.35
39312	NERVE TRUNK, (interfascicular), neurolysis of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $404.95 **Benefit:** 75% = $303.75
39315	NERVE TRUNK, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,046.70 **Benefit:** 75% = $785.05
39318	CUTANEOUS NERVE (including digital nerve), nerve graft to, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $649.45 **Benefit:** 75% = $487.10
39321	NERVE, transposition of (Anaes.) (Assist.) **Fee:** $481.25 **Benefit:** 75% = $360.95
39323	PERCUTANEOUS NEUROTOMY by cryotherapy or radiofrequency lesion generator, not being a service to which another item applies (Anaes.) (Assist.) **Fee:** $281.25 **Benefit:** 75% = $210.95 85% = $239.10
39324	NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve, by open operation (Anaes.) (Assist.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $281.25 **Benefit:** 75% = $210.95 85% = $239.10
39327	NEURECTOMY, NEUROTOMY or removal of tumour from deep peripheral or cranial nerve, by open operation, not being a service to which item 41575, 41576, 41578 or 41579 applies (Anaes.) (Assist.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $481.35 **Benefit:** 75% = $361.05
39330	NEUROLYSIS by open operation without transposition, not being a service associated with a service to which item 39312 applies (Anaes.) (Assist.) **Fee:** $281.25 **Benefit:** 75% = $210.95
39331	CARPAL TUNNEL RELEASE (division of transverse carpal ligament), by any method (Anaes.) **Fee:** $281.25 **Benefit:** 75% = $210.95 85% = $239.10
39333	BRACHIAL PLEXUS, exploration of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $404.95 **Benefit:** 75% = $303.75 85% = $344.25
	CRANIAL NERVES
39500	VESTIBULAR NERVE, section of, via posterior fossa (Anaes.) (Assist.) **Fee:** $1,291.25 **Benefit:** 75% = $968.45
39503	FACIO-HYPOGLOSSAL nerve or FACIO-ACCESSORY nerve, anastomosis of (Anaes.) (Assist.)

	Fee: $970.30 **Benefit:** 75% = $727.75
	CRANIO-CEREBRAL INJURIES
39600	INTRACRANIAL HAEMORRHAGE, burr-hole craniotomy for - including burr-holes (Anaes.) (Assist.) **Fee:** $481.25 **Benefit:** 75% = $360.95
39603	INTRACRANIAL HAEMORRHAGE, osteoplastic craniotomy or extensive craniectomy and removal of haematoma (Anaes.) (Assist.) **Fee:** $1,214.85 **Benefit:** 75% = $911.15
39606	FRACTURED SKULL, depressed or comminuted, operation for (Anaes.) (Assist.) **Fee:** $809.85 **Benefit:** 75% = $607.40
39609	FRACTURED SKULL, compound, without dural penetration, operation for (Anaes.) (Assist.) **Fee:** $970.30 **Benefit:** 75% = $727.75
39612	FRACTURED SKULL, compound, depressed or complicated, with dural penetration and brain laceration, operation for (Anaes.) (Assist.) **Fee:** $1,138.40 **Benefit:** 75% = $853.80
39615	FRACTURED SKULL with rhinorrhoea or otorrhoea, repair of by cranioplasty or endoscopic approach (Anaes.) (Assist.) **Fee:** $1,214.85 **Benefit:** 75% = $911.15
	SKULL BASE SURGERY
39640	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving craniotomy, radical excision of the skull base, and dural repair (Anaes.) (Assist.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $3,080.15 **Benefit:** 75% = $2310.15
39642	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving frontal craniotomy with lateral rhinotomy for clearance of paranasal sinus extension (intracranial procedure) (Anaes.) (Assist.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $3,238.25 **Benefit:** 75% = $2428.70
39646	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving frontal craniotomy with lateral rhinotomy and radical clearance of paranasal sinus and orbital fossa extensions, with intracranial decompression of the optic nerve, (intracranial procedure) (Anaes.) (Assist.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $3,712.05 **Benefit:** 75% = $2784.05
39650	TUMOUR INVOLVING MIDDLE CRANIAL FOSSA AND INFRA-TEMPORAL FOSSA, removal of, craniotomy and radical or sub-total radical excision, with division and reconstruction of zygomatic arch, (intracranial procedure) (Anaes.) (Assist.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $2,685.25 **Benefit:** 75% = $2013.95
39653	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision (intracranial procedure), not being a service to which item 39654 or

	39656 applies (Anaes.) (Assist.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $4,778.40 **Benefit:** 75% = $3583.80
39654	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure), conjoint surgery, principal surgeon (Anaes.) (Assist.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $3,475.25 **Benefit:** 75% = $2606.45
39656	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure) conjoint surgery, co-surgeon (Assist.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $2,606.35 **Benefit:** 75% = $1954.80
39658	TUMOUR INVOLVING THE CLIVUS, radical or sub-total radical excision of, involving transoral or transmaxillary approach (Anaes.) (Assist.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $3,080.15 **Benefit:** 75% = $2310.15
39660	TUMOUR OR VASCULAR LESION OF CAVERNOUS SINUS, radical excision of, involving craniotomy with or without intracranial carotid artery exposure (Anaes.) (Assist.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $3,080.15 **Benefit:** 75% = $2310.15
39662	TUMOUR OR VASCULAR LESION OF FORAMEN MAGNUM, radical excision of, via transcondylar or far lateral suboccipital approach (Anaes.) (Assist.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $3,080.15 **Benefit:** 75% = $2310.15
	INTRA-CRANIAL NEOPLASMS
39700	SKULL TUMOUR, benign or malignant, excision of, excluding cranioplasty (Anaes.) (Assist.) **Fee:** $565.50 **Benefit:** 75% = $424.15
39703	INTRACRANIAL tumour, cyst or other brain tissue, burr-hole and biopsy of, or drainage of, or both (Anaes.) (Assist.) **Fee:** $527.30 **Benefit:** 75% = $395.50
39706	INTRACRANIAL tumour, biopsy or decompression of via osteoplastic flap OR biopsy and decompression of via osteoplastic flap (Anaes.) (Assist.) **Fee:** $1,130.65 **Benefit:** 75% = $848.00
39709	CRANIOTOMY for removal of glioma, metastatic carcinoma or any other tumour in cerebrum, cerebellum or brain stem - not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,612.15 **Benefit:** 75% = $1209.15
39712	CRANIOTOMY FOR REMOVAL OF MENINGIOMA, pinealoma, cranio-pharyngioma, intraventricular tumour or any other intracranial tumour, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $2,910.85 **Benefit:** 75% = $2183.15

39715	PITUITARY TUMOUR, removal of, by transcranial or transphenoidal approach (Anaes.) (Assist.) **Fee:** $2,017.05 **Benefit:** 75% = $1512.80
39718	ARACHNOIDAL CYST, craniotomy for (Anaes.) (Assist.) **Fee:** $886.25 **Benefit:** 75% = $664.70
39721	CRANIOTOMY, involving osteoplastic flap, for re-opening post-operatively for haemorrhage, swelling, etc (Anaes.) (Assist.) **Fee:** $809.85 **Benefit:** 75% = $607.40
	CEREBROVASCULAR DISEASE
39800	ANEURYSM, clipping or reinforcement of sac (Anaes.) (Assist.) **Fee:** $2,903.25 **Benefit:** 75% = $2177.45
39803	INTRACRANIAL ARTERIOVENOUS MALFORMATION, excision of (Anaes.) (Assist.) **Fee:** $2,903.25 **Benefit:** 75% = $2177.45
39806	ANEURYSM, or arteriovenous malformation, intracranial proximal artery clipping of (Anaes.) (Assist.) **Fee:** $1,306.30 **Benefit:** 75% = $979.75
39812	INTRACRANIAL ANEURYSM or arteriovenous fistula, ligation of cervical vessel or vessels (Anaes.) (Assist.) **Fee:** $641.85 **Benefit:** 75% = $481.40
39815	CAROTID-CAVERNOUS FISTULA, obliteration of - combined cervical and intracranial procedure (Anaes.) (Assist.) **Fee:** $1,856.50 **Benefit:** 75% = $1392.40 85% = $1771.80
39818	EXTRACRANIAL TO INTRACRANIAL BYPASS using superficial temporal artery (Anaes.) (Assist.) **Fee:** $1,856.50 **Benefit:** 75% = $1392.40
39821	EXTRACRANIAL TO INTRACRANIAL BYPASS using saphenous vein graft (Anaes.) (Assist.) **Fee:** $2,204.45 **Benefit:** 75% = $1653.35
	INFECTION
39900	INTRACRANIAL INFECTION, drainage of, via burr-hole - including burr-hole (Anaes.) (Assist.) **Fee:** $527.30 **Benefit:** 75% = $395.50
39903	INTRACRANIAL ABSCESS, excision of (Anaes.) (Assist.) **Fee:** $1,612.15 **Benefit:** 75% = $1209.15
39906	OSTEOMYELITIS OF SKULL or removal of infected bone flap, craniectomy for (Anaes.) (Assist.) **Fee:** $809.85 **Benefit:** 75% = $607.40
	CEREBROSPINAL FLUID CIRCULATION DISORDERS
40000	VENTRICULO-CISTERNOSTOMY (Torkildsen's operation) (Anaes.) (Assist.) **Fee:** $932.10 **Benefit:** 75% = $699.10
40003	CRANIAL OR CISTERNAL SHUNT DIVERSION, insertion of (Anaes.) (Assist.)

	Fee: $932.10 **Benefit:** 75% = $699.10
40006	LUMBAR SHUNT DIVERSION, insertion of (Anaes.) (Assist.) **Fee:** $733.50 **Benefit:** 75% = $550.15
40009	CRANIAL, CISTERNAL OR LUMBAR SHUNT, revision or removal of (Anaes.) (Assist.) **Fee:** $534.80 **Benefit:** 75% = $401.10
40012	THIRD VENTRICULOSTOMY (open or endoscopic) with or without endoscopic septum pellucidotomy (Anaes.) (Assist.) **Fee:** $1,046.70 **Benefit:** 75% = $785.05
40015	SUBTEMPORAL DECOMPRESSION (Anaes.) (Assist.) **Fee:** $648.85 **Benefit:** 75% = $486.65
40018	LUMBAR CEREBROSPINAL FLUID DRAIN, insertion of (Anaes.) **Fee:** $161.95 **Benefit:** 75% = $121.50 85% = $137.70
	CONGENITAL DISORDERS
40100	MENINGOCELE, excision and closure of (Anaes.) (Assist.) **Fee:** $702.80 **Benefit:** 75% = $527.10
40103	MYELOMENINGOCELE, excision and closure of, including skin flaps or Z plasty where performed (Anaes.) (Assist.) **Fee:** $1,031.50 **Benefit:** 75% = $773.65
40106	ARNOLD-CHIARI MALFORMATION, decompression of (Anaes.) (Assist.) **Fee:** $1,046.70 **Benefit:** 75% = $785.05
40109	ENCEPHALOCOELE, excision and closure of (Anaes.) (Assist.) **Fee:** $1,130.65 **Benefit:** 75% = $848.00
40112	TETHERED CORD, release of, including lipomeningocele or diastematomyelia (Anaes.) (Assist.) **Fee:** $1,451.60 **Benefit:** 75% = $1088.70
40115	CRANIOSTENOSIS, operation for - single suture (Anaes.) (Assist.) **Fee:** $733.50 **Benefit:** 75% = $550.15
40118	CRANIOSTENOSIS, operation for - more than 1 suture (Anaes.) (Assist.) **Fee:** $970.30 **Benefit:** 75% = $727.75
	SKULL RECONSTRUCTION
40600	CRANIOPLASTY, reconstructive (Anaes.) (Assist.) **Fee:** $970.30 **Benefit:** 75% = $727.75
	EPILEPSY
40700	CORPUS CALLOSUM, anterior section of, for epilepsy (Anaes.) (Assist.) **Fee:** $1,772.55 **Benefit:** 75% = $1329.45
40701	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, subcutaneous placement of

	electrical pulse generator, for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.) **Fee:** $346.05 **Benefit:** 75% = $259.55
40702	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical repositioning or removal of electrical pulse generator inserted for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.) **Fee:** $161.95 **Benefit:** 75% = $121.50
40703	CORTICECTOMY, TOPECTOMY or PARTIAL LOBECTOMY for epilepsy (Anaes.) (Assist.) **Fee:** $1,489.75 **Benefit:** 75% = $1117.35
40704	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical placement of lead, including connection of lead to left vagus nerve and intra-operative test stimulation, for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.) **Fee:** $684.95 **Benefit:** 75% = $513.75
40705	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical repositioning or removal of lead attached to left vagus nerve for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.) **Fee:** $615.05 **Benefit:** 75% = $461.30
40706	HEMISPHERECTOMY for intractable epilepsy (Anaes.) (Assist.) **Fee:** $2,177.40 **Benefit:** 75% = $1633.05 85% = $2092.70
40707	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, electrical analysis and programming of vagus nerve stimulation therapy device using external wand, for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery **Fee:** $192.75 **Benefit:** 75% = $144.60 85% = $163.85
40708	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical replacement of battery in electrical pulse generator inserted for: (a) management of refractory generalised epilepsy; or (b) treating refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.) **Fee:** $346.05 **Benefit:** 75% = $259.55

40709	BURR-HOLE PLACEMENT of intracranial depth or surface electrodes (Anaes.) (Assist.) **Fee:** $527.30 **Benefit:** 75% = $395.50
40712	INTRACRANIAL ELECTRODE PLACEMENT via craniotomy (Anaes.) (Assist.) **Fee:** $1,061.90 **Benefit:** 75% = $796.45
	STEREOTACTIC PROCEDURES
40800	STEREOTACTIC ANATOMICAL LOCALISATION, as an independent procedure (Anaes.) (Assist.) **Fee:** $648.85 **Benefit:** 75% = $486.65 85% = $564.15
40801	FUNCTIONAL STEREOTACTIC procedure including computer assisted anatomical localisation, physiological localisation, and lesion production in the basal ganglia, brain stem or deep white matter tracts, not being a service associated with deep brain stimulation for Parkinson's disease, essential tremor or dystonia (Anaes.) (Assist.) **Fee:** $1,773.75 **Benefit:** 75% = $1330.35
40803	INTRACRANIAL STEREOTACTIC PROCEDURE BY ANY METHOD, not being a service to which item 40800 or 40801 applies (Anaes.) (Assist.) **Fee:** $1,214.85 **Benefit:** 75% = $911.15 85% = $1130.15
40850	DEEP BRAIN STIMULATION (unilateral) functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability (Anaes.) (Assist.) **Fee:** $2,300.70 **Benefit:** 75% = $1725.55
40851	DEEP BRAIN STIMULATION (bilateral) functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) (Assist.) **Fee:** $4,026.40 **Benefit:** 75% = $3019.80
40852	DEEP BRAIN STIMULATION (unilateral) subcutaneous placement of neurostimulator receiver or pulse generator for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or

	Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) (Assist.) **Fee:** $346.05 **Benefit:** 75% = $259.55
40854	DEEP BRAIN STIMULATION (unilateral) revision or removal of brain electrode for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) **Fee:** $534.80 **Benefit:** 75% = $401.10
40856	DEEP BRAIN STIMULATION (unilateral) removal or replacement of neurostimulator receiver or pulse generator for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) **Fee:** $259.55 **Benefit:** 75% = $194.70
40858	DEEP BRAIN STIMULATION (unilateral) placement, removal or replacement of extension lead for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) **Fee:** $534.80 **Benefit:** 75% = $401.10
40860	DEEP BRAIN STIMULATION (unilateral) target localisation incorporating anatomical and physiological techniques, including intra-operative clinical evaluation, for the insertion of a single neurostimulation wire for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) **Fee:** $2,055.05 **Benefit:** 75% = $1541.30
40862	DEEP BRAIN STIMULATION (unilateral) electronic analysis and programming of neurostimulator pulse generator for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) **Fee:** $192.75 **Benefit:** 75% = $144.60 85% = $163.85

T8. SURGICAL OPERATIONS	7. NEUROSURGICAL
	MISCELLANEOUS
40903	NEUROENDOSCOPY, for inspection of an intraventricular lesion, with or without biopsy including burr hole (Anaes.) (Assist.) **Fee:** $563.40 **Benefit:** 75% = $422.55
40905	CRANIOTOMY, performed in association with items 45767, 45776, 45782 and 45785 for the correction of craniofacial abnormalities (Anaes.) **Fee:** $611.35 **Benefit:** 75% = $458.55 85% = $526.65

T8. SURGICAL OPERATIONS	8. EAR, NOSE AND THROAT
	Group T8. Surgical Operations
	Subgroup 8. Ear, Nose And Throat
41500	EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.) (See para TN.8.72 of explanatory notes to this Category) **Fee:** $83.80 **Benefit:** 75% = $62.85 85% = $71.25
New 41501	Examination of glottal cycles and vibratory characteristics of the vocal folds by a specialist in the practice of the specialist's specialty of otolaryngology using videostroboscopy, including capturing audio, video, frequency and intensity, for confirmation of diagnosis , or for confirmation of treatment effectiveness where there is failure to progress or respond as expected, for: • dysphonia where non stroboscopic techniques of the visualising the larynx have failed to identify any frank abnormality of the vocal folds; or • benign vocal fold lesions; or • premalignant or malignant laryngeal lesions; or • vocal fold motion impairment or glottal insufficiency; or • evaluation of vocal fold function after treatment or phonosurgery other than a service associated with a service to which item 41764 applies or with a services associated with the administration of a general anaesthetic (See para TN.8.76 of explanatory notes to this Category) **Fee:** $188.55 **Benefit:** 75% = $141.45 85% = $160.30
41503	EAR, foreign body in, removal of, involving incision of external auditory canal (Anaes.) **Fee:** $242.60 **Benefit:** 75% = $181.95 85% = $206.25
41506	AURAL POLYP, removal of (Anaes.) **Fee:** $146.30 **Benefit:** 75% = $109.75 85% = $124.40
41509	EXTERNAL AUDITORY MEATUS, surgical removal of keratosis obturans from, not being a service to which another item in this Group applies (Anaes.) **Fee:** $165.55 **Benefit:** 75% = $124.20 85% = $140.75
41512	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (Anaes.) (Assist.) **Fee:** $595.25 **Benefit:** 75% = $446.45
41515	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, being a service

	associated with a service to which item 41530, 41548, 41557, 41560 or 41563 applies (Anaes.) (Assist.) (See para TN.8.73 of explanatory notes to this Category) **Fee:** $390.70 **Benefit:** 75% = $293.05
41518	EXTERNAL AUDITORY MEATUS, removal of EXOSTOSES IN (Anaes.) (Assist.) **Fee:** $943.60 **Benefit:** 75% = $707.70
41521	Correction of AUDITORY CANAL STENOSIS, including meatoplasty, with or without grafting (Anaes.) (Assist.) **Fee:** $1,004.65 **Benefit:** 75% = $753.50
41524	RECONSTRUCTION OF EXTERNAL AUDITORY CANAL, being a service associated with a service to which items 41557, 41560 and 41563 apply (Anaes.) (Assist.) (See para TN.8.74 of explanatory notes to this Category) **Fee:** $290.25 **Benefit:** 75% = $217.70
41527	MYRINGOPLASTY, transcanal approach (Rosen incision) (Anaes.) (Assist.) **Fee:** $597.00 **Benefit:** 75% = $447.75
41530	MYRINGOPLASTY, postaural or endaural approach with or without mastoid inspection (Anaes.) **Fee:** $972.60 **Benefit:** 75% = $729.45
41533	ATTICOTOMY without reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.) **Fee:** $1,162.60 **Benefit:** 75% = $871.95
41536	ATTICOTOMY with reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.) **Fee:** $1,302.20 **Benefit:** 75% = $976.65
41539	OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.) **Fee:** $1,107.35 **Benefit:** 75% = $830.55
41542	OSSICULAR CHAIN RECONSTRUCTION AND MYRINGOPLASTY (Anaes.) (Assist.) **Fee:** $1,213.35 **Benefit:** 75% = $910.05
41545	MASTOIDECTOMY (CORTICAL) (Anaes.) (Assist.) **Fee:** $529.60 **Benefit:** 75% = $397.20
41548	OBLITERATION OF THE MASTOID CAVITY (Anaes.) (Assist.) **Fee:** $702.80 **Benefit:** 75% = $527.10
41551	MASTOIDECTOMY, intact wall technique, with myringoplasty (Anaes.) (Assist.) **Fee:** $1,618.55 **Benefit:** 75% = $1213.95
41554	MASTOIDECTOMY, intact wall technique, with myringoplasty and ossicular chain reconstruction (Anaes.) (Assist.) **Fee:** $1,907.00 **Benefit:** 75% = $1430.25
41557	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) (Anaes.) (Assist.) **Fee:** $1,107.35 **Benefit:** 75% = $830.55

41560	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) AND MYRINGOPLASTY (Anaes.) **Fee:** $1,213.35 **Benefit:** 75% = $910.05
41563	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), MYRINGOPLASTY AND OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.) **Fee:** $1,502.05 **Benefit:** 75% = $1126.55
41564	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), OBLITERATION OF THE MASTOID CAVITY, BLIND SAC CLOSURE OF EXTERNAL AUDITORY CANAL AND OBLITERATION OF EUSTACHIAN TUBE (Anaes.) (Assist.) **Fee:** $1,942.40 **Benefit:** 75% = $1456.80
41566	REVISION OF MASTOIDECTOMY (radical, modified radical or intact wall), including myringoplasty (Anaes.) (Assist.) **Fee:** $1,107.35 **Benefit:** 75% = $830.55
41569	DECOMPRESSION OF FACIAL NERVE in its mastoid portion (Anaes.) (Assist.) **Fee:** $1,213.35 **Benefit:** 75% = $910.05
41572	LABYRINTHOTOMY OR DESTRUCTION OF LABYRINTH (Anaes.) (Assist.) **Fee:** $1,049.75 **Benefit:** 75% = $787.35
41575	CEREBELLO PONTINE ANGLE TUMOUR, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach transmastoid, translabyrinthine or retromastoid procedure (including aftercare) (Anaes.) (Assist.) **Fee:** $2,474.65 **Benefit:** 75% = $1856.00
41576	CEREBELLO - PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach - intracranial procedure (including aftercare) not being a service to which item 41578 or 41579 applies (Anaes.) (Assist.) **Fee:** $3,712.05 **Benefit:** 75% = $2784.05
41578	CEREBELLO PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $2,474.65 **Benefit:** 75% = $1856.00
41579	CEREBELLO-PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,856.00 **Benefit:** 75% = $1392.00
41581	TUMOUR INVOLVING INFRA-TEMPORAL FOSSA, removal of, involving craniotomy and radical excision of (Anaes.) (Assist.) **Fee:** $2,846.35 **Benefit:** 75% = $2134.80
41584	PARTIAL TEMPORAL BONE RESECTION for removal of tumour involving mastoidectomy with or without decompression of facial nerve (Anaes.) (Assist.) **Fee:** $1,953.40 **Benefit:** 75% = $1465.05
41587	TOTAL TEMPORAL BONE RESECTION for removal of tumour (Anaes.) (Assist.) **Fee:** $2,660.50 **Benefit:** 75% = $1995.40

41590	ENDOLYMPHATIC SAC, TRANSMASTOID DECOMPRESSION with or without drainage of (Anaes.) (Assist.) **Fee:** $1,213.35 **Benefit:** 75% = $910.05
41593	TRANSLABYRINTHINE VESTIBULAR NERVE SECTION (Anaes.) (Assist.) **Fee:** $1,581.40 **Benefit:** 75% = $1186.05
41596	RETROLABYRINTHINE VESTIBULAR NERVE SECTION or COCHLEAR NERVE SECTION, or BOTH (Anaes.) (Assist.) **Fee:** $1,767.35 **Benefit:** 75% = $1325.55
41599	INTERNAL AUDITORY MEATUS, exploration by middle cranial fossa approach with cranial nerve decompression (Anaes.) (Assist.) **Fee:** $1,767.35 **Benefit:** 75% = $1325.55
41603	OSSEO-INTEGRATION PROCEDURE - implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients: - With a permanent or long term hearing loss; and - Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and - With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted. Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.) **Fee:** $511.90 **Benefit:** 75% = $383.95 85% = $435.15
41604	OSSEO-INTEGRATION PROCEDURE - fixation of transcutaneous abutment implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients: - With a permanent or long term hearing loss; and - Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and - With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted. Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.) **Fee:** $189.50 **Benefit:** 75% = $142.15 85% = $161.10
41608	STAPEDECTOMY (Anaes.) (Assist.) **Fee:** $1,107.35 **Benefit:** 75% = $830.55
41611	STAPES MOBILISATION (Anaes.) (Assist.) **Fee:** $712.50 **Benefit:** 75% = $534.40
41614	ROUND WINDOW SURGERY including repair of cochleotomy (Anaes.) (Assist.) **Fee:** $1,107.35 **Benefit:** 75% = $830.55 85% = $1022.65
41615	OVAL WINDOW SURGERY, including repair of fistula, not being a service associated with a service

	to which any other item in this Group applies (Anaes.) (Assist.) **Fee:** $1,107.35 **Benefit:** 75% = $830.55 85% = $1022.65
41617	COCHLEAR IMPLANT, insertion of, including mastoidectomy (Anaes.) (Assist.) **Fee:** $1,925.50 **Benefit:** 75% = $1444.15
41618	Middle ear implant, partially implantable, insertion of, via mastoidectomy, for patients with: (a) stable sensorineural hearing loss; and (b) outer ear pathology that prevents the use of a conventional hearing aid; and (c) a PTA4 of less than 80 dBHL; and (d) bilateral, symmetrical hearing loss with PTA thresholds in both ears within 20 dBHL (0.5-4kHz) of each other; and (e) speech perception discrimination of at least 65% correct for word lists with appropriately amplified sound; and (f) a normal middle ear; and (g) normal tympanometry; and (h) on audiometry, an air-bone gap of less than 10 dBHL (0.5-4kHz) across all frequencies; and (i) no other inner ear disorders (Anaes.) (Assist.) **Fee:** $1,907.00 **Benefit:** 75% = $1430.25
41620	GLOMUS TUMOUR, transtympanic removal of (Anaes.) (Assist.) **Fee:** $837.75 **Benefit:** 75% = $628.35
41623	GLOMUS TUMOUR, transmastoid removal of, including mastoidectomy (Anaes.) (Assist.) **Fee:** $1,213.35 **Benefit:** 75% = $910.05
41626	ABSCESS OR INFLAMMATION OF MIDDLE EAR, operation for (excluding aftercare) (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $146.30 **Benefit:** 75% = $109.75 85% = $124.40
41629	MIDDLE EAR, EXPLORATION OF (Anaes.) (Assist.) **Fee:** $529.60 **Benefit:** 75% = $397.20
41632	MIDDLE EAR, insertion of tube for DRAINAGE OF (including myringotomy) (Anaes.) **Fee:** $242.60 **Benefit:** 75% = $181.95 85% = $206.25
41635	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty (Anaes.) (Assist.) **Fee:** $1,162.60 **Benefit:** 75% = $871.95 85% = $1077.90
41638	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more,

	with or without myringoplasty with ossicular chain reconstruction (Anaes.) (Assist.) **Fee:** $1,451.20 **Benefit:** 75% = $1088.40
41641	PERFORATION OF TYMPANUM, cauterisation or diathermy of (Anaes.) **Fee:** $48.20 **Benefit:** 75% = $36.15 85% = $41.00
41644	EXCISION OF RIM OF EARDRUM PERFORATION, not being a service associated with myringoplasty (Anaes.) **Fee:** $145.10 **Benefit:** 75% = $108.85 85% = $123.35
41647	EAR TOILET requiring use of operating microscope and microinspection of tympanic membrane with or without general anaesthesia (Anaes.) **Fee:** $111.65 **Benefit:** 75% = $83.75 85% = $94.95
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.) **Fee:** $111.65 **Benefit:** 75% = $83.75 85% = $94.95
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.) **Fee:** $73.10 **Benefit:** 75% = $54.85 85% = $62.15
41656	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $124.80 **Benefit:** 75% = $93.60 85% = $106.10
41659	NOSE, removal of FOREIGN BODY IN, other than by simple probing (Anaes.) **Fee:** $78.80 **Benefit:** 75% = $59.10 85% = $67.00
41662	NASAL POLYP OR POLYPI (SIMPLE), removal of (See para TN.8.75 of explanatory notes to this Category) **Fee:** $83.80 **Benefit:** 75% = $62.85 85% = $71.25
41668	NASAL POLYP OR POLYPI, removal of (Anaes.) (See para TN.8.75 of explanatory notes to this Category) **Fee:** $223.45 **Benefit:** 75% = $167.60
41671	NASAL SEPTUM, SEPTOPLASTY, SUBMUCOUS RESECTION or closure of septal perforation (Anaes.) (See para TN.8.104 of explanatory notes to this Category) **Fee:** $491.00 **Benefit:** 75% = $368.25
41672	NASAL SEPTUM, reconstruction of (Anaes.) (Assist.) **Fee:** $612.50 **Benefit:** 75% = $459.40
41674	Cauterisation (other than by chemical means) or cauterisation by chemical means when performed under general anaesthesia or diathermy of septum or turbinates—one or more of these procedures (including any consultation on the same occasion) other than a service associated with another operation on the

	nose (Anaes.) **Fee:** $102.10 **Benefit:** 75% = $76.60 85% = $86.80
41677	NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) **Fee:** $91.45 **Benefit:** 75% = $68.60 85% = $77.75
41683	DIVISION OF NASAL ADHESIONS, with or without stenting not being a service associated with any other operation on the nose and not performed during the postoperative period of a nasal operation (Anaes.) **Fee:** $119.10 **Benefit:** 75% = $89.35 85% = $101.25
41686	DISLOCATION OF TURBINATE OR TURBINATES, 1 or both sides, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $73.10 **Benefit:** 75% = $54.85 85% = $62.15
41689	TURBINECTOMY or turbinectomies, partial or total, unilateral (Anaes.) **Fee:** $138.70 **Benefit:** 75% = $104.05
41692	TURBINATES, submucous resection of, unilateral (Anaes.) **Fee:** $180.90 **Benefit:** 75% = $135.70
41698	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.) **Fee:** $33.05 **Benefit:** 75% = $24.80 85% = $28.10
41701	MAXILLARY ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission to hospital) not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $93.35 **Benefit:** 75% = $70.05
41704	MAXILLARY ANTRUM, LAVAGE OF each attendance at which the procedure is performed, including any associated consultation (Anaes.) **Fee:** $36.90 **Benefit:** 75% = $27.70 85% = $31.40
41707	MAXILLARY ARTERY, transantral ligation of (Anaes.) (Assist.) **Fee:** $455.75 **Benefit:** 75% = $341.85
41710	ANTROSTOMY (RADICAL) (Anaes.) (Assist.) **Fee:** $529.60 **Benefit:** 75% = $397.20
41713	ANTROSTOMY (RADICAL) with transantral ethmoidectomy or transantral vidian neurectomy (Anaes.) (Assist.) **Fee:** $616.20 **Benefit:** 75% = $462.15
41716	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.) **Fee:** $300.45 **Benefit:** 75% = $225.35
41719	ANTRUM, drainage of, through tooth socket (Anaes.) **Fee:** $119.45 **Benefit:** 75% = $89.60 85% = $101.55

41722	OROANTRAL FISTULA, plastic closure of (Anaes.) (Assist.) **Fee:** $597.00 **Benefit:** 75% = $447.75 85% = $512.30
41725	ETHMOIDAL ARTERY OR ARTERIES, transorbital ligation of (unilateral) (Anaes.) (Assist.) **Fee:** $455.75 **Benefit:** 75% = $341.85
41728	LATERAL RHINOTOMY with removal of tumour (Anaes.) (Assist.) **Fee:** $911.65 **Benefit:** 75% = $683.75
41729	DERMOID OF NOSE, excision of, with intranasal extension (Anaes.) (Assist.) **Fee:** $577.75 **Benefit:** 75% = $433.35
41731	FRONTONASAL ETHMOIDECTOMY by external approach with or without sphenoidectomy (Anaes.) (Assist.) **Fee:** $789.55 **Benefit:** 75% = $592.20
41734	RADICAL FRONTOETHMOIDECTOMY with osteoplastic flap (Anaes.) (Assist.) **Fee:** $1,030.25 **Benefit:** 75% = $772.70
41737	FRONTAL SINUS, OR ETHMOIDAL SINUSES ON THE ONE SIDE, intranasal operation on (Anaes.) (Assist.) **Fee:** $491.00 **Benefit:** 75% = $368.25
41740	FRONTAL SINUS, catheterisation of (Anaes.) **Fee:** $59.75 **Benefit:** 75% = $44.85
41743	FRONTAL SINUS, trephine of (Anaes.) (Assist.) **Fee:** $342.85 **Benefit:** 75% = $257.15
41746	FRONTAL SINUS, radical obliteration of (Anaes.) (Assist.) **Fee:** $789.55 **Benefit:** 75% = $592.20 85% = $704.85
41749	ETHMOIDAL SINUSES, external operation on (Anaes.) (Assist.) **Fee:** $616.20 **Benefit:** 75% = $462.15
41752	SPHENOIDAL SINUS, intranasal operation on (Anaes.) (Assist.) **Fee:** $300.45 **Benefit:** 75% = $225.35
41755	EUSTACHIAN TUBE, catheterisation of (Anaes.) **Fee:** $47.25 **Benefit:** 75% = $35.45 85% = $40.20
41764	NASENDOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX and LARYNX, one or more of these procedures, unilateral or bilateral examination (Anaes.) **Fee:** $124.80 **Benefit:** 75% = $93.60 85% = $106.10
41767	NASOPHARYNGEAL ANGIOFIBROMA, removal of (Anaes.) (Assist.) **Fee:** $748.80 **Benefit:** 75% = $561.60 85% = $664.10
41770	PHARYNGEAL POUCH, removal of, with or without cricopharyngeal myotomy (Anaes.) (Assist.)

	Fee: $712.50 **Benefit:** 75% = $534.40
41773	PHARYNGEAL POUCH, ENDOSCOPIC RESECTION OF (Dohlman's operation) (Anaes.) (Assist.) **Fee:** $597.00 **Benefit:** 75% = $447.75
41776	CRICOPHARYNGEAL MYOTOMY with or without inversion of pharyngeal pouch (Anaes.) (Assist.) **Fee:** $595.25 **Benefit:** 75% = $446.45
41779	PHARYNGOTOMY (lateral), with or without total excision of tongue (Anaes.) (Assist.) **Fee:** $712.50 **Benefit:** 75% = $534.40
41782	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY (Anaes.) (Assist.) **Fee:** $967.35 **Benefit:** 75% = $725.55 85% = $882.65
41785	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY with partial or total glossectomy (Anaes.) (Assist.) **Fee:** $1,200.05 **Benefit:** 75% = $900.05
41786	UVULOPALATOPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.) (Assist.) **Fee:** $748.80 **Benefit:** 75% = $561.60
41787	UVULECTOMY AND PARTIAL PALATECTOMY WITH LASER INCISION OF THE PALATE, with or without tonsillectomy, 1 or more stages, including any revision procedures within 12 months (Anaes.) (Assist.) **Fee:** $577.75 **Benefit:** 75% = $433.35 85% = $493.05
41789	Tonsils or tonsils and adenoids, removal of, in a person aged less than 12 years (including any examination of the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a service to which item 41764 applies (Anaes.) **Fee:** $300.45 **Benefit:** 75% = $225.35
41793	Tonsils or tonsils and adenoids, removal of, in a person 12 years of age or over (including any examination of the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a service to which item 41764 applies (Anaes.) **Fee:** $377.45 **Benefit:** 75% = $283.10
41797	TONSILS OR TONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general anaesthesia, following removal of (Anaes.) **Fee:** $146.30 **Benefit:** 75% = $109.75
41801	Adenoids, removal of (including any examination of the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a service to which item 41764 applies (Anaes.) **Fee:** $165.55 **Benefit:** 75% = $124.20
41804	LINGUAL TONSIL OR LATERAL PHARYNGEAL BANDS, removal of (Anaes.) **Fee:** $91.45 **Benefit:** 75% = $68.60

41807	PERITONSILLAR ABSCESS (quinsy), incision of (Anaes.) **Fee:** $71.20 **Benefit:** 75% = $53.40 85% = $60.55
41810	UVULOTOMY or UVULECTOMY (Anaes.) **Fee:** $36.15 **Benefit:** 75% = $27.15 85% = $30.75
41813	VALLECULAR OR PHARYNGEAL CYSTS, removal of (Anaes.) (Assist.) **Fee:** $362.05 **Benefit:** 75% = $271.55
41816	OESOPHAGOSCOPY (with rigid oesophagoscope) (Anaes.) **Fee:** $188.55 **Benefit:** 75% = $141.45 85% = $160.30
41822	OESOPHAGOSCOPY (with rigid oesophagoscope), with biopsy (Anaes.) **Fee:** $242.60 **Benefit:** 75% = $181.95
41825	OESOPHAGOSCOPY (with rigid oesophagoscope), with removal of foreign body (Anaes.) (Assist.) **Fee:** $362.05 **Benefit:** 75% = $271.55
41828	OESOPHAGEAL STRICTURE, dilatation of, without oesophagoscopy (Anaes.) **Fee:** $53.05 **Benefit:** 75% = $39.80 85% = $45.10
41831	Oesophagus, endoscopic pneumatic dilatation of, for treatment of achalasia (Anaes.) (Assist.) **Fee:** $362.70 **Benefit:** 75% = $272.05 85% = $308.30
41832	OESOPHAGUS, balloon dilatation of, using interventional imaging techniques (Anaes.) **Fee:** $232.15 **Benefit:** 75% = $174.15 85% = $197.35
41834	LARYNGECTOMY (TOTAL) (Anaes.) (Assist.) **Fee:** $1,309.80 **Benefit:** 75% = $982.35
41837	VERTICAL HEMILARYNGECTOMY including tracheostomy (Anaes.) (Assist.) **Fee:** $1,255.85 **Benefit:** 75% = $941.90
41840	SUPRAGLOTTIC LARYNGECTOMY including tracheostomy (Anaes.) (Assist.) **Fee:** $1,544.10 **Benefit:** 75% = $1158.10
41843	LARYNGOPHARYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUITY after laryngopharyngectomy USING STOMACH OR BOWEL (Anaes.) (Assist.) **Fee:** $1,357.85 **Benefit:** 75% = $1018.40
41855	MICROLARYNGOSCOPY (Anaes.) (Assist.) **Fee:** $292.80 **Benefit:** 75% = $219.60
41858	MICROLARYNGOSCOPY with removal of juvenile papillomata (Anaes.) (Assist.) (See para TN.8.77 of explanatory notes to this Category) **Fee:** $502.05 **Benefit:** 75% = $376.55
41861	MICROLARYNGOSCOPY with removal of benign lesions of the larynx by laser surgery (Anaes.) (Assist.)

	Fee: $613.95 **Benefit:** 75% = $460.50
41864	MICROLARYNGOSCOPY WITH REMOVAL OF TUMOUR (Anaes.) (Assist.) **Fee:** $414.00 **Benefit:** 75% = $310.50
41867	MICROLARYNGOSCOPY with arytenoidectomy (Anaes.) (Assist.) **Fee:** $623.20 **Benefit:** 75% = $467.40
41868	LARYNGEAL WEB, division of, using microlarygoscopic techniques (Anaes.) **Fee:** $394.90 **Benefit:** 75% = $296.20
41870	INJECTION OF VOCAL CORD BY TEFLON, FAT, COLLAGEN OR GELFOAM (Anaes.) (Assist.) **Fee:** $462.15 **Benefit:** 75% = $346.65
41873	LARYNX, FRACTURED, operation for (Anaes.) (Assist.) **Fee:** $597.00 **Benefit:** 75% = $447.75 85% = $512.30
41876	LARYNX, external operation on, OR LARYNGOFISSURE with or without cordectomy (Anaes.) (Assist.) **Fee:** $597.00 **Benefit:** 75% = $447.75 85% = $512.30
41879	LARYNGOPLASTY or TRACHEOPLASTY, including tracheostomy (Anaes.) (Assist.) **Fee:** $967.35 **Benefit:** 75% = $725.55
41880	TRACHEOSTOMY by a percutaneous technique using sequential dilatation or partial splitting method to allow insertion of a cuffed tracheostomy tube (Anaes.) **Fee:** $258.20 **Benefit:** 75% = $193.65
41881	TRACHEOSTOMY by open exposure of the trachea, including separation of the strap muscles or division of the thyroid isthmus, where performed (Anaes.) (Assist.) **Fee:** $408.20 **Benefit:** 75% = $306.15
41884	CRICOTHYROSTOMY by direct stab or Seldinger technique, using mini tracheostomy device (Anaes.) **Fee:** $92.50 **Benefit:** 75% = $69.40
41885	TRACHE-OESOPHAGEAL FISTULA, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $292.50 **Benefit:** 75% = $219.40 85% = $248.65
41886	TRACHEA, removal of foreign body in (Anaes.) **Fee:** $180.90 **Benefit:** 75% = $135.70 85% = $153.80
41889	BRONCHOSCOPY, as an independent procedure (Anaes.) **Fee:** $180.90 **Benefit:** 75% = $135.70 85% = $153.80
41892	BRONCHOSCOPY with 1 or more endobronchial biopsies or other diagnostic or therapeutic procedures (Anaes.) **Fee:** $238.80 **Benefit:** 75% = $179.10 85% = $203.00
41895	BRONCHUS, removal of foreign body in (Anaes.) (Assist.)

	Fee: $373.65 **Benefit:** 75% = $280.25
41898	FIBREOPTIC BRONCHOSCOPY with 1 or more transbronchial lung biopsies, with or without bronchial or bronchoalveolar lavage, with or without the use of interventional imaging (Anaes.) (Assist.) **Fee:** $261.05 **Benefit:** 75% = $195.80 85% = $221.90
41901	ENDOSCOPIC LASER RESECTION OF ENDOBRONCHIAL TUMOURS for relief of obstruction including any associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $613.95 **Benefit:** 75% = $460.50
41904	BRONCHOSCOPY with dilatation of tracheal stricture (Anaes.) **Fee:** $250.45 **Benefit:** 75% = $187.85 85% = $212.90
41905	TRACHEA OR BRONCHUS, dilatation of stricture and endoscopic insertion of stent (Anaes.) (Assist.) **Fee:** $460.60 **Benefit:** 75% = $345.45
41907	NASAL SEPTUM BUTTON, insertion of (Anaes.) **Fee:** $124.80 **Benefit:** 75% = $93.60 85% = $106.10
41910	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.) **Fee:** $396.50 **Benefit:** 75% = $297.40

	Group T8. Surgical Operations
	Subgroup 9. Ophthalmology
42503	OPHTHALMOLOGICAL EXAMINATION under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $104.15 **Benefit:** 75% = $78.15
42505	Complete removal from the eye of a trans-trabecular drainage device or devices, with or without replacement, following device related medical complications necessitating complete removal. (Anaes.) **Fee:** $305.55 **Benefit:** 75% = $229.20 85% = $259.75 **Extended Medicare Safety Net Cap:** $45.85
42506	EYE, ENUCLEATION OF, with or without sphere implant (Anaes.) (Assist.) **Fee:** $488.95 **Benefit:** 75% = $366.75 85% = $415.65
42509	EYE, ENUCLEATION OF, with insertion of integrated implant (Anaes.) (Assist.) **Fee:** $618.80 **Benefit:** 75% = $464.10
42510	EYE, enucleation of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes.) (Assist.) **Fee:** $713.30 **Benefit:** 75% = $535.00
42512	GLOBE, EVISCERATION OF (Anaes.) (Assist.) **Fee:** $488.95 **Benefit:** 75% = $366.75 85% = $415.65
42515	GLOBE, EVISCERATION OF, AND INSERTION OF INTRASCLERAL BALL OR CARTILAGE

	(Anaes.) (Assist.) **Fee:** $618.80 **Benefit:** 75% = $464.10
42518	ANOPHTHALMIC ORBIT, INSERTION OF CARTILAGE OR ARTIFICIAL IMPLANT as a delayed procedure, or REMOVAL OF IMPLANT FROM SOCKET, or PLACEMENT OF A MOTILITY INTEGRATING PEG by drilling into an existing orbital implant (Anaes.) (Assist.) **Fee:** $359.00 **Benefit:** 75% = $269.25
42521	ANOPHTHALMIC SOCKET, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (Anaes.) (Assist.) **Fee:** $1,222.45 **Benefit:** 75% = $916.85
42524	ORBIT, SKIN GRAFT TO, as a delayed procedure (Anaes.) **Fee:** $207.85 **Benefit:** 75% = $155.90 85% = $176.70
42527	CONTRACTED SOCKET, RECONSTRUCTION INCLUDING MUCOUS MEMBRANE GRAFTING AND STENT MOULD (Anaes.) (Assist.) **Fee:** $412.55 **Benefit:** 75% = $309.45
42530	ORBIT, EXPLORATION with or without biopsy, requiring REMOVAL OF BONE (Anaes.) (Assist.) **Fee:** $641.85 **Benefit:** 75% = $481.40
42533	ORBIT, EXPLORATION OF, with drainage or biopsy not requiring removal of bone (Anaes.) (Assist.) **Fee:** $412.55 **Benefit:** 75% = $309.45
42536	ORBIT, EXENTERATION OF, with or without skin graft and with or without temporalis muscle transplant (Anaes.) (Assist.) **Fee:** $847.95 **Benefit:** 75% = $636.00
42539	ORBIT, EXPLORATION OF, with removal of tumour or foreign body, requiring removal of bone (Anaes.) (Assist.) **Fee:** $1,207.20 **Benefit:** 75% = $905.40
42542	ORBIT, exploration of anterior aspect with removal of tumour or foreign body (Anaes.) (Assist.) **Fee:** $511.90 **Benefit:** 75% = $383.95
42543	ORBIT, exploration of retrobulbar aspect with removal of tumour or foreign body (Anaes.) (Assist.) **Fee:** $898.00 **Benefit:** 75% = $673.50
42545	ORBIT, decompression of, for dysthyroid eye disease, by fenestration of 2 or more walls, or by the removal of intraorbital peribulbar and retrobulbar fat from each quadrant of the orbit, 1 eye (Anaes.) (Assist.) **Fee:** $1,298.80 **Benefit:** 75% = $974.10
42548	OPTIC NERVE MENINGES, incision of (Anaes.) (Assist.) **Fee:** $771.55 **Benefit:** 75% = $578.70
42551	EYE, PENETRATING WOUND OR RUPTURE OF, not involving intraocular structures repair involving suture of cornea or sclera, or both, not being a service to which item 42632 applies (Anaes.) (Assist.)

	Fee: $641.85 **Benefit:** 75% = $481.40 85% = $557.15
42554	EYE, PENETRATING WOUND OR RUPTURE OF, with incarceration or prolapse of uveal tissue repair (Anaes.) (Assist.) **Fee:** $748.80 **Benefit:** 75% = $561.60
42557	EYE, PENETRATING WOUND OR RUPTURE OF, with incarceration of lens or vitreous repair (Anaes.) (Assist.) **Fee:** $1,046.70 **Benefit:** 75% = $785.05
42563	INTRAOCULAR FOREIGN BODY, removal from anterior segment (Anaes.) (Assist.) **Fee:** $527.30 **Benefit:** 75% = $395.50 85% = $448.25
42569	INTRAOCULAR FOREIGN BODY, removal from posterior segment (Anaes.) (Assist.) **Fee:** $1,046.70 **Benefit:** 75% = $785.05
42572	ORBITAL ABSCESS OR CYST, drainage of (Anaes.) **Fee:** $119.25 **Benefit:** 75% = $89.45 85% = $101.40
42573	DERMOID, periorbital, excision of, on a person 10 years of age or over (Anaes.) **Fee:** $231.10 **Benefit:** 75% = $173.35 85% = $196.45
42574	DERMOID, orbital, excision of (Anaes.) (Assist.) **Fee:** $491.00 **Benefit:** 75% = $368.25 85% = $417.35
42575	TARSAL CYST, extirpation of (Anaes.) **Fee:** $84.05 **Benefit:** 75% = $63.05 85% = $71.45
42576	DERMOID, periorbital, excision of, on a person under 10 years of age (Anaes.) **Fee:** $300.45 **Benefit:** 75% = $225.35 85% = $255.40
42581	ECTROPION OR ENTROPION, tarsal cauterisation of (Anaes.) **Fee:** $119.25 **Benefit:** 75% = $89.45 85% = $101.40
42584	TARSORRHAPHY (Anaes.) (Assist.) **Fee:** $281.25 **Benefit:** 75% = $210.95 85% = $239.10
42587	TRICHIASIS (due to causes other than trachoma), treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.) **Fee:** $52.80 **Benefit:** 75% = $39.60 85% = $44.90
42588	TRICHIASIS (due to trachoma), treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.) **Fee:** $52.80 **Benefit:** 75% = $39.60 85% = $44.90
42590	CANTHOPLASTY, medial or lateral (Anaes.) (Assist.) **Fee:** $343.75 **Benefit:** 75% = $257.85 85% = $292.20 **Extended Medicare Safety Net Cap:** $275.00
42593	LACRIMAL GLAND, excision of palpebral lobe (Anaes.) **Fee:** $207.85 **Benefit:** 75% = $155.90

42596	LACRIMAL SAC, excision of, or operation on (Anaes.) (Assist.) **Fee:** $511.90 **Benefit:** 75% = $383.95 85% = $435.15
42599	LACRIMAL CANALICULAR SYSTEM, establishment of patency by closed operation using silicone tubes or similar, 1 eye (Anaes.) (Assist.) **Fee:** $641.85 **Benefit:** 75% = $481.40 85% = $557.15
42602	LACRIMAL CANALICULAR SYSTEM, establishment of patency by open operation, 1 eye (Anaes.) (Assist.) **Fee:** $641.85 **Benefit:** 75% = $481.40 85% = $557.15
42605	LACRIMAL CANALICULUS, immediate repair of (Anaes.) (Assist.) **Fee:** $473.55 **Benefit:** 75% = $355.20 85% = $402.55
42608	LACRIMAL DRAINAGE by insertion of glass tube, as an independent procedure (Anaes.) (Assist.) **Fee:** $305.55 **Benefit:** 75% = $229.20 85% = $259.75
42610	NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, unilateral, with or without lavage - under general anaesthesia (Anaes.) **Fee:** $97.80 **Benefit:** 75% = $73.35 85% = $83.15
42611	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, bilateral, with or without lavage - under general anaesthesia (Anaes.) **Fee:** $146.65 **Benefit:** 75% = $110.00 85% = $124.70
42614	NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing to establish patency of the lacrimal passage and/or site of obstruction, unilateral, including lavage, not being a service associated with a service to which item 42610 applies (excluding aftercare) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $49.05 **Benefit:** 75% = $36.80 85% = $41.70
42615	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing to establish patency of the lacrimal passage and/or site of obstruction, bilateral, including lavage, not being a service associated with a service to which item 42611 applies (excluding aftercare) **Fee:** $73.40 **Benefit:** 75% = $55.05 85% = $62.40
42617	PUNCTUM SNIP operation (Anaes.) **Fee:** $139.15 **Benefit:** 75% = $104.40 85% = $118.30
42620	PUNCTUM, occlusion of, by use of a plug (Anaes.) **Fee:** $53.50 **Benefit:** 75% = $40.15 85% = $45.50
42622	PUNCTUM, permanent occlusion of, by use of electrical cautery (Anaes.) **Fee:** $84.05 **Benefit:** 75% = $63.05 85% = $71.45
42623	DACRYOCYSTORHINOSTOMY (Anaes.) (Assist.) **Fee:** $710.65 **Benefit:** 75% = $533.00
42626	DACRYOCYSTORHINOSTOMY where a previous dacryocystorhinostomy has been performed (Anaes.) (Assist.)

	Fee: $1,146.10 **Benefit:** 75% = $859.60 85% = $1061.40
42629	CONJUNCTIVORHINOSTOMY including dacryocystorhinostomy and fashioning of conjunctival flaps (Anaes.) (Assist.) **Fee:** $863.30 **Benefit:** 75% = $647.50
42632	CONJUNCTIVAL PERITOMY OR REPAIR OF CORNEAL LACERATION by conjunctival flap (Anaes.) **Fee:** $119.25 **Benefit:** 75% = $89.45 85% = $101.40
42635	CORNEAL PERFORATIONS, sealing of, with tissue adhesive (Anaes.) (Assist.) **Fee:** $305.55 **Benefit:** 75% = $229.20 85% = $259.75
42638	CONJUNCTIVAL GRAFT OVER CORNEA (Anaes.) (Assist.) **Fee:** $382.00 **Benefit:** 75% = $286.50 85% = $324.70
42641	AUTOCONJUNCTIVAL TRANSPLANT, or mucous membrane graft (Anaes.) (Assist.) **Fee:** $496.55 **Benefit:** 75% = $372.45 85% = $422.10
42644	CORNEA OR SCLERA, complete removal of embedded foreign body from - not more than once on the same day by the same practitioner (excluding aftercare) (Anaes.) (See para TN.8.78, TN.8.4 of explanatory notes to this Category) **Fee:** $73.30 **Benefit:** 75% = $55.00 85% = $62.35
42647	CORNEAL SCARS, removal of, by partial keratectomy, not being a service associated with a service to which item 42686 applies (Anaes.) **Fee:** $207.85 **Benefit:** 75% = $155.90 85% = $176.70
42650	CORNEA, epithelial debridement for corneal ulcer or corneal erosion (excluding aftercare) (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $73.30 **Benefit:** 75% = $55.00 85% = $62.35
42651	CORNEA, epithelial debridement for eliminating band keratopathy (Anaes.) **Fee:** $163.35 **Benefit:** 75% = $122.55 85% = $138.85
42652	Corneal collagen cross linking, on a person with a corneal ectatic disorder, with evidence of progression—per eye. (Anaes.) (See para TN.8.136 of explanatory notes to this Category) **Fee:** $1,219.20 **Benefit:** 75% = $914.40 85% = $1134.50
42653	CORNEA transplantation of (Anaes.) (Assist.) **Fee:** $1,328.65 **Benefit:** 75% = $996.50
42656	CORNEA, transplantation of, second and subsequent procedures (Anaes.) (Assist.) **Fee:** $1,696.15 **Benefit:** 75% = $1272.15
42662	SCLERA, transplantation of, full thickness, including collection of donor material (Anaes.) (Assist.) **Fee:** $916.75 **Benefit:** 75% = $687.60
42665	SCLERA, transplantation of, superficial or lamellar, including collection of donor material (Anaes.) (Assist.)

	Fee: $611.30 **Benefit:** 75% = $458.50 85% = $526.60
42667	RUNNING CORNEAL SUTURE, manipulation of, performed within 4 months of corneal grafting, to reduce astigmatism where a reduction of 2 dioptres of astigmatism is obtained, including any associated consultation **Fee:** $144.20 **Benefit:** 75% = $108.15 85% = $122.60
42668	CORNEAL SUTURES, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (Anaes.) **Fee:** $76.50 **Benefit:** 75% = $57.40 85% = $65.05
42672	CORNEAL INCISONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres following anterior segment surgery, including appropriate measurements and calculations, performed as an independent procedure (Anaes.) (Assist.) (See para TN.8.79 of explanatory notes to this Category) **Fee:** $916.75 **Benefit:** 75% = $687.60 85% = $832.05
42673	ADDITIONAL CORNEAL INCISIONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres, including appropriate measurements and calculations, performed in conjunction with other anterior segment surgery (Anaes.) (Assist.) **Fee:** $458.30 **Benefit:** 75% = $343.75 85% = $389.60
42676	CONJUNCTIVA, biopsy of, as an independent procedure **Fee:** $117.55 **Benefit:** 75% = $88.20 85% = $99.95
42677	CONJUNCTIVA, CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at which treatment is given including any associated consultation (Anaes.) **Fee:** $61.95 **Benefit:** 75% = $46.50 85% = $52.70
42680	CONJUNCTIVA, cryotherapy to, for melanotic lesions or similar using CO^2 or N^20 (Anaes.) **Fee:** $305.55 **Benefit:** 75% = $229.20 85% = $259.75
42683	CONJUNCTIVAL CYSTS, removal of, requiring admission to hospital or approved day-hospital facility (Anaes.) **Fee:** $122.30 **Benefit:** 75% = $91.75
42686	PTERYGIUM, removal of (Anaes.) **Fee:** $278.05 **Benefit:** 75% = $208.55 85% = $236.35
42689	PINGUECULA, removal of, not being a service associated with the fitting of contact lenses (Anaes.) **Fee:** $119.25 **Benefit:** 75% = $89.45 85% = $101.40
42692	LIMBIC TUMOUR, removal of, excluding Pterygium (Anaes.) (Assist.) **Fee:** $281.25 **Benefit:** 75% = $210.95 85% = $239.10
42695	LIMBIC TUMOUR, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes.) (Assist.) **Fee:** $458.30 **Benefit:** 75% = $343.75 85% = $389.60
42698	LENS EXTRACTION, excluding surgery performed for the correction of refractive error *except for*

	anisometropia greater than 3 dioptres following the removal of cataract in the first eye (Anaes.) (See para TN.8.80 of explanatory notes to this Category) **Fee:** $604.25 **Benefit:** 75% = $453.20 85% = $519.55
42701	INTRAOCULAR LENS, insertion of, excluding surgery performed for the correction of refractive error *except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye* (Anaes.) (See para TN.8.80 of explanatory notes to this Category) **Fee:** $337.00 **Benefit:** 75% = $252.75 85% = $286.45
42702	LENS EXTRACTION AND INSERTION OF INTRAOCULAR LENS, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye (Anaes.) **Fee:** $772.80 **Benefit:** 75% = $579.60 85% = $688.10 **Extended Medicare Safety Net Cap:** $115.95
42703	INTRAOCULAR LENS or IRIS PROSTHESIS insertion of, into the posterior chamber with fixation to the iris or sclera (Anaes.) (Assist.) **Fee:** $581.20 **Benefit:** 75% = $435.90 85% = $496.50
42704	INTRAOCULAR LENS, REMOVAL or REPOSITIONING of by open operation, not being a service associated with a service to which item 42701 applies (Anaes.) **Fee:** $473.55 **Benefit:** 75% = $355.20 85% = $402.55
42705	LENS EXTRACTION AND INSERTION OF INTRAOCULAR LENS, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye, performed in association with insertion of a trans-trabecular drainage device or devices, in a patient diagnosed with open angle glaucoma who is not adequately responsive to topical anti-glaucoma medications or who is intolerant of anti-glaucoma medication. (Anaes.) **Fee:** $925.70 **Benefit:** 75% = $694.30 85% = $841.00 **Extended Medicare Safety Net Cap:** $138.90
42707	INTRAOCULAR LENS, REMOVAL of and REPLACEMENT with a different lens, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye (Anaes.) **Fee:** $809.85 **Benefit:** 75% = $607.40 85% = $725.15
42710	INTRAOCULAR LENS, removal of, and replacement with a lens inserted into the posterior chamber and fixated to the iris or sclera (Anaes.) (Assist.) **Fee:** $916.75 **Benefit:** 75% = $687.60 85% = $832.05
42713	IRIS SUTURING, McCannell technique or similar, for fixation of intraocular lens or repair of iris defect (Anaes.) (Assist.) **Fee:** $382.00 **Benefit:** 75% = $286.50 85% = $324.70
42716	CATARACT, JUVENILE, removal of, including subsequent needlings (Anaes.) (Assist.) **Fee:** $1,214.85 **Benefit:** 75% = $911.15 85% = $1130.15
42719	REMOVAL OF VITREOUS, and/or CAPSULAR or LENS MATERIAL, via a limbal approach, not being a service associated with a service to which item 42698, 42702, 42716, 42725 or 42731 applies (Anaes.) (Assist.)

	Fee: $527.30 **Benefit:** 75% = $395.50 85% = $448.25
42725	Vitrectomy via pars plana sclerotomy, including one or more of the following: (a) removal of vitreous; (b) division of vitreous bands; (c) removal of epiretinal membranes; (d) capsulotomy (Anaes.) (Assist.) **Fee:** $1,359.85 **Benefit:** 75% = $1019.90
42731	LIMBAL OR PARS PLANA LENSECTOMY combined with vitrectomy, not being a service associated with items 42698, 42702, 42719, or 42725 (Anaes.) (Assist.) **Fee:** $1,543.30 **Benefit:** 75% = $1157.50
42734	Capsulotomy, other than by laser, and other than a service associated with a service to which item 42725 or 42731 applies (Anaes.) (Assist.) **Fee:** $305.55 **Benefit:** 75% = $229.20 85% = $259.75
42738	PARACENTESIS OF ANTERIOR CHAMBER OR VITREOUS CAVITY, or both, for the injection of therapeutic substances, or the removal of aqueous or vitreous humours for diagnostic or therapeutic purposes, 1 or more of, as an independent procedure. (See para TN.8.121 of explanatory notes to this Category) **Fee:** $305.55 **Benefit:** 75% = $229.20 85% = $259.75 **Extended Medicare Safety Net Cap:** $244.45
42739	PARACENTESIS OF ANTERIOR CHAMBER OR VITREOUS CAVITY, or both, for the injection of therapeutic substances, or the removal of aqueous or vitreous humours for diagnostic or therapeutic purposes, 1 or more of, as an independent procedure, for a patient requiring anaesthetic services. (Anaes.) (See para TN.8.121 of explanatory notes to this Category) **Fee:** $305.55 **Benefit:** 75% = $229.20 85% = $259.75 **Extended Medicare Safety Net Cap:** $244.45
42740	INTRAVITREAL INJECTION OF THERAPEUTIC SUBSTANCES, or the removal of vitreous humour for diagnostic purposes, 1 or more of, as a procedure associated with other intraocular surgery. (Anaes.) (See para TN.8.121 of explanatory notes to this Category) **Fee:** $305.55 **Benefit:** 75% = $229.20 85% = $259.75 **Extended Medicare Safety Net Cap:** $244.45
42741	Posterior juxtascleral depot injection of a therapeutic substance, for the treatment of subfoveal choroidal neovascularisation due to age-related macular degeneration, 1 or more of (Anaes.) (See para TN.8.81 of explanatory notes to this Category) **Fee:** $305.55 **Benefit:** 75% = $229.20 85% = $259.75
42743	ANTERIOR CHAMBER, IRRIGATION OF BLOOD FROM, as an independent procedure (Anaes.) (Assist.) **Fee:** $641.85 **Benefit:** 75% = $481.40 85% = $557.15

42744	Needle revision of glaucoma filtration bleb, following glaucoma filtering procedure (Anaes.) **Fee:** $305.35 **Benefit:** 75% = $229.05 85% = $259.55
42746	GLAUCOMA, filtering operation for, where conservative therapies have failed, are likely to fail, or are contraindicated (Anaes.) (Assist.) **Fee:** $970.30 **Benefit:** 75% = $727.75
42749	GLAUCOMA, filtering operation for, where previous filtering operation has been performed (Anaes.) (Assist.) **Fee:** $1,214.85 **Benefit:** 75% = $911.15
42752	GLAUCOMA, insertion of drainage device incorporating an extraocular reservoir for, such as a Molteno device (Anaes.) (Assist.) (See para TN.8.83 of explanatory notes to this Category) **Fee:** $1,359.85 **Benefit:** 75% = $1019.90
42755	GLAUCOMA, removal of drainage device incorporating an extraocular reservoir for, such as a Molteno device (Anaes.) **Fee:** $168.10 **Benefit:** 75% = $126.10 85% = $142.90
42758	Goniotomy for the treatment of primary congenital glaucoma, excluding the minimally invasive implantation of glaucoma drainage devices (Anaes.) (Assist.) **Fee:** $710.65 **Benefit:** 75% = $533.00
42761	DIVISION OF ANTERIOR OR POSTERIOR SYNECHIAE, as an independent procedure, other than by laser (Anaes.) (Assist.) **Fee:** $527.30 **Benefit:** 75% = $395.50 85% = $448.25
42764	IRIDECTOMY (including excision of tumour of iris) OR IRIDOTOMY, as an independent procedure, other than by laser (Anaes.) (Assist.) **Fee:** $527.30 **Benefit:** 75% = $395.50 85% = $448.25
42767	TUMOUR, INVOLVING CILIARY BODY OR CILIARY BODY AND IRIS, excision of (Anaes.) (Assist.) **Fee:** $1,107.80 **Benefit:** 75% = $830.85
42770	CYCLODESTRUCTIVE procedures for the treatment of intractable glaucoma, treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) (See para TN.8.82 of explanatory notes to this Category) **Fee:** $299.50 **Benefit:** 75% = $224.65 85% = $254.60
42773	DETACHED RETINA, pneumatic retinopexy for, not being a service associated with a service to which item 42776 applies (Anaes.) (Assist.) **Fee:** $916.75 **Benefit:** 75% = $687.60 85% = $832.05
42776	DETACHED RETINA, buckling or resection operation for (Anaes.) (Assist.) **Fee:** $1,359.85 **Benefit:** 75% = $1019.90
42779	DETACHED RETINA, revision of scleral buckling operation for (Anaes.) (Assist.) **Fee:** $1,696.15 **Benefit:** 75% = $1272.15

42782	LASER TRABECULOPLASTY, for the treatment of glaucoma. Each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes.) (Assist.) (See para TN.8.84 of explanatory notes to this Category) **Fee:** $458.30 **Benefit:** 75% = $343.75 85% = $389.60
42785	LASER IRIDOTOMY - each treatment episode to 1 eye, to a maximum of 3 treatments to that eye in a 2 year period (Anaes.) (Assist.) (See para TN.8.85 of explanatory notes to this Category) **Fee:** $359.00 **Benefit:** 75% = $269.25 85% = $305.15
42788	Laser capsulotomy—each treatment episode to one eye, to a maximum of 2 treatments to that eye in a 2 year period—other than a service associated with a service to which item 42702 applies (Anaes.) (Assist.) (See para TN.8.86 of explanatory notes to this Category) **Fee:** $359.00 **Benefit:** 75% = $269.25 85% = $305.15
42791	Laser vitreolysis or corticolysis of lens material or fibrinolysis, excluding vitreolysis in the posterior vitreous cavity—each treatment to one eye, to a maximum of 3 treatments to that eye in a 2 year period (Anaes.) (Assist.) (See para TN.8.87 of explanatory notes to this Category) **Fee:** $359.00 **Benefit:** 75% = $269.25 85% = $305.15
42794	DIVISION OF SUTURE BY LASER following glaucoma filtration surgery, each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (See para TN.8.88 of explanatory notes to this Category) **Fee:** $68.75 **Benefit:** 75% = $51.60 85% = $58.45
42801	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, insertion of (Anaes.) (Assist.) **Fee:** $1,066.50 **Benefit:** 75% = $799.90
42802	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, removal of (Anaes.) (Assist.) **Fee:** $533.10 **Benefit:** 75% = $399.85
42805	TANTALUM MARKERS, surgical insertion to the sclera to localise the tumour base to assist in planning of radiotherapy of choroidal melanomas, 1 or more (Anaes.) (Assist.) **Fee:** $595.90 **Benefit:** 75% = $446.95 85% = $511.20
42806	IRIS TUMOUR, laser photocoagulation of (Anaes.) (Assist.) **Fee:** $359.00 **Benefit:** 75% = $269.25 85% = $305.15
42807	PHOTOMYDRIASIS, laser **Fee:** $361.50 **Benefit:** 75% = $271.15 85% = $307.30
42808	Laser peripheral iridoplasty **Fee:** $361.50 **Benefit:** 75% = $271.15 85% = $307.30
42809	RETINA, photocoagulation of, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.) **Fee:** $458.30 **Benefit:** 75% = $343.75 85% = $389.60

42810	PHOTOTHERAPEUTIC KERATECTOMY, by laser, for corneal scarring or disease, excluding surgery for refractive error (Anaes.) **Fee:** $576.80 **Benefit:** 75% = $432.60 85% = $492.10
42811	TRANSPUPILLARY THERMOTHERAPY, for treatment of choroidal and retinal tumours or vascular malformations (Anaes.) **Fee:** $458.30 **Benefit:** 75% = $343.75 85% = $389.60
42812	Removal of scleral buckling material, from an eye having undergone previous scleral buckling surgery (Anaes.) **Fee:** $168.10 **Benefit:** 75% = $126.10 85% = $142.90
42815	VITREOUS CAVITY, removal of silicone oil or other liquid vitreous substitutes from, during a procedure other than that in which the vitreous substitute is inserted (Anaes.) (Assist.) **Fee:** $641.85 **Benefit:** 75% = $481.40
42818	RETINA, CRYOTHERAPY TO, as an independent procedure, or when performed in conjunction with item 42809 or 42770 (Anaes.) **Fee:** $595.90 **Benefit:** 75% = $446.95 85% = $511.20
42821	OCULAR TRANSILLUMINATION, for the diagnosis and measurement of intraocular tumours (Anaes.) **Fee:** $91.80 **Benefit:** 75% = $68.85 85% = $78.05
42824	RETROBULBAR INJECTION OF ALCOHOL OR OTHER DRUG, as an independent procedure **Fee:** $71.00 **Benefit:** 75% = $53.25 85% = $60.35
42833	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES on a patient aged 15 years or over (Anaes.) (Assist.) **Fee:** $595.90 **Benefit:** 75% = $446.95
42836	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES, on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.) **Fee:** $741.10 **Benefit:** 75% = $555.85
42839	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 OR MORE MUSCLES on a patient aged 15 years or over (Anaes.) (Assist.) **Fee:** $710.65 **Benefit:** 75% = $533.00
42842	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 or MORE MUSCLES, on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.) **Fee:** $886.25 **Benefit:** 75% = $664.70
42845	READJUSTMENT OF ADJUSTABLE SUTURES, 1 or both eyes, as an independent procedure following an operation for correction of squint (Anaes.) (See para TN.8.89 of explanatory notes to this Category)

	Fee: $192.45 **Benefit:** 75% = $144.35 85% = $163.60
42848	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 15 years or over (Anaes.) (Assist.) **Fee:** $710.65 **Benefit:** 75% = $533.00
42851	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.) **Fee:** $886.25 **Benefit:** 75% = $664.70
42854	RUPTURED MEDIAL PALPEBRAL LIGAMENT or ruptured EXTRAOCULAR MUSCLE, repair of (Anaes.) (Assist.) **Fee:** $412.55 **Benefit:** 75% = $309.45 85% = $350.70
42857	RESUTURING OF WOUND FOLLOWING INTRAOCULAR PROCEDURES with or without excision of prolapsed iris (Anaes.) (Assist.) **Fee:** $412.55 **Benefit:** 75% = $309.45 85% = $350.70
42860	EYELID (upper or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid retractors (Anaes.) (Assist.) **Fee:** $916.75 **Benefit:** 75% = $687.60 85% = $832.05
42863	EYELID, recession of (Anaes.) (Assist.) **Fee:** $786.95 **Benefit:** 75% = $590.25 85% = $702.25
42866	ENTROPION or TARSAL ECTROPION, repair of, by tightening, shortening or repair of inferior retractors by open operation across the entire width of the eyelid (Anaes.) (Assist.) **Fee:** $763.90 **Benefit:** 75% = $572.95 85% = $679.20
42869	EYELID closure in facial nerve paralysis, insertion of foreign implant for (Anaes.) (Assist.) **Fee:** $557.80 **Benefit:** 75% = $418.35 85% = $474.15
42872	EYEBROW, elevation of, by skin excision, to correct for a reduced field of vision caused by paretic, involutional, or traumatic eyebrow descent/ptosis to a position below the superior orbital rim (Anaes.) **Fee:** $244.55 **Benefit:** 75% = $183.45 85% = $207.90
43021	Photodynamic therapy, one eye, including the infusion of Verteporfin continuously through a peripheral vein, using a non-thermal laser at a wavelength of 689nm, for the treatment of choroidal neovascularisation. **Fee:** $462.35 **Benefit:** 75% = $346.80 85% = $393.00
43022	Photodynamic therapy, both eyes, including the infusion of Verteporfin continuously through a peripheral vein, using a non-thermal laser at a wavelength of 689nm, for the treatment of choroidal neovascularisation. **Fee:** $554.90 **Benefit:** 75% = $416.20 85% = $471.70
43023	Infusion of Verteporfin for discontinued photodynamic therapy, where a session of therapy which would have been provided under item 43021 or 43022 has been discontinued on medical grounds. **Fee:** $89.90 **Benefit:** 75% = $67.45 85% = $76.45

T8. SURGICAL OPERATIONS	10. OPERATIONS FOR OSTEOMYELITIS
	Group T8. Surgical Operations
	Subgroup 10. Operations For Osteomyelitis
	ACUTE
43500	OPERATION ON PHALANX (Anaes.) **Fee:** $125.30 **Benefit:** 75% = $94.00
43503	OPERATION ON STERNUM, CLAVICLE, RIB, ULNA, RADIUS, CARPUS, TIBIA, FIBULA, TARSUS, SKULL, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE (Anaes.) **Fee:** $208.00 **Benefit:** 75% = $156.00
43506	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.) **Fee:** $362.05 **Benefit:** 75% = $271.55
43509	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.) **Fee:** $362.05 **Benefit:** 75% = $271.55
	CHRONIC
43512	OPERATION ON SCAPULA, STERNUM, CLAVICLE, RIB, ULNA, RADIUS, METACARPUS, CARPUS, PHALANX, TIBIA, FIBULA, METATARSUS, TARSUS, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE or ANY COMBINATION OF ADJOINING BONES (Anaes.) (Assist.) **Fee:** $362.05 **Benefit:** 75% = $271.55
43515	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.) **Fee:** $362.05 **Benefit:** 75% = $271.55 85% = $307.75
43518	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.) **Fee:** $597.00 **Benefit:** 75% = $447.75
43521	OPERATION ON SKULL (Anaes.) (Assist.) **Fee:** $471.95 **Benefit:** 75% = $354.00
43524	OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 43515, 43518 or 43521 (Anaes.) (Assist.) **Fee:** $597.00 **Benefit:** 75% = $447.75 85% = $512.30

T8. SURGICAL OPERATIONS	11. PAEDIATRIC
	Group T8. Surgical Operations
	Subgroup 11. Paediatric
	SURGERY IN NEONATE OR YOUNG CHILD
43801	INTESTINAL MALROTATION with or without volvulus, laparotomy for, not involving bowel resection (Anaes.) (Assist.) **Fee:** $972.60 **Benefit:** 75% = $729.45

43804	INTESTINAL MALROTATION with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (Anaes.) (Assist.) **Fee:** $1,035.55 **Benefit:** 75% = $776.70
43805	UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, on a person under 10 years of age (Anaes.) **Fee:** $362.05 **Benefit:** 75% = $271.55
43807	DUODENAL ATRESIA or STENOSIS, duodenoduodenostomy or duodenojejunostomy for (Anaes.) (Assist.) **Fee:** $1,129.80 **Benefit:** 75% = $847.35
43810	JEJUNAL ATRESIA, bowel resection and anastomosis for, with or without tapering (Anaes.) (Assist.) **Fee:** $1,318.10 **Benefit:** 75% = $988.60
43813	MECONIUM ILEUS, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intesinal perforation with or without meconium peritonitis (Anaes.) (Assist.) **Fee:** $1,318.10 **Benefit:** 75% = $988.60
43816	ILEAL ATRESIA, COLONIC ATRESIA OR MECONIUM ILEUS not being a service associated with a service to which item 43813 applies, laparotomy for (Anaes.) (Assist.) **Fee:** $1,223.85 **Benefit:** 75% = $917.90
43819	Agangliosis Coli, laparotomy for, with or without frozen section biopsies and formation of stoma (Anaes.) (Assist.) **Fee:** $988.50 **Benefit:** 75% = $741.40
43822	ANORECTAL MALFORMATION, laparotomy and colostomy for (Anaes.) (Assist.) **Fee:** $988.50 **Benefit:** 75% = $741.40
43825	NEONATAL ALIMENTARY OBSTRUCTION, laparotomy for, not being a service to which any other item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $1,129.80 **Benefit:** 75% = $847.35
43828	ACUTE NEONATAL NECROTISING ENTEROCOLITIS, laparotomy for, with resection, including any anastomoses or stoma formation (Anaes.) (Assist.) **Fee:** $1,248.20 **Benefit:** 75% = $936.15
43831	ACUTE NEONATAL NECROTISING ENTEROCOLITIS where no definitive procedure is possible, laparotomy for (Anaes.) (Assist.) **Fee:** $972.60 **Benefit:** 75% = $729.45
43832	BRANCHIAL FISTULA, on a person under 10 years of age. Removal of, (Anaes.) (Assist.) **Fee:** $663.40 **Benefit:** 75% = $497.55
43834	BOWEL RESECTION for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (Anaes.) (Assist.) **Fee:** $1,129.80 **Benefit:** 75% = $847.35
43835	STRANGULATED, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel

	resection, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $688.50 **Benefit:** 75% = $516.40
43837	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (Anaes.) (Assist.) **Fee:** $1,412.15 **Benefit:** 75% = $1059.15
43838	Diaphragmatic hernia, congential repair of, by thoracic or abdominal approach, not being a service to which any of items 31569 to 31581 apply, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $1,264.40 **Benefit:** 75% = $948.30
43840	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, diagnosed after the first day of life and before 20 days of age (Anaes.) (Assist.) **Fee:** $1,223.85 **Benefit:** 75% = $917.90
43841	FEMORAL OR INGUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to which item 30403 or 43835 applies, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $613.50 **Benefit:** 75% = $460.15
43843	OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, not being a service to which item 43846 applies (Anaes.) (Assist.) **Fee:** $1,883.00 **Benefit:** 75% = $1412.25
43846	OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, in infant of birth weight less than 1500 grams (Anaes.) (Assist.) **Fee:** $2,024.20 **Benefit:** 75% = $1518.15
43849	OESOPHAGEAL ATRESIA, gastrostomy for (Anaes.) (Assist.) **Fee:** $517.80 **Benefit:** 75% = $388.35
43852	OESOPHAGEAL ATRESIA, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (Anaes.) (Assist.) **Fee:** $1,647.50 **Benefit:** 75% = $1235.65
43855	OESOPHAGEAL ATRESIA, delayed primary anastomosis for (Anaes.) (Assist.) **Fee:** $1,741.80 **Benefit:** 75% = $1306.35
43858	OESOPHAGEAL ATRESIA, cervical oesophagostomy for (Anaes.) (Assist.) **Fee:** $611.90 **Benefit:** 75% = $458.95
43861	CONGENITAL CYSTADENOMATOID MALFORMATION OR CONGENITAL LOBAR EMPHYSEMA, thoracotomy and lung resection for (Anaes.) (Assist.) **Fee:** $1,694.75 **Benefit:** 75% = $1271.10
43864	GASTROSCHISIS, operation for (Anaes.) (Assist.) **Fee:** $1,271.05 **Benefit:** 75% = $953.30
43867	GASTROSCHISIS or Exomphalos, secondary operation for, with removal of silo (Anaes.) (Assist.) **Fee:** $706.10 **Benefit:** 75% = $529.60

43870	EXOMPHALOS containing small bowel only, operation for (Anaes.) (Assist.) **Fee:** $988.50 **Benefit:** 75% = $741.40
43873	EXOMPHALOS containing small bowel and other viscera, operation for (Anaes.) (Assist.) **Fee:** $1,318.10 **Benefit:** 75% = $988.60
43876	SACROCOCCYGEAL TERATOMA, excision of, by posterior approach (Anaes.) (Assist.) **Fee:** $1,129.80 **Benefit:** 75% = $847.35
43879	SACROCOCCYGEAL TERATOMA, excision of, by combined posterior and abdominal approach (Anaes.) (Assist.) **Fee:** $1,318.10 **Benefit:** 75% = $988.60
43882	CLOACAL EXSTROPHY, operation for (Anaes.) (Assist.) **Fee:** $1,694.75 **Benefit:** 75% = $1271.10 85% = $1610.05
	THORACIC SURGERY
43900	TRACHEO-OESOPHAGEAL FISTULA without atresia, division and repair of (Anaes.) (Assist.) **Fee:** $1,129.80 **Benefit:** 75% = $847.35
43903	OESOPHAGEAL ATRESIA or CORROSIVE OESOPHAGEAL STRICTURE, oesophageal replacement for, utilizing gastric tube, jejunum or colon (Anaes.) (Assist.) **Fee:** $1,883.00 **Benefit:** 75% = $1412.25
43906	OESOPHAGUS, resection of congenital, anastomic or corrosive stricture and anastomosis, not being a service to which item 43903 applies (Anaes.) (Assist.) **Fee:** $1,647.50 **Benefit:** 75% = $1235.65
43909	TRACHEOMALACIA, aortopexy for (Anaes.) (Assist.) **Fee:** $1,647.50 **Benefit:** 75% = $1235.65
43912	THORACOTOMY and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal teratoma (Anaes.) (Assist.) **Fee:** $1,556.50 **Benefit:** 75% = $1167.40
43915	EVENTRATION, plication of diaphragm for (Anaes.) (Assist.) **Fee:** $1,176.85 **Benefit:** 75% = $882.65
	ABDOMINAL SURGERY
43930	HYPERTROPHIC PYLORIC STENOSIS, pyloromyotomy for (Anaes.) (Assist.) **Fee:** $452.55 **Benefit:** 75% = $339.45
43933	IDIOPATHIC INTUSSUSCEPTION, laparotomy and manipulative reduction of (Anaes.) (Assist.) **Fee:** $529.75 **Benefit:** 75% = $397.35
43936	INTUSSUSCEPTION, laparotomy and resection with anastomosis (Anaes.) (Assist.) **Fee:** $988.50 **Benefit:** 75% = $741.40
43939	VENTRAL HERNIA following neonatal closure of exomphalos or gastroschisis, repair of (Anaes.)

	(Assist.) **Fee:** $753.15 **Benefit:** 75% = $564.90
43942	ABDOMINAL WALL VITELLO INTESTINAL REMNANT, excision of (Anaes.) **Fee:** $235.40 **Benefit:** 75% = $176.55
43945	PATENT VITELLO INTESTINAL DUCT, excision of (Anaes.) (Assist.) **Fee:** $988.50 **Benefit:** 75% = $741.40
43948	UMBILICAL GRANULOMA, excision of, under general anaesthesia (Anaes.) **Fee:** $141.35 **Benefit:** 75% = $106.05
43951	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (Anaes.) (Assist.) **Fee:** $885.25 **Benefit:** 75% = $663.95
43954	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (Anaes.) (Assist.) **Fee:** $1,082.80 **Benefit:** 75% = $812.10
43957	GASTRO-OESOPHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or without hiatus hernia, in child with neurological disease, with gastrostomy (Anaes.) (Assist.) **Fee:** $1,176.85 **Benefit:** 75% = $882.65
43960	ANORECTAL MALFORMATION, perineal anoplasty of (Anaes.) (Assist.) **Fee:** $414.00 **Benefit:** 75% = $310.50
43963	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of (Anaes.) (Assist.) **Fee:** $1,647.50 **Benefit:** 75% = $1235.65
43966	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes.) (Assist.) **Fee:** $1,883.00 **Benefit:** 75% = $1412.25
43969	PERSISTENT CLOACA, total correction of, with genital repair using posterior sagittal approach, with or without laparotomy (Anaes.) (Assist.) **Fee:** $2,589.10 **Benefit:** 75% = $1941.85
43972	CHOLEDOCHAL CYST, resection of, with 1 duct anastomosis (Anaes.) (Assist.) **Fee:** $1,883.00 **Benefit:** 75% = $1412.25
43975	CHOLEDOCHAL CYST, resection of, with 2 duct anastomoses (Anaes.) (Assist.) **Fee:** $2,212.55 **Benefit:** 75% = $1659.45
43978	BILIARY ATRESIA, portoenterostomy for (Anaes.) (Assist.) **Fee:** $1,883.00 **Benefit:** 75% = $1412.25
43981	NEPHROBLASTOMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed

	(Anaes.) (Assist.) **Fee:** $517.80 **Benefit:** 75% = $388.35
43984	NEPHROBLASTOMA, radical nephrectomy for (Anaes.) (Assist.) **Fee:** $1,318.10 **Benefit:** 75% = $988.60
43987	NEUROBLASTOMA, radical excision of (Anaes.) (Assist.) **Fee:** $1,459.40 **Benefit:** 75% = $1094.55
43990	Aganglionosis Coli, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends to sigmoid colon (Anaes.) (Assist.) **Fee:** $1,788.90 **Benefit:** 75% = $1341.70
43993	Aganglionosis Coli, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends into descending or transverse colon with or without resiting of stoma (Anaes.) (Assist.) **Fee:** $1,930.05 **Benefit:** 75% = $1447.55
43996	Aganglionosis Coli, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or without side to side ileocolic anastomosis (Anaes.) (Assist.) **Fee:** $2,165.45 **Benefit:** 75% = $1624.10
43999	Aganglionosis Coli, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.) **Fee:** $270.80 **Benefit:** 75% = $203.10
44101	RECTUM, examination of, on a person under 2 years of age, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.) **Fee:** $339.40 **Benefit:** 75% = $254.55
44102	RECTUM, examination of, on a person 2 years of age or over, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.) **Fee:** $261.05 **Benefit:** 75% = $195.80
44104	RECTAL PROLAPSE, SUBMUCOSAL or perirectal injection for, on a person under 2 years of age, under general anaesthesia (Anaes.) **Fee:** $59.60 **Benefit:** 75% = $44.70 85% = $50.70
44105	RECTAL PROLAPSE, SUBMUCOSAL or perirectal injection for, on a person 2 years of age or over, under general anaesthesia (Anaes.) **Fee:** $45.80 **Benefit:** 75% = $34.35 85% = $38.95
44108	INGUINAL HERNIA repair at age less than 12 months (Anaes.) (Assist.) **Fee:** $499.30 **Benefit:** 75% = $374.50
44111	OBSTRUCTED OR STRANGULATED INGUINAL HERNIA, repair, at age, less than 12 months including orchidopexy when performed (Anaes.) (Assist.) **Fee:** $584.85 **Benefit:** 75% = $438.65 85% = $500.15
44114	INGUINAL HERNIA repair at age less than 12 months when orchidopexy also required (Anaes.) (Assist.)

T8. SURGICAL OPERATIONS	11. PAEDIATRIC
	Fee: $584.85 **Benefit:** 75% = $438.65
	MISCELLANEOUS SURGERY
44130	LYMPHADENECTOMY, for atypical mycobacterial infection or other granulomatous disease (Anaes.) (Assist.) **Fee:** $470.70 **Benefit:** 75% = $353.05 85% = $400.10
44133	TORTICOLLIS, open division of sternomastoid muscle for (Anaes.) (Assist.) **Fee:** $373.65 **Benefit:** 75% = $280.25
44136	INGROWN TOE NAIL, operation for, under general anaesthesia (Anaes.) **Fee:** $172.20 **Benefit:** 75% = $129.15 85% = $146.40

T8. SURGICAL OPERATIONS	12. AMPUTATIONS
	Group T8. Surgical Operations
	Subgroup 12. Amputations
44325	HAND, MIDCARPAL OR TRANSMETACARPAL, amputation of (Anaes.) (Assist.) **Fee:** $300.45 **Benefit:** 75% = $225.35 85% = $255.40
44328	HAND, FOREARM OR THROUGH ARM, amputation of (Anaes.) (Assist.) **Fee:** $362.05 **Benefit:** 75% = $271.55
44331	AMPUTATION AT SHOULDER (Anaes.) (Assist.) **Fee:** $597.00 **Benefit:** 75% = $447.75
44334	INTERSCAPULOTHORACIC AMPUTATION (Anaes.) (Assist.) **Fee:** $1,213.35 **Benefit:** 75% = $910.05 85% = $1128.65
44338	1 DIGIT of foot, amputation of (Anaes.) **Fee:** $146.30 **Benefit:** 75% = $109.75 85% = $124.40
44342	2 DIGITS of 1 foot, amputation of (Anaes.) **Fee:** $223.45 **Benefit:** 75% = $167.60
44346	3 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) **Fee:** $258.05 **Benefit:** 75% = $193.55
44350	4 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) **Fee:** $292.80 **Benefit:** 75% = $219.60 85% = $248.90
44354	5 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) **Fee:** $335.10 **Benefit:** 75% = $251.35
44358	TOE, including metatarsal or part of metatarsal each toe , amputation of (Anaes.) **Fee:** $186.85 **Benefit:** 75% = $140.15
44359	ONE OR MORE TOES OF ONE FOOT, amputation of, including if performed, excision of 1 or more metatarsal bones of the foot, performed for diabetic or other microvascular disease, excluding aftercare

	(Anaes.) (Assist.) **Fee:** $268.15 **Benefit:** 75% = $201.15
44361	FOOT AT ANKLE (Syme, Pirogoff types), amputation of (Anaes.) (Assist.) **Fee:** $362.05 **Benefit:** 75% = $271.55
44364	FOOT, MIDTARSAL OR TRANSMETATARSAL, amputation of (Anaes.) (Assist.) **Fee:** $300.45 **Benefit:** 75% = $225.35
44367	AMPUTATION THROUGH THIGH, AT KNEE OR BELOW KNEE (Anaes.) (Assist.) **Fee:** $530.30 **Benefit:** 75% = $397.75
44370	AMPUTATION AT HIP (Anaes.) (Assist.) **Fee:** $731.70 **Benefit:** 75% = $548.80
44373	HINDQUARTER, amputation of (Anaes.) (Assist.) **Fee:** $1,502.05 **Benefit:** 75% = $1126.55 85% = $1417.35
44376	AMPUTATION STUMP, reamputation of, to provide adequate skin and muscle cover (Assist.) **Derived Fee:** 75% of the original amputation fee

	Group T8. Surgical Operations
	Subgroup 13. Plastic And Reconstructive Surgery
	GENERAL
45000	Single stage local muscle flap repair, on eyelid, nose, lip, neck, hand, thumb, finger or genitals not in association with any of items 31356 to 31376 (Anaes.) **Fee:** $550.00 **Benefit:** 75% = $412.50 85% = $467.50
45003	Single stage local myocutaneous flap repair to one defect, simple and small not in association with any of items 31356 to 31376 (Anaes.) **Fee:** $611.30 **Benefit:** 75% = $458.50 85% = $526.60 **Extended Medicare Safety Net Cap:** $489.05
45006	SINGLE STAGE LARGE MYOCUTANEOUS FLAP REPAIR to 1 defect, (pectoralis major, latissimus dorsi, or similar large muscle) (Anaes.) (Assist.) **Fee:** $1,054.25 **Benefit:** 75% = $790.70
45009	SINGLE STAGE LOCAL muscle flap repair to 1 defect, simple and small (Anaes.) (Assist.) **Fee:** $385.10 **Benefit:** 75% = $288.85
45012	SINGLE STAGE LARGE MUSCLE FLAP REPAIR to 1 defect, (pectoralis major, gastrocnemius, gracilis or similar large muscle) (Anaes.) (Assist.) **Fee:** $645.15 **Benefit:** 75% = $483.90
45015	MUSCLE OR MYOCUTANEOUS FLAP, delay of (Anaes.)

	Fee: $305.55 **Benefit:** 75% = $229.20
45018	Dermis, dermofat or fascia graft (excluding transfer of fat by injection), if the service is not associated with neurosurgical services for spinal disorders mentioned in any of items 51011 to 51171 (Anaes.) (Assist.) **Fee:** $481.25 **Benefit:** 75% = $360.95 85% = $409.10
45019	Full face chemical peel for severely sun-damaged skin, if: (a) the damage affects at least 75% of the facial skin surface area; and (b) the damage involves photo-damage (dermatoheliosis); and (c) the photo-damage involves: (i) a solar keratosis load exceeding 30 individual lesions; or (ii) solar lentigines; or (iii) freckling, yellowing or leathering of the skin; or (iv) solar kertoses which have proven refractory to, or recurred following, medical therapies; and (d) at least medium depth peeling agents are used; and (e) the chemical peel is performed in the operating theatre of a hospital by a medical practitioner recognised as a specialist in the specialty of dermatology or plastic surgery. Applicable once only in any 12 month period (Anaes.) **Fee:** $403.05 **Benefit:** 75% = $302.30
45021	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.) (See para TN.8.91 of explanatory notes to this Category) **Fee:** $180.20 **Benefit:** 75% = $135.15 85% = $153.20
45024	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.) (See para TN.8.91 of explanatory notes to this Category) **Fee:** $404.95 **Benefit:** 75% = $303.75 85% = $344.25
45025	CARBON DIOXIDE LASER OR ERBIUM LASER (not including fractional laser therapy) resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.) (See para TN.8.91 of explanatory notes to this Category) **Fee:** $180.20 **Benefit:** 75% = $135.15 85% = $153.20 **Extended Medicare Safety Net Cap:** $144.20
45026	CARBON DIOXIDE LASER OR ERBIUM LASER (not including fractional laser therapy) resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.) (See para TN.8.91 of explanatory notes to this Category) **Fee:** $404.95 **Benefit:** 75% = $303.75 85% = $344.25 **Extended Medicare Safety Net Cap:** $324.00

45027	ANGIOMA, cauterisation of or injection into, where undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $122.30 **Benefit:** 75% = $91.75 85% = $104.00
45030	ANGIOMA (haemangioma or lymphangioma or both) of skin and subcutaneous tissue (excluding facial muscle or breast) or mucous surface, small, excision and suture of (Anaes.) **Fee:** $131.30 **Benefit:** 75% = $98.50 85% = $111.65
45033	ANGIOMA, (haemangioma or lymphangioma or both), large or involving deeper tissue including facial muscle or breast, excision and suture of (Anaes.) **Fee:** $244.55 **Benefit:** 75% = $183.45 85% = $207.90
45035	ANGIOMA (haemangioma or lymphangioma or both), large and deep, involving muscles or nerves, excision of (Anaes.) (Assist.) **Fee:** $713.30 **Benefit:** 75% = $535.00
45036	ANGIOMA (haemangioma or lymphangioma or both) of neck, deep, excision of (Anaes.) (Assist.) **Fee:** $1,146.10 **Benefit:** 75% = $859.60
45039	ARTERIOVENOUS MALFORMATION (3 centimetres or less) of superficial tissue, excision of (Anaes.) **Fee:** $244.55 **Benefit:** 75% = $183.45 85% = $207.90
45042	ARTERIOVENOUS MALFORMATION, (greater than 3 centimetres), excision of (Anaes.) (Assist.) **Fee:** $313.35 **Benefit:** 75% = $235.05 85% = $266.35
45045	ARTERIOVENOUS MALFORMATION on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.) **Fee:** $313.35 **Benefit:** 75% = $235.05 85% = $266.35
45048	LYMPHOEDEMATOUS tissue or lymphangiectasis, of lower leg and foot, or thigh, or upper arm, or forearm and hand, major excision of (Anaes.) (Assist.) **Fee:** $786.95 **Benefit:** 75% = $590.25
45051	Contour reconstruction by open repair of contour defects, due to deformity, if: (a) contour reconstructive surgery is indicated because the deformity is secondary to congenital absence of tissue or has arisen from trauma (other than trauma from previous cosmetic surgery); and (b) insertion of a non-biological implant is required, other than one or more of the following: (i) insertion of a non-biological implant that is a component of another service specified in Group T8; (ii) injection of liquid or semisolid material; (iii) an oral and maxillofacial implant service to which item 52321 applies; (iv) a service to insert mesh; and (c) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.)

	Fee: $481.35 **Benefit:** 75% = $361.05
45054	LIMB OR CHEST, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (Anaes.) (Assist.) (See para TN.8.92 of explanatory notes to this Category) **Fee:** $250.05 **Benefit:** 75% = $187.55
45060	Developmental breast abnormality, single stage correction of, if: (a) the correction involves either: (i) bilateral mastopexy for symmetrical tubular breasts; or (ii) surgery on both breasts with a combination of insertion of one or more implants (which must have at least a 10% volume difference), mastopexy or reduction mammaplasty, if there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least 20% in normally shaped breasts, or 10% in tubular breasts or in breasts with abnormally high inframammary folds; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes Applicable only once per occasion on which the service is provided (Anaes.) (Assist.) **Fee:** $1,291.65 **Benefit:** 75% = $968.75
45061	Developmental breast abnormality, 2 stage correction of, first stage, involving surgery on both breasts with a combination of insertion of one or more tissue expanders, mastopexy or reduction mammaplasty, if: (a) there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least: (i) 20% in normally shaped breasts; or (ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes. Applicable only once per occasion on which the service is provided (Anaes.) (Assist.) **Fee:** $1,291.65 **Benefit:** 75% = $968.75
45062	Developmental breast abnormality, 2 stage correction of, second stage, involving surgery on both breasts with a combination of exchange of one or more tissue expanders for one or more implants (which must have at least a 10% volume difference), mastopexy or reduction mammaplasty, if: (a) there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least: (i) 20% in normally shaped breasts; or (ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes.

	Applicable only once per occasion on which the service is provided (Anaes.) (Assist.) **Fee:** $934.70 **Benefit:** 75% = $701.05
	SKIN FLAP SURGERY
45200	Single stage local flap, if indicated to repair one defect, simple and small, excluding flap for male pattern baldness and excluding H-flap or double advancement flap not in association with any of items 31356 to 31376 (Anaes.) (See para TN.8.93 of explanatory notes to this Category) **Fee:** $288.90 **Benefit:** 75% = $216.70 85% = $245.60 **Extended Medicare Safety Net Cap:** $231.15
45201	Muscle, myocutaneous or skin flap, where clinically indicated to repair one surgical excision made in the removal of a malignant or non-malignant skin lesion (only in association with items 31000, 31001, 31002, 31003, 31004, 31005, 31358, 31359, 31360, 31363, 31364, 31369, 31370, 31371, 31373 or 31376)-may be claimed only once per defect (Anaes.) (See para TN.8.93 of explanatory notes to this Category) **Fee:** $420.55 **Benefit:** 75% = $315.45 85% = $357.50
45202	Muscle, myocutaneous or skin flap, where clinically indicated to repair one surgical excision made in the removal of a malignant or non-malignant skin lesion in a patient, if the clinical relevance of the procedure is clearly annotated in the patient's record and either: (a) item 45201 applies and additional flap repair is required for the same defect; or (b) item 45201 does not apply and either: (i) the patient has severe pre-existing scarring, severe skin atrophy or sclerodermoid changes; or (ii) the repair is contiguous with a free margin (Anaes.) (See para TN.8.93, TN.8.126 of explanatory notes to this Category) **Fee:** $420.55 **Benefit:** 75% = $315.45 85% = $357.50
45203	Single stage local flap, if indicated to repair one defect, complicated or large, excluding flap for male pattern baldness and excluding H-flap or double advancement flap not in association with any of items 31356 to 31376 (Anaes.) (Assist.) (See para TN.8.93 of explanatory notes to this Category) **Fee:** $412.55 **Benefit:** 75% = $309.45 85% = $350.70 **Extended Medicare Safety Net Cap:** $330.05
45206	Single stage local flap if indicated to repair one defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals and excluding H-flap or double advancement flap not in association with any of items 31356 to 31376 (Anaes.) (See para TN.8.93 of explanatory notes to this Category) **Fee:** $389.70 **Benefit:** 75% = $292.30 85% = $331.25 **Extended Medicare Safety Net Cap:** $311.80
45207	H-flap or double advancement flap if indicated to repair one defect, on eyelid, eyebrow or forehead not in association with any of items 31356 to 31376 (Anaes.) **Fee:** $389.70 **Benefit:** 75% = $292.30 85% = $331.25
45209	DIRECT FLAP REPAIR (cross arm, abdominal or similar), first stage (Anaes.) (Assist.) **Fee:** $481.35 **Benefit:** 75% = $361.05 85% = $409.15

45212	DIRECT FLAP REPAIR (cross arm, abdominal or similar), second stage (Anaes.) **Fee:** $238.80 **Benefit:** 75% = $179.10 85% = $203.00
45215	DIRECT FLAP REPAIR, cross leg, first stage (Anaes.) (Assist.) **Fee:** $1,030.25 **Benefit:** 75% = $772.70
45218	DIRECT FLAP REPAIR, cross leg, second stage (Anaes.) (Assist.) **Fee:** $462.15 **Benefit:** 75% = $346.65
45221	DIRECT FLAP REPAIR, small (cross finger or similar), first stage (Anaes.) **Fee:** $265.75 **Benefit:** 75% = $199.35 85% = $225.90
45224	DIRECT FLAP REPAIR, small (cross finger or similar), second stage (Anaes.) **Fee:** $119.45 **Benefit:** 75% = $89.60 85% = $101.55
45227	INDIRECT FLAP OR TUBED PEDICLE, formation of (Anaes.) (Assist.) **Fee:** $452.55 **Benefit:** 75% = $339.45 85% = $384.70
45230	DIRECT OR INDIRECT FLAP OR TUBED PEDICLE, delay of (Anaes.) **Fee:** $226.30 **Benefit:** 75% = $169.75 85% = $192.40
45233	INDIRECT FLAP OR TUBED PEDICLE, preparation of intermediate or final site and attachment to the site (Anaes.) (Assist.) **Fee:** $481.35 **Benefit:** 75% = $361.05 85% = $409.15
45236	INDIRECT FLAP OR TUBED PEDICLE, spreading of pedicle, as a separate procedure (Anaes.) **Fee:** $377.45 **Benefit:** 75% = $283.10
45239	DIRECT, INDIRECT OR LOCAL FLAP, revision of, by incision and suture, not being a service to which item 45240 applies (Anaes.) **Fee:** $265.75 **Benefit:** 75% = $199.35 85% = $225.90
45240	DIRECT, INDIRECT OR LOCAL FLAP, revision of, by liposuction, not being a service to which item 45239, 45497, 45498 or 45499 applies (Anaes.) **Fee:** $265.75 **Benefit:** 75% = $199.35 85% = $225.90
	FREE GRAFTS
45400	FREE GRAFTING (split skin) of a granulating area, small (Anaes.) **Fee:** $208.00 **Benefit:** 75% = $156.00 85% = $176.80
45403	FREE GRAFTING (split skin) of a granulating area, extensive (Anaes.) (Assist.) **Fee:** $414.00 **Benefit:** 75% = $310.50 85% = $351.90
45406	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving not more than 3 per cent of total body surface (Anaes.) (Assist.) (See para TN.8.94 of explanatory notes to this Category) **Fee:** $458.30 **Benefit:** 75% = $343.75 85% = $389.60
45409	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 3 per cent or more

	but less than 6 per cent of total body surface (Anaes.) (Assist.) (See para TN.8.94 of explanatory notes to this Category) **Fee:** $611.30 **Benefit:** 75% = $458.50
45412	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 6 per cent or more but less than 9 per cent of total body surface (Anaes.) (Assist.) (See para TN.8.94 of explanatory notes to this Category) **Fee:** $840.55 **Benefit:** 75% = $630.45
45415	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 9 per cent or more but less than 12 per cent of total body surface (Anaes.) (Assist.) (See para TN.8.94 of explanatory notes to this Category) **Fee:** $916.75 **Benefit:** 75% = $687.60
45418	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 12 per cent or more but less than 15 per cent of total body surface (Anaes.) (Assist.) (See para TN.8.94 of explanatory notes to this Category) **Fee:** $993.20 **Benefit:** 75% = $744.90
45439	FREE GRAFTING (split skin) to 1 defect, including elective dissection, small (Anaes.) **Fee:** $288.90 **Benefit:** 75% = $216.70 85% = $245.60
45442	FREE GRAFTING (split skin) to 1 defect, including elective dissection, extensive (Anaes.) (Assist.) **Fee:** $595.90 **Benefit:** 75% = $446.95 85% = $511.20
45445	FREE GRAFTING (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of, and removal of mould) (Anaes.) (Assist.) **Fee:** $565.50 **Benefit:** 75% = $424.15 85% = $480.80
45448	FREE GRAFTING (split skin) to 1 defect, including elective dissection on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, not being a service to which item 45442 or 45445 applies (Anaes.) **Fee:** $382.00 **Benefit:** 75% = $286.50 85% = $324.70
45451	FREE GRAFTING (full thickness), to 1 defect, excluding grafts for male pattern baldness (Anaes.) (Assist.) **Fee:** $481.35 **Benefit:** 75% = $361.05 85% = $409.15
45460	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *15 percent or more but less than 20 percent* of total body surface - one surgeon (Anaes.) (Assist.) **Fee:** $1,273.35 **Benefit:** 75% = $955.05
45461	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *15 percent or more but less than 20 percent* of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $907.55 **Benefit:** 75% = $680.70
45462	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *15 percent or more but less than 20 percent* of total body surface - conjoint surgery, co- surgeon (Assist.) **Fee:** $684.85 **Benefit:** 75% = $513.65
45464	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *20 percent or*

	more but less than 30 percent of total body surface - one surgeon (Anaes.) (Assist.) **Fee:** $1,943.70 **Benefit:** 75% = $1457.80
45465	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *20 percent or more but less than 30 percent* of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $1,384.80 **Benefit:** 75% = $1038.60 85% = $1300.10
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.) **Fee:** $1,044.40 **Benefit:** 75% = $783.30 85% = $959.70
45468	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *30 percent or more but less than 40 percent* of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $1,861.95 **Benefit:** 75% = $1396.50
45469	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *30 percent or more but less than 40 percent* of total body surface - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,404.80 **Benefit:** 75% = $1053.60 85% = $1320.10
45471	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *40 percent or more but less than 50 percent* of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $2,340.50 **Benefit:** 75% = $1755.40 85% = $2255.80
45472	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *40 percent or more but less than 50 percent* of total body surface - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,765.40 **Benefit:** 75% = $1324.05 85% = $1680.70
45474	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *50 percent or more but less than 60 percent* of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $2,817.65 **Benefit:** 75% = $2113.25 85% = $2732.95
45475	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *50 percent or more but less than 60 percent* of total body surface - conjoint surgery, co-surgeon (Assist.) **Fee:** $2,125.95 **Benefit:** 75% = $1594.50 85% = $2041.25
45477	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *60 percent or more but less than 70 percent* of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $3,294.90 **Benefit:** 75% = $2471.20 85% = $3210.20
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.) **Fee:** $2,485.20 **Benefit:** 75% = $1863.90 85% = $2400.50
45480	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *70 percent or more but less than 80 percent* of total body surface - conjoint surgery, principal surgeon (Anaes.)

	(Assist.) **Fee:** $3,772.00 **Benefit:** 75% = $2829.00 85% = $3687.30
45481	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *70 percent or more but less than 80 percent* of total body surface - conjoint surgery, co-surgeon (Assist.) **Fee:** $2,845.90 **Benefit:** 75% = $2134.45 85% = $2761.20
45483	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *80 percent or more* of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $4,297.65 **Benefit:** 75% = $3223.25 85% = $4212.95
45484	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving *80 percent or more* of total body surface - conjoint surgery, co-surgeon (Assist.) **Fee:** $3,242.55 **Benefit:** 75% = $2431.95 85% = $3157.85
45485	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - upper eyelid, nose, lip, ear or palm of the hand (Anaes.) (Assist.) **Fee:** $536.15 **Benefit:** 75% = $402.15
45486	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - forehead, cheek, anterior aspect of the neck, chin, plantar aspect of the foot, heel or genitalia (Anaes.) (Assist.) **Fee:** $458.30 **Benefit:** 75% = $343.75
45487	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of toe (Anaes.) (Assist.) **Fee:** $412.55 **Benefit:** 75% = $309.45 85% = $350.70
45488	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 1 digit of the hand (Anaes.) (Assist.) **Fee:** $458.30 **Benefit:** 75% = $343.75
45489	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 2 digits of the hand (Anaes.) (Assist.) **Fee:** $687.65 **Benefit:** 75% = $515.75 85% = $602.95
45490	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 3 digits of the hand (Anaes.) (Assist.) **Fee:** $916.95 **Benefit:** 75% = $687.75
45491	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 4 digits of the hand (Anaes.) (Assist.) **Fee:** $1,146.10 **Benefit:** 75% = $859.60
45492	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 5 digits of the hand (Anaes.) (Assist.) **Fee:** $1,375.25 **Benefit:** 75% = $1031.45
45493	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - portion of digit of hand (Anaes.) (Assist.) **Fee:** $412.55 **Benefit:** 75% = $309.45

45494	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of face (excluding ears) (Anaes.) (Assist.) **Fee:** $1,664.90 **Benefit:** 75% = $1248.70 85% = $1580.20
	OTHER GRAFTS AND MISCELLANEOUS PROCEDURES
45496	FLAP, free tissue transfer using microvascular techniques - *revision of*, by open operation (Anaes.) **Fee:** $422.70 **Benefit:** 75% = $317.05
45497	FLAP, free tissue transfer using microvascular techniques, *or* any autogenous breast reconstruction - *complete revision of*, by liposuction (Anaes.) **Fee:** $330.15 **Benefit:** 75% = $247.65
45498	FLAP, free tissue transfer using microvascular techniques, *or* any autogenous breast reconstruction - *staged revision of*, by liposuction - first stage (Anaes.) **Fee:** $265.75 **Benefit:** 75% = $199.35
45499	FLAP, free tissue transfer using microvascular techniques, *or* any autogenous breast reconstruction - *staged revision of*, by liposuction - second stage (Anaes.) **Fee:** $198.10 **Benefit:** 75% = $148.60
45500	MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.) **Fee:** $1,107.80 **Benefit:** 75% = $830.85
45501	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.) **Fee:** $1,803.10 **Benefit:** 75% = $1352.35
45502	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.) **Fee:** $1,803.10 **Benefit:** 75% = $1352.35
45503	MICRO-ARTERIAL OR MICRO-VENOUS GRAFT using microsurgical techniques (Anaes.) (Assist.) **Fee:** $2,062.85 **Benefit:** 75% = $1547.15
45504	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.) **Fee:** $1,803.10 **Benefit:** 75% = $1352.35
45505	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.) **Fee:** $1,803.10 **Benefit:** 75% = $1352.35
45506	SCAR, of face or neck, not more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty (Anaes.) (See para TN.8.95 of explanatory notes to this Category) **Fee:** $223.45 **Benefit:** 75% = $167.60 85% = $189.95
45512	SCAR, of face or neck, more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty (Anaes.)

	(See para TN.8.95 of explanatory notes to this Category) **Fee:** $300.45 **Benefit:** 75% = $225.35 85% = $255.40
45515	SCAR, other than on face or neck, not more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or where performed by a specialist in the practice of his or her specialty (Anaes.) (See para TN.8.95 of explanatory notes to this Category) **Fee:** $189.50 **Benefit:** 75% = $142.15 85% = $161.10
45518	SCAR, other than on face or neck, more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her speciality (Anaes.) (See para TN.8.95 of explanatory notes to this Category) **Fee:** $229.30 **Benefit:** 75% = $172.00 85% = $194.95
45519	EXTENSIVE BURN SCARS OF SKIN (more than 1 percent of body surface area), excision of, for correction of scar contracture (Anaes.) (Assist.) **Fee:** $435.90 **Benefit:** 75% = $326.95
45520	Reduction mammaplasty (unilateral) with surgical repositioning of nipple, in the context of breast cancer or developmental abnormality of the breast (Anaes.) (Assist.) **Fee:** $914.85 **Benefit:** 75% = $686.15
45522	Reduction mammaplasty (unilateral) without surgical repositioning of the nipple: (a) excluding the treatment of gynaecomastia; and (b) not with insertion of any prosthesis (Anaes.) (Assist.) **Fee:** $641.85 **Benefit:** 75% = $481.40
45523	Reduction mammaplasty (bilateral) with surgical repositioning of the nipple: (a) for patients with macromastia and experiencing pain in the neck or shoulder region; and (b) not with insertion of any prosthesis (Anaes.) (Assist.) **Fee:** $1,372.30 **Benefit:** 75% = $1029.25
45524	Mammaplasty, augmentation (unilateral) in the context of: (a) breast cancer; or (b) developmental abnormality of the breast, if there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least: (i) 20% in normally shaped breasts; or (ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds. Applicable only once per occasion on which the service is provided (Anaes.) (Assist.) (See para TN.8.96 of explanatory notes to this Category) **Fee:** $753.50 **Benefit:** 75% = $565.15
45527	Breast reconstruction (unilateral), following mastectomy, using a permanent prosthesis (Anaes.) (Assist.)

	(See para TN.8.96 of explanatory notes to this Category) **Fee:** $753.50 **Benefit:** 75% = $565.15
45528	Mammaplasty, augmentation, bilateral (other than a service to which item 45527 applies), if: (a) reconstructive surgery is indicated because of: (i) developmental malformation of breast tissue (excluding hypomastia); or (ii) disease of or trauma to the breast (other than trauma resulting from previous elective cosmetic surgery); or (iii) amastia secondary to a congenital endocrine disorder; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.) (See para TN.8.96 of explanatory notes to this Category) **Fee:** $1,130.15 **Benefit:** 75% = $847.65
45530	Breast reconstruction (unilateral), using a latissimus dorsi or other large muscle or myocutaneous flap, including repair of secondary skin defect, if required, excluding repair of muscular aponeurotic layer, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177 or 30179 applies (H) (Anaes.) (Assist.) (See para TN.8.97 of explanatory notes to this Category) **Fee:** $1,117.00 **Benefit:** 75% = $837.75
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.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $1,265.00 **Benefit:** 75% = $948.75
45536	BREAST RECONSTRUCTION using breast sharing technique (second stage) including division of pedicle, insetting of breast flap, with closure of donor site or other similar procedure (Anaes.) (Assist.) **Fee:** $465.20 **Benefit:** 75% = $348.90
45539	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.) **Fee:** $1,088.35 **Benefit:** 75% = $816.30
45542	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - removal of tissue expansion unit and insertion of permanent prosthesis (Anaes.) (Assist.) **Fee:** $623.20 **Benefit:** 75% = $467.40
45545	NIPPLE OR AREOLA or both, reconstruction of, by any surgical technique (Anaes.) (Assist.) (See para TN.8.100 of explanatory notes to this Category) **Fee:** $632.50 **Benefit:** 75% = $474.40 85% = $547.80 **Extended Medicare Safety Net Cap:** $506.00
45546	NIPPLE OR AREOLA or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple

	(See para TN.8.100 of explanatory notes to this Category) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
45548	BREAST PROSTHESIS, removal of, as an independent procedure (Anaes.) **Fee:** $281.25 **Benefit:** 75% = $210.95 85% = $239.10
45551	Breast prosthesis, removal of, with excision of at least half of the fibrous capsule, not with insertion of any prosthesis. The excised specimen must be sent for histopathology and the volume removed must be documented in the histopathology report (Anaes.) (Assist.) **Fee:** $450.80 **Benefit:** 75% = $338.10
45553	Breast prosthesis, removal of and replacement with another prosthesis, following medical complications (for rupture, migration of prosthetic material or symptomatic capsular contracture), if: (a) either: (i) it is demonstrated by intra-operative photographs post-removal that removal alone would cause unacceptable deformity; or (ii) the original implant was inserted in the context of breast cancer or developmental abnormality; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.) (See para TN.8.98 of explanatory notes to this Category) **Fee:** $580.75 **Benefit:** 75% = $435.60
45554	Breast prosthesis, removal and replacement with another prosthesis, following medical complications (for rupture, migration of prosthetic material or symptomatic capsular contracture), including excision of at least half of the fibrous capsule or formation of a new pocket, or both, if: (a) either: (i) it is demonstrated by intra-operative photographs post-removal that removal alone would cause unacceptable deformity; or (ii) the original implant was inserted in the context of breast cancer or developmental abnormality; and (b) the excised specimen is sent for histopathology and the volume removed is documented in the histopathology report; and (c) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.) (See para TN.8.98 of explanatory notes to this Category) **Fee:** $710.65 **Benefit:** 75% = $533.00
45556	Breast ptosis, correction of (unilateral), in the context of breast cancer or developmental abnormality, if photographic evidence (including anterior, left lateral and right lateral views) and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes Applicable only once per occasion on which the service is provided (Anaes.) (Assist.) (See para TN.8.99 of explanatory notes to this Category) **Fee:** $778.30 **Benefit:** 75% = $583.75

45558	Breast ptosis, correction by mastopexy of (bilateral), if: (a) at least two-thirds of the breast tissue, including the nipple, lies inferior to the infra-mammary fold where the nipple is located at the most dependent, inferior part of the breast contour; and (b) if the patient has been pregnant—the correction is performed not less than 1 year, or more than 7 years, after completion of the most recent pregnancy of the patient; and (c) photographic evidence (including anterior, left lateral and right lateral views), with a marker at the level of the inframammary fold, demonstrating the clinical need for this service, is documented in the patient notes Applicable only once per lifetime (Anaes.) (Assist.) (See para TN.8.99 of explanatory notes to this Category) **Fee:** $1,167.35 **Benefit:** 75% = $875.55
45560	HAIR TRANSPLANTATION for the treatment of alopecia of congenital or traumatic origin or due to disease, excluding male pattern baldness, not being a service to which another item in this Group applies (Anaes.) **Fee:** $481.25 **Benefit:** 75% = $360.95 85% = $409.10 **Extended Medicare Safety Net Cap:** $168.45
45561	MICROVASCULAR ANASTOMOSIS of artery or vein using microsurgical techniques, for supercharging of pedicled flaps (Anaes.) (Assist.) **Fee:** $1,803.10 **Benefit:** 75% = $1352.35
45562	FREE TRANSFER OF TISSUE involving raising of tissue on vascular or neurovascular pedicle, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.) **Fee:** $1,117.00 **Benefit:** 75% = $837.75 85% = $1032.30
45563	NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.) **Fee:** $1,117.00 **Benefit:** 75% = $837.75 85% = $1032.30
45564	Free transfer of tissue reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 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, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies-conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $2,587.05 **Benefit:** 75% = $1940.30
45565	Free transfer of tissue reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 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, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies-conjoint surgery, conjoint specialist surgeon (H) (Assist.)

	(See para TN.8.8 of explanatory notes to this Category) **Fee:** $1,940.35 **Benefit:** 75% = $1455.30
45566	TISSUE EXPANSION not being a service to which item 45539 or 45542 applies - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.) **Fee:** $1,088.35 **Benefit:** 75% = $816.30
45568	TISSUE EXPANDER, removal of, with complete excision of fibrous capsule (Anaes.) (Assist.) **Fee:** $450.80 **Benefit:** 75% = $338.10
45569	CLOSURE OF ABDOMEN WITH RECONSTRUCTION OF UMBILICUS, with or without lipectomy, being a service associated with items 45562, 45564, 45565 or 45530 (Anaes.) (Assist.) **Fee:** $688.45 **Benefit:** 75% = $516.35
45570	CLOSURE OF ABDOMEN, repair of musculoaponeurotic layer, being a service associated with item 45569 (Anaes.) (Assist.) **Fee:** $929.60 **Benefit:** 75% = $697.20 85% = $844.90
45572	INTRA OPERATIVE TISSUE EXPANSION performed during an operation when combined with a service to which another item in Group T8 applies including expansion injections and excluding treatment of male pattern baldness (Anaes.) **Fee:** $296.35 **Benefit:** 75% = $222.30 85% = $251.90
45575	FACIAL NERVE PARALYSIS, free fascia graft for (Anaes.) (Assist.) **Fee:** $731.70 **Benefit:** 75% = $548.80 85% = $647.00
45578	FACIAL NERVE PARALYSIS, muscle transfer for (Anaes.) (Assist.) **Fee:** $847.40 **Benefit:** 75% = $635.55
45581	FACIAL NERVE PALSY, excision of tissue for (Anaes.) **Fee:** $281.25 **Benefit:** 75% = $210.95 85% = $239.10
45584	Liposuction (suction assisted lipolysis) to one regional area (one limb or trunk), for treatment of post traumatic pseudolipoma, if photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (See para TN.8.8, TN.8.101 of explanatory notes to this Category) **Fee:** $641.85 **Benefit:** 75% = $481.40
45585	Liposuction (suction assisted lipolysis) to one regional area (one limb or trunk), other than a service associated with a service to which item 31525 applies, if: (a) the liposuction is for: (i) the treatment of Barraquer-Simons syndrome, lymphoedema or macrodystrophia lipomatosa; or (ii) the reduction of a buffalo hump that is secondary to an endocrine disorder or pharmacological treatment of a medical condition; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (See para TN.8.8, TN.8.101 of explanatory notes to this Category) **Fee:** $641.85 **Benefit:** 75% = $481.40

45587	Meloplasty for correction of facial asymmetry if: (a) the asymmetry is secondary to trauma (including previous surgery), a congenital condition or a medical condition (such as facial nerve palsy); and (b) the meloplasty is limited to one side of the face (Anaes.) (Assist.) (See para TN.8.102 of explanatory notes to this Category) **Fee:** $905.10 **Benefit:** 75% = $678.85
45588	Meloplasty (excluding browlifts and chinlift platysmaplasties), bilateral, if: (a) surgery is indicated to correct a functional impairment due to a congenital condition, disease (excluding post-acne scarring) or trauma (other than trauma resulting from previous elective cosmetic surgery); and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.) (See para TN.8.102 of explanatory notes to this Category) **Fee:** $1,357.80 **Benefit:** 75% = $1018.35
45590	ORBITAL CAVITY, reconstruction of a wall or floor, with or without foreign implant (Anaes.) (Assist.) **Fee:** $491.00 **Benefit:** 75% = $368.25
45593	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.) **Fee:** $576.75 **Benefit:** 75% = $432.60
45596	MAXILLA, total resection of (Anaes.) (Assist.) **Fee:** $914.85 **Benefit:** 75% = $686.15
45597	MAXILLA, total resection of both maxillae (Anaes.) (Assist.) **Fee:** $1,224.70 **Benefit:** 75% = $918.55
45599	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.) **Fee:** $951.55 **Benefit:** 75% = $713.70 85% = $866.85
45602	MANDIBLE, including lower border, OR MAXILLA, sub-total resection of (Anaes.) (Assist.) **Fee:** $710.65 **Benefit:** 75% = $533.00
45605	MANDIBLE OR MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.) **Fee:** $597.00 **Benefit:** 75% = $447.75
45608	MANDIBLE, hemimandibular reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (Anaes.) (Assist.) **Fee:** $840.55 **Benefit:** 75% = $630.45
45611	MANDIBLE, condylectomy (Anaes.) (Assist.) **Fee:** $481.35 **Benefit:** 75% = $361.05
45614	EYELID, WHOLE THICKNESS RECONSTRUCTION OF other than by direct suture only (Anaes.) (Assist.)

	Fee: $597.00 **Benefit:** 75% = $447.75 85% = $512.30 **Extended Medicare Safety Net Cap:** $477.60
45617	Upper eyelid, reduction of, if: (a) the reduction is for any of the following: (i) skin redundancy that causes a visual field defect (confirmed by an optometrist or ophthalmologist) or intertriginous inflammation of the eyelid; (ii) herniation of orbital fat in exophthalmos; (iii) facial nerve palsy; (iv) post-traumatic scarring; (v) the restoration of symmetry of contralateral upper eyelid in respect of one of the conditions mentioned in subparagraphs (i) to (iv); and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (See para TN.8.103 of explanatory notes to this Category) **Fee:** $238.80 **Benefit:** 75% = $179.10 85% = $203.00 **Extended Medicare Safety Net Cap:** $191.05
45620	Lower eyelid, reduction of, if: (a) the reduction is for: (i) herniation of orbital fat in exophthalmos, facial nerve palsy or post-traumatic scarring; or (ii) the restoration of symmetry of the contralateral lower eyelid in respect of one of these conditions; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (See para TN.8.103 of explanatory notes to this Category) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60 **Extended Medicare Safety Net Cap:** $265.00
45623	Ptosis of upper eyelid (unilateral), correction of, by: (a) sutured elevation of the tarsal plate on the eyelid retractors (Muller's or levator muscle or levator aponeurosis); or (b) sutured suspension to the brow/frontalis muscle; Not applicable to a service for repair of mechanical ptosis to which item 45617 applies (Anaes.) (Assist.) **Fee:** $734.60 **Benefit:** 75% = $550.95 85% = $649.90 **Extended Medicare Safety Net Cap:** $587.70
45624	Ptosis of upper eyelid, correction of, by: (a) sutured elevation of the tarsal plate on the eyelid retractors (Muller's or levator muscle or levator aponeurosis); or

	(b) sutured suspension to the brow/frontalis muscle; if a previous ptosis surgery has been performed on that side (Anaes.) (Assist.) **Fee:** $952.40 **Benefit:** 75% = $714.30 85% = $867.70 **Extended Medicare Safety Net Cap:** $761.95
45625	PTOSIS of eyelid, correction of eyelid height by revision of levator sutures within one week of primary repair by levator resection or advancement, performed in the operating theatre of a hospital (Anaes.) **Fee:** $190.55 **Benefit:** 75% = $142.95
Amend 45626	Ectropion or entropion, not caused by trachoma, correction of (unilateral) (Anaes.) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60
New 45627 S	Ectropion or entropion, caused by trachoma, correction of (unilateral) (Anaes.) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60
45629	SYMBLEPHARON, grafting for (Anaes.) (Assist.) **Fee:** $481.35 **Benefit:** 75% = $361.05 85% = $409.15
45632	Rhinoplasty, partial, involving correction of lateral or alar cartilages, if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (See para TN.8.104 of explanatory notes to this Category) **Fee:** $520.15 **Benefit:** 75% = $390.15 85% = $442.15 **Extended Medicare Safety Net Cap:** $416.15
45635	Rhinoplasty, partial, involving correction of bony vault only, if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (See para TN.8.104 of explanatory notes to this Category) **Fee:** $597.00 **Benefit:** 75% = $447.75 85% = $512.30 **Extended Medicare Safety Net Cap:** $477.60
45641	Rhinoplasty, total, including correction of all bony and cartilaginous elements of the external nose, with or without autogenous cartilage or bone graft from a local site (nasal), if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or

	(ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (See para TN.8.104 of explanatory notes to this Category) **Fee:** $1,083.05 **Benefit:** 75% = $812.30
45644	Rhinoplasty, total, including correction of all bony and cartilaginous elements of the external nose involving autogenous bone or cartilage graft obtained from distant donor site, including obtaining of graft, if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.) (See para TN.8.104 of explanatory notes to this Category) **Fee:** $1,299.90 **Benefit:** 75% = $974.95
45645	CHOANAL ATRESIA, repair of by puncture and dilatation (Anaes.) **Fee:** $227.20 **Benefit:** 75% = $170.40
45646	CHOANAL ATRESIA - correction by open operation with bone removal (Anaes.) (Assist.) **Fee:** $914.85 **Benefit:** 75% = $686.15 85% = $830.15
45647	FACE, contour restoration of 1 region, using autogenous bone or cartilage graft (not being a service to which item 45644 applies) (Anaes.) (Assist.) (See para TN.8.105 of explanatory notes to this Category) **Fee:** $1,299.90 **Benefit:** 75% = $974.95
45650	Rhinoplasty, revision of, if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (See para TN.8.104 of explanatory notes to this Category) **Fee:** $150.15 **Benefit:** 75% = $112.65 85% = $127.65
45652	Rhinophyma of a moderate or severe degree, carbon dioxide laser or erbium laser excision - ablation of (Anaes.) **Fee:** $362.05 **Benefit:** 75% = $271.55 85% = $307.75 **Extended Medicare Safety Net Cap:** $289.65
45653	RHINOPHYMA, shaving of (Anaes.) **Fee:** $362.05 **Benefit:** 75% = $271.55 85% = $307.75

45656	COMPOSITE GRAFT (Chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes.) (Assist.) **Fee:** $510.30 **Benefit:** 75% = $382.75 85% = $433.80
45659	Correction of a congenital deformity of the ear if: (a) the patient is less than 18 years of age; and (b) the deformity is characterised by an absence of the antihelical fold and/or large scapha and/or large concha; and (c) photographic evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.) **Fee:** $529.60 **Benefit:** 75% = $397.20
45660	EXTERNAL EAR, COMPLEX TOTAL RECONSTRUCTION OF, using multiple costal cartilage grafts to form a framework, including the harvesting and sculpturing of the cartilage and its insertion, for congenital absence, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) - performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.) **Fee:** $2,924.80 **Benefit:** 75% = $2193.60
45661	EXTERNAL EAR, COMPLEX TOTAL RECONSTRUCTION OF, elevation of costal cartilage framework using cartilage previously stored in abdominal wall, including the use of local skin and fascia flaps and full thickness skin graft to cover cartilage (second stage) - performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.) **Fee:** $1,299.90 **Benefit:** 75% = $974.95
45662	CONGENITAL ATRESIA, reconstruction of external auditory canal (Anaes.) (Assist.) **Fee:** $712.50 **Benefit:** 75% = $534.40
45665	LIP, EYELID OR EAR, FULL THICKNESS WEDGE EXCISION OF, with repair by direct sutures (Anaes.) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60
45668	VERMILIONECTOMY, by surgical excision (Anaes.) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60
45669	Vermilionectomy for biopsy-confirmed cellular atypia, using carbon dioxide laser or erbium laser excision - ablation (Anaes.) (See para TN.8.106 of explanatory notes to this Category) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60
45671	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) **Fee:** $847.40 **Benefit:** 75% = $635.55 85% = $762.70
45674	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) **Fee:** $246.45 **Benefit:** 75% = $184.85 85% = $209.50
45675	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.) **Fee:** $491.00 **Benefit:** 75% = $368.25

45676	MACROSTOMIA, operation for (Anaes.) (Assist.) **Fee:** $584.50 **Benefit:** 75% = $438.40
45677	CLEFT LIP, unilateral primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) **Fee:** $550.00 **Benefit:** 75% = $412.50
45680	CLEFT LIP, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) **Fee:** $687.65 **Benefit:** 75% = $515.75
45683	CLEFT LIP, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) **Fee:** $763.90 **Benefit:** 75% = $572.95
45686	CLEFT LIP, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) **Fee:** $901.70 **Benefit:** 75% = $676.30
45689	CLEFT LIP, lip adhesion procedure, unilateral or bilateral (Anaes.) (Assist.) **Fee:** $265.95 **Benefit:** 75% = $199.50
45692	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.) **Fee:** $305.55 **Benefit:** 75% = $229.20 85% = $259.75
45695	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.) **Fee:** $496.55 **Benefit:** 75% = $372.45
45698	CLEFT LIP, primary columella lengthening procedure, bilateral (Anaes.) **Fee:** $466.10 **Benefit:** 75% = $349.60
45701	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) **Fee:** $840.55 **Benefit:** 75% = $630.45
45704	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) **Fee:** $305.55 **Benefit:** 75% = $229.20 85% = $259.75
45707	CLEFT PALATE, primary repair (Anaes.) (Assist.) **Fee:** $794.45 **Benefit:** 75% = $595.85
45710	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.) **Fee:** $496.55 **Benefit:** 75% = $372.45
45713	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.) **Fee:** $565.50 **Benefit:** 75% = $424.15
45714	ORO-NASAL FISTULA, plastic closure of, including services to which item 45200, 45203 or 45239 applies (Anaes.) (Assist.) **Fee:** $794.45 **Benefit:** 75% = $595.85

45716	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.) **Fee:** $794.45 **Benefit:** 75% = $595.85
45720	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and excluding services to which item 47933or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $982.25 **Benefit:** 75% = $736.70 85% = $897.55
45723	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $1,107.80 **Benefit:** 75% = $830.85
45726	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $1,251.75 **Benefit:** 75% = $938.85
45729	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $1,405.80 **Benefit:** 75% = $1054.35
45731	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $1,425.15 **Benefit:** 75% = $1068.90
45732	MANDIBLE OR MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $1,604.45 **Benefit:** 75% = $1203.35
45735	MANDIBLE AND MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $1,636.85 **Benefit:** 75% = $1227.65
45738	MANDIBLE AND MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)

	(See para TN.8.107 of explanatory notes to this Category) **Fee:** $1,841.40 **Benefit:** 75% = $1381.05
45741	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $1,800.65 **Benefit:** 75% = $1350.50
45744	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $2,024.60 **Benefit:** 75% = $1518.45
45747	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty (when performed) and transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $1,964.50 **Benefit:** 75% = $1473.40 85% = $1879.80
45752	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) (See para TN.8.107 of explanatory notes to this Category) **Fee:** $2,200.40 **Benefit:** 75% = $1650.30
45753	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III(Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) **Fee:** $2,213.45 **Benefit:** 75% = $1660.10 85% = $2128.75
45754	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) **Fee:** $2,653.40 **Benefit:** 75% = $1990.05
45755	TEMPOROMANDIBULAR PARTIAL OR TOTAL MENISCECTOMY (Anaes.) (Assist.) **Fee:** $373.65 **Benefit:** 75% = $280.25 85% = $317.65
45758	TEMPORO-MANDIBULAR JOINT, arthroplasty (Anaes.) (Assist.) **Fee:** $668.60 **Benefit:** 75% = $501.45
45761	GENIOPLASTY, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)

	(See para TN.8.108 of explanatory notes to this Category) **Fee:** $760.65 **Benefit:** 75% = $570.50
45767	HYPERTELORISM, correction of, intracranial (Anaes.) (Assist.) **Fee:** $2,551.85 **Benefit:** 75% = $1913.90 85% = $2467.15
45770	HYPERTELORISM, correction of, subcranial (Anaes.) (Assist.) **Fee:** $1,954.70 **Benefit:** 75% = $1466.05
45773	TREACHER COLLINS SYNDROME, PERIORBITAL CORRECTION OF, with rib and iliac bone grafts (Anaes.) (Assist.) **Fee:** $1,781.45 **Benefit:** 75% = $1336.10 85% = $1696.75
45776	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, intracranial (Anaes.) (Assist.) **Fee:** $1,781.45 **Benefit:** 75% = $1336.10
45779	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, extracranial (Anaes.) (Assist.) **Fee:** $1,309.80 **Benefit:** 75% = $982.35
45782	FRONTOORBITAL ADVANCEMENT, UNILATERAL (Anaes.) (Assist.) **Fee:** $1,001.45 **Benefit:** 75% = $751.10 85% = $916.75
45785	CRANIAL VAULT RECONSTRUCTION for oxycephaly, brachycephaly, turricephaly or similar condition (bilateral frontoorbital advancement) (Anaes.) (Assist.) **Fee:** $1,694.80 **Benefit:** 75% = $1271.10
45788	GLENOID FOSSA, ZYGOMATIC ARCH AND TEMPORAL BONE, RECONSTRUCTION OF, (Obwegeser technique) (Anaes.) (Assist.) **Fee:** $1,675.50 **Benefit:** 75% = $1256.65
45791	ABSENT CONDYLE AND ASCENDING RAMUS in hemifacial microsomia, CONSTRUCTION OF, not including harvesting of graft material (Anaes.) (Assist.) **Fee:** $905.10 **Benefit:** 75% = $678.85
45794	OSSEO-INTEGRATION PROCEDURE - extra-oral, implantation of titanium fixture, not for implantable bone conduction hearing system device (Anaes.) **Fee:** $511.90 **Benefit:** 75% = $383.95 85% = $435.15
45797	OSSEO-INTEGRATION PROCEDURE, fixation of transcutaneous abutment, not for implantable bone conduction hearing system device (Anaes.) **Fee:** $189.50 **Benefit:** 75% = $142.15 85% = $161.10
	ORAL AND MAXILLOFACIAL SURGERY
45799	ASPIRATION BIOPSY of 1 or MORE JAW CYSTS as an independent procedure to obtain material for diagnostic purposes and not being a service associated with an operative procedure on the same day (Anaes.) **Fee:** $29.90 **Benefit:** 75% = $22.45 85% = $25.45
45801	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an

	operation),in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 45803 applies (Anaes.) (See para TN.8.109 of explanatory notes to this Category) **Fee:** $128.95 **Benefit:** 75% = $96.75 85% = $109.65
45803	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes.) (Assist.) (See para TN.8.109 of explanatory notes to this Category) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60
45805	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.) (See para TN.8.109 of explanatory notes to this Category) **Fee:** $175.25 **Benefit:** 75% = $131.45 85% = $149.00
45807	TUMOUR, CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, removal of, not being a service to which another item in this Subgroup applies, involving muscle, bone, or other deep tissue (Anaes.) (See para TN.8.109 of explanatory notes to this Category) **Fee:** $250.45 **Benefit:** 75% = $187.85 85% = $212.90
45809	TUMOUR OR DEEP CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), in the oral and maxillofacial region, removal of, requiring wide excision, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) (See para TN.8.109 of explanatory notes to this Category) **Fee:** $377.45 **Benefit:** 75% = $283.10 85% = $320.85
45811	TUMOUR, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.) (See para TN.8.109 of explanatory notes to this Category) **Fee:** $510.30 **Benefit:** 75% = $382.75 85% = $433.80
45813	TUMOUR, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.) (See para TN.8.109 of explanatory notes to this Category) **Fee:** $597.00 **Benefit:** 75% = $447.75 85% = $512.30
45815	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.) (Assist.) **Fee:** $362.05 **Benefit:** 75% = $271.55 85% = $307.75
45817	OPERATION on SKULL for OSTEOMYELITIS (Anaes.) (Assist.) **Fee:** $471.95 **Benefit:** 75% = $354.00 85% = $401.20

45819	OPERATION ON ANY COMBINATION OF ADJOINING BONES IN THE ORAL AND MAXILLOFACIAL REGION, being bones referred to in item 45817 (Anaes.) (Assist.) **Fee:** $596.95 **Benefit:** 75% = $447.75 85% = $512.25
45821	BONE GROWTH STIMULATOR IN THE ORAL AND MAXILLOFACIAL REGION, insertion of (Anaes.) (Assist.) **Fee:** $386.90 **Benefit:** 75% = $290.20 85% = $328.90
45823	ARCH BARS, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia where undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $110.65 **Benefit:** 75% = $83.00
45825	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) **Fee:** $343.75 **Benefit:** 75% = $257.85 85% = $292.20
45827	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.) **Fee:** $328.55 **Benefit:** 75% = $246.45 85% = $279.30
45829	MAXILLARY TUBEROSITY, reduction of (Anaes.) **Fee:** $250.65 **Benefit:** 75% = $188.00 85% = $213.10
45831	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.) **Fee:** $328.55 **Benefit:** 75% = $246.45 85% = $279.30
45833	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.) **Fee:** $412.55 **Benefit:** 75% = $309.45 85% = $350.70
45835	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - more than 20 lesions (Anaes.) (Assist.) **Fee:** $511.90 **Benefit:** 75% = $383.95 85% = $435.15
45837	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.) **Fee:** $595.90 **Benefit:** 75% = $446.95 85% = $511.20
45839	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.) (Assist.) **Fee:** $595.90 **Benefit:** 75% = $446.95 85% = $511.20
45841	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.) **Fee:** $481.25 **Benefit:** 75% = $360.95 85% = $409.10
45843	ALVEOLAR RIDGE AUGMENTATION - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.) **Fee:** $295.15 **Benefit:** 75% = $221.40 85% = $250.90
45845	OSSEO-INTEGRATION PROCEDURE - intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) **Fee:** $511.90 **Benefit:** 75% = $383.95 85% = $435.15

45847	OSSEO-INTEGRATION PROCEDURE - fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) **Fee:** $189.50 **Benefit:** 75% = $142.15 85% = $161.10
45849	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.) **Fee:** $590.20 **Benefit:** 75% = $442.65 85% = $505.50
45851	TEMPOROMANDIBULAR JOINT, manipulation of, performed in the operating theatre of a hospital, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) **Fee:** $145.25 **Benefit:** 75% = $108.95
45853	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.) **Fee:** $905.10 **Benefit:** 75% = $678.85 85% = $820.40
45855	TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes.) (Assist.) **Fee:** $415.25 **Benefit:** 75% = $311.45 85% = $353.00
45857	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedure of that joint, not being a service associated with any other arthroscopic procedure of the temporomandibular joint (Anaes.) (Assist.) **Fee:** $664.25 **Benefit:** 75% = $498.20 85% = $579.55
45859	TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $334.85 **Benefit:** 75% = $251.15 85% = $284.65
45861	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $886.25 **Benefit:** 75% = $664.70 85% = $801.55
45863	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $982.45 **Benefit:** 75% = $736.85 85% = $897.75
45865	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.) **Fee:** $295.15 **Benefit:** 75% = $221.40 85% = $250.90
45867	TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $317.30 **Benefit:** 75% = $238.00 85% = $269.75
45869	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without meniscus or capsular surgery, including partial or total meniscectomy when performed, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,207.20 **Benefit:** 75% = $905.40 85% = $1122.50
45871	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar

	head surgery, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,359.85 **Benefit:** 75% = $1019.90 85% = $1275.15
45873	TEMPOROMANDIBULAR JOINT, surgery of, involving procedures to which items 45863, 45867, 45869 and 45871 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,528.10 **Benefit:** 75% = $1146.10 85% = $1443.40
45875	TEMPOROMANDIBULAR JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $478.25 **Benefit:** 75% = $358.70 85% = $406.55
45877	TEMPOROMANDIBULAR JOINT, arthrodesis of, with synovectomy if performed, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $478.25 **Benefit:** 75% = $358.70 85% = $406.55
45879	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) **Fee:** $317.30 **Benefit:** 75% = $238.00 85% = $269.75
45882	The treatment of a premalignant lesion of the oral mucosa by a treatment using cryotherapy, diathermy or carbon dioxide laser. **Fee:** $43.70 **Benefit:** 75% = $32.80 85% = $37.15
45885	Facial, mandibular or lingual artery or vein or artery and vein, ligation of, not being a service to which item 41707 applies (Anaes.) (Assist.) **Fee:** $450.80 **Benefit:** 75% = $338.10 85% = $383.20
45888	FOREIGN BODY, in the oral and maxillofacial region, deep, removal of using interventional imaging techniques (Anaes.) (Assist.) **Fee:** $420.15 **Benefit:** 75% = $315.15 85% = $357.15
45891	SINGLE-STAGE LOCAL FLAP where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.) **Fee:** $612.10 **Benefit:** 75% = $459.10 85% = $527.40
45894	FREE GRAFTING, in the oral and maxillofacial region, (mucosa or split skin) of a granulating area (Anaes.) **Fee:** $208.00 **Benefit:** 75% = $156.00 85% = $176.80
45897	ALVEOLAR CLEFT (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes.) (Assist.) **Fee:** $1,086.20 **Benefit:** 75% = $814.65 85% = $1001.50
45900	MANDIBLE, fixation by intermaxillary wiring, excluding wiring for obesity **Fee:** $245.00 **Benefit:** 75% = $183.75 85% = $208.25
45939	PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.)

	Fee: $454.25 **Benefit:** 75% = $340.70 85% = $386.15
45945	MANDIBLE, treatment of a dislocation of, requiring open reduction (Anaes.) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
45975	MAXILLA, unilateral or bilateral, treatment of fracture of, not requiring splinting (See para TN.8.110 of explanatory notes to this Category) **Fee:** $131.25 **Benefit:** 75% = $98.45 85% = $111.60
45978	MANDIBLE, treatment of fracture of, not requiring splinting (See para TN.8.110 of explanatory notes to this Category) **Fee:** $160.40 **Benefit:** 75% = $120.30 85% = $136.35
45981	ZYGOMATIC BONE, treatment of fracture of, not requiring surgical reduction (See para TN.8.110 of explanatory notes to this Category) **Fee:** $87.00 **Benefit:** 75% = $65.25 85% = $73.95
45984	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction not involving plate(s) (Anaes.) (Assist.) (See para TN.8.110 of explanatory notes to this Category) **Fee:** $626.50 **Benefit:** 75% = $469.90 85% = $541.80
45987	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.) (See para TN.8.110 of explanatory notes to this Category) **Fee:** $626.50 **Benefit:** 75% = $469.90 85% = $541.80
45990	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction involving the use of plate(s) (Anaes.) (Assist.) (See para TN.8.110 of explanatory notes to this Category) **Fee:** $855.75 **Benefit:** 75% = $641.85 85% = $771.05
45993	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.) (See para TN.8.110 of explanatory notes to this Category) **Fee:** $855.75 **Benefit:** 75% = $641.85 85% = $771.05
45996	MANDIBLE, treatment of a closed fracture of, involving a joint surface (Anaes.) (See para TN.8.110 of explanatory notes to this Category) **Fee:** $242.60 **Benefit:** 75% = $181.95 85% = $206.25

T8. SURGICAL OPERATIONS 14. HAND SURGERY

	Group T8. Surgical Operations
	Subgroup 14. Hand Surgery
46300	*Note: Items 46300 to 46534 are restricted to surgery on the hand/s.* INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrodesis of, with

	synovectomy if performed (Anaes.) (Assist.) **Fee:** $343.80 **Benefit:** 75% = $257.85
46303	CARPOMETACARPAL JOINT, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $382.10 **Benefit:** 75% = $286.60
46306	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, interposition arthroplasty of and including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.) **Fee:** $534.90 **Benefit:** 75% = $401.20
46307	INTERPHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT - volar plate arthroplasty for traumatic deformity including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.) **Fee:** $534.90 **Benefit:** 75% = $401.20
46309	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 1 joint (Anaes.) (Assist.) **Fee:** $534.90 **Benefit:** 75% = $401.20
46312	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 2 joints (Anaes.) (Assist.) **Fee:** $687.80 **Benefit:** 75% = $515.85
46315	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 3 joints (Anaes.) (Assist.) **Fee:** $917.00 **Benefit:** 75% = $687.75
46318	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 4 joints (Anaes.) (Assist.) **Fee:** $1,146.30 **Benefit:** 75% = $859.75
46321	INTERPHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 5 or more joints (Anaes.) (Assist.) **Fee:** $1,375.55 **Benefit:** 75% = $1031.70 85% = $1290.85
46324	CARPAL BONE REPLACEMENT ARTHROPLASTY including associated tendon transfer or realignment when performed (Anaes.) (Assist.) **Fee:** $820.25 **Benefit:** 75% = $615.20
46325	CARPAL BONE REPLACEMENT OR RESECTION ARTHROPLASTY using adjacent tendon or other soft tissue including associated tendon transfer or realignment when performed (Anaes.) (Assist.) **Fee:** $856.00 **Benefit:** 75% = $642.00
46327	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of (Anaes.) **Fee:** $206.40 **Benefit:** 75% = $154.80 85% = $175.45
46330	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous or capsular

	repair with or without arthrotomy (Anaes.) (Assist.) **Fee:** $351.65 **Benefit:** 75% = $263.75
46333	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous repair of, using free tissue graft or implant (Anaes.) (Assist.) **Fee:** $573.05 **Benefit:** 75% = $429.80
46336	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, synovectomy, capsulectomy or debridement of, not being a service associated with any procedure related to that joint (Anaes.) (Assist.) **Fee:** $267.50 **Benefit:** 75% = $200.65 85% = $227.40
46339	EXTENSOR TENDONS or FLEXOR TENDONS of hand or wrist, synovectomy of (Anaes.) (Assist.) **Fee:** $473.65 **Benefit:** 75% = $355.25 85% = $402.65
46342	DISTAL RADIOULNAR JOINT or CARPOMETACARPAL JOINT OR JOINTS, synovectomy of (Anaes.) (Assist.) **Fee:** $473.65 **Benefit:** 75% = $355.25
46345	DISTAL RADIOULNAR JOINT, reconstruction or stabilisation of, including fusion, or ligamentous arthroplasty and excision of distal ulna, when performed (Anaes.) (Assist.) **Fee:** $573.05 **Benefit:** 75% = $429.80
46348	DIGIT, synovectomy of flexor tendon or tendons - 1 digit (Anaes.) **Fee:** $248.35 **Benefit:** 75% = $186.30 85% = $211.10
46351	DIGIT, synovectomy of flexor tendon or tendons - 2 digits (Anaes.) (Assist.) **Fee:** $370.65 **Benefit:** 75% = $278.00
46354	DIGIT, synovectomy of flexor tendon or tendons - 3 digits (Anaes.) (Assist.) **Fee:** $496.65 **Benefit:** 75% = $372.50
46357	DIGIT, synovectomy of flexor tendon or tendons - 4 digits (Anaes.) (Assist.) **Fee:** $618.95 **Benefit:** 75% = $464.25
46360	DIGIT, synovectomy of flexor tendon or tendons - 5 digits (Anaes.) (Assist.) **Fee:** $745.10 **Benefit:** 75% = $558.85
46363	TENDON SHEATH OF HAND OR WRIST, open operation on, for STENOSING TENOVAGINITIS (Anaes.) **Fee:** $213.95 **Benefit:** 75% = $160.50 85% = $181.90
46366	DUPUYTREN'S CONTRACTURE, subcutaneous fasciotomy for - each hand (Anaes.) **Fee:** $129.95 **Benefit:** 75% = $97.50 85% = $110.50
46369	DUPUYTREN'S CONTRACTURE, palmar fasciectomy for - 1 hand (Anaes.) **Fee:** $213.95 **Benefit:** 75% = $160.50 85% = $181.90
46372	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - 1 hand

	(Anaes.) (Assist.) **Fee:** $434.80 **Benefit:** 75% = $326.10 85% = $369.60
46375	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - 1 hand (Anaes.) (Assist.) **Fee:** $515.80 **Benefit:** 75% = $386.85 85% = $438.45
46378	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves - 1 hand (Anaes.) (Assist.) **Fee:** $687.80 **Benefit:** 75% = $515.85
46381	INTER-PHALANGEAL JOINT, joint capsule release when performed in conjunction with operation for Dupuytren's Contracture - each procedure (Anaes.) (Assist.) **Fee:** $305.60 **Benefit:** 75% = $229.20
46384	Z PLASTY (or similar local flap procedure) when performed in conjunction with operation for Dupuytren's Contracture - 1 such procedure (Anaes.) (Assist.) **Fee:** $305.60 **Benefit:** 75% = $229.20
46387	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - operation for recurrence in that ray (Anaes.) (Assist.) **Fee:** $630.55 **Benefit:** 75% = $472.95 85% = $545.85
46390	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - operation for recurrence in those rays (Anaes.) (Assist.) **Fee:** $840.75 **Benefit:** 75% = $630.60
46393	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves - operation for recurrence in those rays (Anaes.) (Assist.) **Fee:** $974.35 **Benefit:** 75% = $730.80
46396	PHALANX OR METACARPAL OF THE HAND, osteotomy or osteectomy of, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $334.85 **Benefit:** 75% = $251.15 85% = $284.65
46399	PHALANX OR METACARPAL OF THE HAND, osteotomy of, with internal fixation (Anaes.) (Assist.) **Fee:** $526.10 **Benefit:** 75% = $394.60
46402	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), including obtaining of graft material (Anaes.) (Assist.) **Fee:** $526.10 **Benefit:** 75% = $394.60
46405	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), involving internal fixation and including obtaining of graft material (Anaes.) (Assist.) **Fee:** $642.00 **Benefit:** 75% = $481.50
46408	TENDON, reconstruction of, by tendon graft (Anaes.) (Assist.) **Fee:** $703.05 **Benefit:** 75% = $527.30

46411	FLEXOR TENDON PULLEY, reconstruction of, by graft (Anaes.) (Assist.) **Fee:** $412.65 **Benefit:** 75% = $309.50
46414	ARTIFICIAL TENDON PROSTHESIS, INSERTION OF, in preparation for tendon grafting (Anaes.) (Assist.) **Fee:** $534.80 **Benefit:** 75% = $401.10 85% = $454.60
46417	TENDON transfer for restoration of hand function, each transfer (Anaes.) (Assist.) **Fee:** $496.65 **Benefit:** 75% = $372.50
46420	EXTENSOR TENDON OF HAND OR WRIST, primary repair of, each tendon (Anaes.) **Fee:** $207.85 **Benefit:** 75% = $155.90 85% = $176.70
46423	EXTENSOR TENDON OF HAND OR WRIST, secondary repair of, each tendon (Anaes.) (Assist.) **Fee:** $332.40 **Benefit:** 75% = $249.30 85% = $282.55
46426	FLEXOR TENDON OF HAND OR WRIST, primary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $343.80 **Benefit:** 75% = $257.85
46429	FLEXOR TENDON OF HAND OR WRIST, secondary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $420.25 **Benefit:** 75% = $315.20 85% = $357.25
46432	FLEXOR TENDON OF HAND, primary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $458.55 **Benefit:** 75% = $343.95
46435	FLEXOR TENDON OF HAND, secondary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $534.90 **Benefit:** 75% = $401.20
46438	MALLET FINGER, closed pin fixation of (Anaes.) **Fee:** $137.60 **Benefit:** 75% = $103.20 85% = $117.00
46441	MALLET FINGER, open repair of, including pin fixation when performed (Anaes.) (Assist.) **Fee:** $332.40 **Benefit:** 75% = $249.30 85% = $282.55
46442	MALLET FINGER with intra articular fracture involving more than one third of base of terminal phalanx - open reduction (Anaes.) (Assist.) **Fee:** $285.35 **Benefit:** 75% = $214.05
46444	BOUTONNIERE DEFORMITY without joint contracture, reconstruction of (Anaes.) (Assist.) **Fee:** $496.65 **Benefit:** 75% = $372.50
46447	BOUTONNIERE DEFORMITY with joint contracture, reconstruction of (Anaes.) (Assist.) **Fee:** $618.95 **Benefit:** 75% = $464.25
46450	EXTENSOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) **Fee:** $229.30 **Benefit:** 75% = $172.00

46453	FLEXOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) (Assist.) **Fee:** $382.10 **Benefit:** 75% = $286.60
46456	FINGER, percutaneous tenotomy of (Anaes.) **Fee:** $99.35 **Benefit:** 75% = $74.55 85% = $84.45
46459	OPERATION for OSTEOMYELITIS on distal phalanx (Anaes.) **Fee:** $191.05 **Benefit:** 75% = $143.30 85% = $162.40
46462	OPERATION for OSTEOMYELITIS on middle or proximal phalanx, metacarpal or carpus (Anaes.) (Assist.) **Fee:** $305.60 **Benefit:** 75% = $229.20 85% = $259.80
46464	AMPUTATION of a supernumerary complete digit (Anaes.) **Fee:** $229.30 **Benefit:** 75% = $172.00 85% = $194.95
46465	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) **Fee:** $229.30 **Benefit:** 75% = $172.00 85% = $194.95
46468	AMPUTATION of 2 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $401.20 **Benefit:** 75% = $300.90
46471	AMPUTATION of 3 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $573.05 **Benefit:** 75% = $429.80 85% = $488.35
46474	AMPUTATION of 4 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $745.10 **Benefit:** 75% = $558.85
46477	AMPUTATION of 5 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $917.00 **Benefit:** 75% = $687.75
46480	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover, including metacarpal (Anaes.) (Assist.) **Fee:** $382.10 **Benefit:** 75% = $286.60 85% = $324.80
46483	REVISION of AMPUTATION STUMP to provide adequate soft tissue cover (Anaes.) (Assist.) **Fee:** $305.60 **Benefit:** 75% = $229.20 85% = $259.80
46486	NAIL BED, accurate reconstruction of nail bed laceration using magnification, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $229.30 **Benefit:** 75% = $172.00
46489	NAIL BED, secondary exploration and accurate repair of nail bed deformity using magnification, undertaken in the operating theatre of a hospital (Anaes.) (Assist.) **Fee:** $267.50 **Benefit:** 75% = $200.65

46492	CONTRACTURE OF DIGITS OF HAND, flexor or extensor, correction of, involving tissues deeper than skin and subcutaneous tissue (Anaes.) (Assist.) **Fee:** $366.85 **Benefit:** 75% = $275.15
46494	GANGLION OF HAND, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $223.45 **Benefit:** 75% = $167.60 85% = $189.95
46495	GANGLION OR MUCOUS CYST OF DISTAL DIGIT, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) **Fee:** $206.40 **Benefit:** 75% = $154.80 85% = $175.45
46498	GANGLION OF FLEXOR TENDON SHEATH, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) **Fee:** $223.45 **Benefit:** 75% = $167.60 85% = $189.95
46500	GANGLION OF DORSAL WRIST JOINT, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.) **Fee:** $267.50 **Benefit:** 75% = $200.65 85% = $227.40
46501	GANGLION OF VOLAR WRIST JOINT, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.) **Fee:** $334.45 **Benefit:** 75% = $250.85 85% = $284.30
46502	RECURRENT GANGLION OF DORSAL WRIST JOINT, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.) **Fee:** $307.80 **Benefit:** 75% = $230.85 85% = $261.65
46503	RECURRENT GANGLION OF VOLAR WRIST JOINT, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.) **Fee:** $384.45 **Benefit:** 75% = $288.35 85% = $326.80
46504	NEUROVASCULAR ISLAND FLAP, for pulp innervation (Anaes.) (Assist.) **Fee:** $1,123.25 **Benefit:** 75% = $842.45 85% = $1038.55
46507	DIGIT OR RAY, transposition or transfer of, on vascular pedicle, complete procedure (Anaes.) (Assist.) **Fee:** $1,306.80 **Benefit:** 75% = $980.10
46510	MACRODACTYLY, surgical reduction of enlarged elements - each digit (Anaes.) (Assist.) **Fee:** $356.60 **Benefit:** 75% = $267.45
46513	DIGITAL NAIL OF FINGER OR THUMB, removal of, not being a service to which item 46516 applies (Anaes.) **Fee:** $57.40 **Benefit:** 75% = $43.05 85% = $48.80
46516	DIGITAL NAIL OF FINGER OR THUMB, removal of, in the operating theatre of a hospital (Anaes.) **Fee:** $114.65 **Benefit:** 75% = $86.00
46519	MIDDLE PALMAR, THENAR OR HYPOTHENAR SPACES OF HAND, drainage of (excluding aftercare) (Anaes.)

T8. SURGICAL OPERATIONS	14. HAND SURGERY
	Fee: $143.50 **Benefit:** 75% = $107.65 85% = $122.00
46522	FLEXOR TENDON SHEATH OF FINGER OR THUMB, open operation and drainage for infection (Anaes.) (Assist.) **Fee:** $427.95 **Benefit:** 75% = $321.00
46525	PULP SPACE INFECTION, PARONYCHIA OF HAND, incision for, when performed in an operating theatre of a hospital, not being a service to which another item in this Group applies (excluding after-care) (Anaes.) **Fee:** $57.40 **Benefit:** 75% = $43.05 85% = $48.80
46528	INGROWING NAIL OF FINGER OR THUMB, wedge resection for, including removal of segment of nail, ungual fold and portion of the nail bed (Anaes.) **Fee:** $172.20 **Benefit:** 75% = $129.15 85% = $146.40
46531	INGROWING NAIL OF FINGER OR THUMB, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.) **Fee:** $86.50 **Benefit:** 75% = $64.90 85% = $73.55
46534	NAIL PLATE INJURY OR DEFORMITY, radical excision of nail germinal matrix (Anaes.) **Fee:** $239.25 **Benefit:** 75% = $179.45 85% = $203.40

T8. SURGICAL OPERATIONS	15. ORTHOPAEDIC
	Group T8. Surgical Operations
	Subgroup 15. Orthopaedic
	TREATMENT OF DISLOCATIONS
47000	MANDIBLE, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $71.80 **Benefit:** 75% = $53.85 85% = $61.05
47003	CLAVICLE, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $86.15 **Benefit:** 75% = $64.65 85% = $73.25
47006	CLAVICLE, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $172.95 **Benefit:** 75% = $129.75 85% = $147.05
47009	SHOULDER, treatment of dislocation of, requiring general anaesthesia, not being a service to which item 47012 applies (Anaes.) **Fee:** $172.20 **Benefit:** 75% = $129.15 85% = $146.40
47012	SHOULDER, treatment of dislocation of, requiring general anaesthesia, open reduction (Anaes.) (Assist.) **Fee:** $344.25 **Benefit:** 75% = $258.20
47015	SHOULDER, treatment of dislocation of, not requiring general anaesthesia **Fee:** $86.15 **Benefit:** 75% = $64.65 85% = $73.25
47018	ELBOW, treatment of dislocation of, by closed reduction (Anaes.)

	Fee: $200.75 **Benefit:** 75% = $150.60 85% = $170.65
47021	ELBOW, treatment of dislocation of, by open reduction (Anaes.) (Assist.) **Fee:** $267.80 **Benefit:** 75% = $200.85
47024	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by closed reduction, not being a service associated with fracture or dislocation in the same region (Anaes.) **Fee:** $200.75 **Benefit:** 75% = $150.60 85% = $170.65
47027	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by open reduction, not being a service associated with fracture or dislocation in the same region (Anaes.) (Assist.) **Fee:** $267.80 **Benefit:** 75% = $200.85
47030	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $200.75 **Benefit:** 75% = $150.60 85% = $170.65
47033	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by open reduction (Anaes.) (Assist.) **Fee:** $267.80 **Benefit:** 75% = $200.85 85% = $227.65
47036	INTERPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $86.15 **Benefit:** 75% = $64.65 85% = $73.25
47039	INTERPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $114.65 **Benefit:** 75% = $86.00 85% = $97.50
47042	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $114.65 **Benefit:** 75% = $86.00 85% = $97.50
47045	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $153.15 **Benefit:** 75% = $114.90 85% = $130.20
47048	HIP, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $330.00 **Benefit:** 75% = $247.50 85% = $280.50
47051	HIP, treatment of dislocation of, by open reduction (Anaes.) (Assist.) **Fee:** $439.90 **Benefit:** 75% = $329.95
47054	KNEE, treatment of dislocation of, by closed reduction (Anaes.) (Assist.) **Fee:** $330.00 **Benefit:** 75% = $247.50 85% = $280.50
47057	PATELLA, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $129.05 **Benefit:** 75% = $96.80 85% = $109.70
47060	PATELLA, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $172.20 **Benefit:** 75% = $129.15 85% = $146.40
47063	ANKLE or TARSUS, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $258.25 **Benefit:** 75% = $193.70 85% = $219.55

47066	ANKLE or TARSUS, treatment of dislocation of, by open reduction (Anaes.) (Assist.) **Fee:** $344.25 **Benefit:** 75% = $258.20
47069	TOE, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $71.80 **Benefit:** 75% = $53.85 85% = $61.05
47072	TOE, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $95.50 **Benefit:** 75% = $71.65 85% = $81.20
	TREATMENT OF FRACTURES
47301	Phalanx, middle or proximal, treatment of fracture of, by closed reduction, requiring anaesthesia, not provided on the same occasion as a service described in item 47304, 47307, 47310, 47313, 47316 or 47319 (Anaes.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $88.20 **Benefit:** 75% = $66.15 85% = $75.00
47304	Metacarpal, treatment of fracture of, by closed reduction, requiring anaesthesia, not provided on the same occasion as a service described in item 47301, 47307, 47310, 47313, 47316 or 47319 (Anaes.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $100.50 **Benefit:** 75% = $75.40
47307	Phalanx or metacarpal, treatment of fracture of, by closed reduction with percutaneous K wire fixation (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $203.20 **Benefit:** 75% = $152.40
47310	Phalanx or metacarpal, treatment of fracture of, by open reduction with fixation (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $335.30 **Benefit:** 75% = $251.50
47313	Phalanx or metacarpal, treatment of intra articular fracture of, by closed reduction with percutaneous K wire fixation (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $325.10 **Benefit:** 75% = $243.85
47316	Phalanx or metacarpal, treatment of intra articular fracture of, by open reduction with fixation, not provided on the same occasion as a service to which item 47319 applies (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $645.15 **Benefit:** 75% = $483.90
47319	Middle phalanx, proximal end, treatment of intra articular fracture of, by open reduction with fixation, not provided on the same occasion as a service to which item 47316 applies (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $660.40 **Benefit:** 75% = $495.30
47348	CARPUS (excluding scaphoid), treatment of fracture of, not being a service to which item 47351 applies (Anaes.) **Fee:** $95.50 **Benefit:** 75% = $71.65 85% = $81.20
47351	CARPUS (excluding scaphoid), treatment of fracture of, by open reduction (Anaes.) **Fee:** $239.25 **Benefit:** 75% = $179.45 85% = $203.40

47354	CARPAL SCAPHOID, treatment of fracture of, not being a service to which item 47357 applies (Anaes.) **Fee:** $172.20 **Benefit:** 75% = $129.15 85% = $146.40
47357	CARPAL SCAPHOID, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $382.55 **Benefit:** 75% = $286.95 85% = $325.20
47361	Radius or ulna, or radius and ulna, distal end of, treatment of fracture of, by cast immobilisation, other than a service associated with a service to which item 47362, 47364, 47367, 47370 or 47373 applies (See para TN.8.124 of explanatory notes to this Category) **Fee:** $133.95 **Benefit:** 75% = $100.50 85% = $113.90
47362	Radius or ulna, or radius and ulna, distal end of, treatment of fracture of, by closed reduction, requiring general or major regional anaesthesia, but excluding local infiltration, other than a service associated with a service to which item 47361, 47364, 47367, 47370 or 47373 applies (Anaes.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $200.75 **Benefit:** 75% = $150.60 85% = $170.65
47364	Radius or ulna, distal end of, not involving joint surface, treatment of fracture of, by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $284.50 **Benefit:** 75% = $213.40
47367	Radius, distal end of, treatment of fracture of, by closed reduction with percutaneous fixation, other than a service associated with a service to which item 47361 or 47362 applies (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $227.20 **Benefit:** 75% = $170.40
47370	Radius, distal end of, treatment of intra articular fracture of, by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $412.50 **Benefit:** 75% = $309.40
47373	Ulna, distal end of, treatment of intra articular fracture of, by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (Anaes.) (Assist.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $294.65 **Benefit:** 75% = $221.00
47378	RADIUS OR ULNA, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47381, 47384, 47385 or 47386 applies (Anaes.) **Fee:** $172.20 **Benefit:** 75% = $129.15 85% = $146.40
47381	RADIUS OR ULNA, shaft of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $258.25 **Benefit:** 75% = $193.70
47384	RADIUS OR ULNA, shaft of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $344.25 **Benefit:** 75% = $258.20
47385	RADIUS OR ULNA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction

	undertaken in the operating theatre of a hospital (Anaes.) (Assist.) **Fee:** $296.40 **Benefit:** 75% = $222.30
47386	RADIUS OR ULNA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by open reduction or internal fixation (Anaes.) (Assist.) **Fee:** $478.25 **Benefit:** 75% = $358.70
47387	RADIUS AND ULNA, shafts of, treatment of fracture of, by cast immobilisation, not being a service to which item 47390 or 47393 applies (Anaes.) (Assist.) **Fee:** $277.30 **Benefit:** 75% = $208.00 85% = $235.75
47390	RADIUS AND ULNA, shafts of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $416.10 **Benefit:** 75% = $312.10
47393	RADIUS AND ULNA, shafts of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $554.75 **Benefit:** 75% = $416.10
47396	OLECRANON, treatment of fracture of, not being a service to which item 47399 applies (Anaes.) **Fee:** $191.20 **Benefit:** 75% = $143.40 85% = $162.55
47399	OLECRANON, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $382.55 **Benefit:** 75% = $286.95
47402	OLECRANON, treatment of fracture of, involving excision of olecranon fragment and reimplantation of tendon (Anaes.) (Assist.) **Fee:** $286.85 **Benefit:** 75% = $215.15 85% = $243.85
47405	RADIUS, treatment of fracture of head or neck of, closed reduction of (Anaes.) **Fee:** $191.20 **Benefit:** 75% = $143.40 85% = $162.55
47408	RADIUS, treatment of fracture of head or neck of, open reduction of, including internal fixation and excision where performed (Anaes.) (Assist.) **Fee:** $382.55 **Benefit:** 75% = $286.95
47411	HUMERUS, treatment of fracture of tuberosity of, not being a service to which item 47417 applies (Anaes.) **Fee:** $114.65 **Benefit:** 75% = $86.00 85% = $97.50
47414	HUMERUS, treatment of fracture of tuberosity of, by open reduction (Anaes.) **Fee:** $229.60 **Benefit:** 75% = $172.20 85% = $195.20
47417	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) **Fee:** $267.80 **Benefit:** 75% = $200.85 85% = $227.65
47420	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) **Fee:** $526.10 **Benefit:** 75% = $394.60

47423	HUMERUS, proximal, treatment of fracture of, not being a service to which item 47426, 47429 or 47432 applies (Anaes.) **Fee:** $219.95 **Benefit:** 75% = $165.00 85% = $187.00
47426	HUMERUS, proximal, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $330.00 **Benefit:** 75% = $247.50
47429	HUMERUS, proximal, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $439.90 **Benefit:** 75% = $329.95
47432	HUMERUS, proximal, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $549.95 **Benefit:** 75% = $412.50
47435	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) **Fee:** $420.90 **Benefit:** 75% = $315.70 85% = $357.80
47438	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) **Fee:** $669.70 **Benefit:** 75% = $502.30
47441	HUMERUS, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) **Fee:** $836.95 **Benefit:** 75% = $627.75
47444	HUMERUS, shaft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies (Anaes.) **Fee:** $229.60 **Benefit:** 75% = $172.20 85% = $195.20
47447	HUMERUS, shaft of, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $344.25 **Benefit:** 75% = $258.20
47450	HUMERUS, shaft of, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.) **Fee:** $459.20 **Benefit:** 75% = $344.40
47451	HUMERUS, shaft of, treatment of fracture of, by intramedullary fixation (Anaes.) (Assist.) **Fee:** $553.50 **Benefit:** 75% = $415.15
47453	HUMERUS, distal, (supracondylar or condylar), treatment of fracture of, not being a service to which item 47456 or 47459 applies (Anaes.) (Assist.) **Fee:** $267.80 **Benefit:** 75% = $200.85 85% = $227.65
47456	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $401.85 **Benefit:** 75% = $301.40
47459	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by open reduction, undertaken in the operating theatre of a hospital (Anaes.) (Assist.)

	Fee: $535.70 **Benefit:** 75% = $401.80
47462	CLAVICLE, treatment of fracture of, not being a service to which item 47465 applies (Anaes.) **Fee:** $114.65 **Benefit:** 75% = $86.00 85% = $97.50
47465	CLAVICLE, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $229.60 **Benefit:** 75% = $172.20 85% = $195.20
47466	STERNUM, treatment of fracture of, not being a service to which item 47467 applies (Anaes.) **Fee:** $114.65 **Benefit:** 75% = $86.00 85% = $97.50
47467	STERNUM, treatment of fracture of, by open reduction (Anaes.) **Fee:** $229.60 **Benefit:** 75% = $172.20
47468	SCAPULA, neck or glenoid region of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $439.90 **Benefit:** 75% = $329.95 85% = $373.95
47471	RIBS (1 or more), treatment of fracture of - each attendance **Fee:** $43.70 **Benefit:** 75% = $32.80 85% = $37.15
47474	PELVIC RING, treatment of fracture of, not involving disruption of pelvic ring or acetabulum **Fee:** $191.20 **Benefit:** 75% = $143.40 85% = $162.55
47477	PELVIC RING, treatment of fracture of, with disruption of pelvic ring or acetabulum **Fee:** $239.25 **Benefit:** 75% = $179.45 85% = $203.40
47480	PELVIC RING, treatment of fracture of, requiring traction (Anaes.) (Assist.) **Fee:** $478.25 **Benefit:** 75% = $358.70
47483	PELVIC RING, treatment of fracture of, requiring control by external fixation (Anaes.) (Assist.) **Fee:** $573.90 **Benefit:** 75% = $430.45
47486	PELVIC RING, treatment of fracture of, by open reduction and involving internal fixation of anterior segment, including diastasis of pubic symphysis (Anaes.) (Assist.) **Fee:** $956.50 **Benefit:** 75% = $717.40
47489	PELVIC RING, treatment of fracture of, by open reduction and involving internal fixation of posterior segment (including sacro-iliac joint), with or without fixation of anterior segment (Anaes.) (Assist.) **Fee:** $1,434.80 **Benefit:** 75% = $1076.10
47492	ACETABULUM, treatment of fracture of, and associated dislocation of hip (Anaes.) **Fee:** $239.25 **Benefit:** 75% = $179.45 85% = $203.40
47495	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring traction (Anaes.) (Assist.) **Fee:** $478.25 **Benefit:** 75% = $358.70 85% = $406.55
47498	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring internal fixation, with or without traction (Anaes.) (Assist.) **Fee:** $717.35 **Benefit:** 75% = $538.05

47501	ACETABULUM, treatment of single column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $956.50 **Benefit:** 75% = $717.40
47504	ACETABULUM, treatment of T-shape fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $1,434.80 **Benefit:** 75% = $1076.10 85% = $1350.10
47507	ACETABULUM, treatment of transverse fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $1,434.80 **Benefit:** 75% = $1076.10
47510	ACETABULUM, treatment of double column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $1,434.80 **Benefit:** 75% = $1076.10
47513	SACRO-ILIAC JOINT DISRUPTION, treatment of, requiring internal fixation, being a service associated with a service to which items 47501 to 47510 apply (Anaes.) (Assist.) **Fee:** $382.55 **Benefit:** 75% = $286.95
47516	FEMUR, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.) **Fee:** $439.90 **Benefit:** 75% = $329.95 85% = $373.95
47519	FEMUR, treatment of trochanteric or subcapital fracture of, by internal fixation (Anaes.) (Assist.) **Fee:** $880.05 **Benefit:** 75% = $660.05
47522	FEMUR, treatment of subcapital fracture of, by hemi-arthroplasty (Anaes.) (Assist.) **Fee:** $765.30 **Benefit:** 75% = $574.00
47525	FEMUR, treatment of fracture of, for slipped capital femoral epiphysis (Anaes.) (Assist.) **Fee:** $880.05 **Benefit:** 75% = $660.05
47528	FEMUR, treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.) **Fee:** $765.30 **Benefit:** 75% = $574.00
47531	FEMUR, treatment of fracture of shaft, by intramedullary fixation and cross fixation (Anaes.) (Assist.) **Fee:** $975.60 **Benefit:** 75% = $731.70
47534	FEMUR, condylar region of, treatment of intra-articular (T-shaped condylar) fracture of, requiring internal fixation, with or without internal fixation of 1 or more osteochondral fragments (Anaes.) (Assist.) **Fee:** $1,100.00 **Benefit:** 75% = $825.00
47537	FEMUR, condylar region of, treatment of fracture of, requiring internal fixation of 1 or more osteochondral fragments, not being a service associated with a service to which item 47534 applies (Anaes.) (Assist.)

	Fee: $439.90 **Benefit:** 75% = $329.95 85% = $373.95
47540	HIP SPICA OR SHOULDER SPICA, application of, as an independent procedure (Anaes.) **Fee:** $219.95 **Benefit:** 75% = $165.00 85% = $187.00
47543	TIBIA, plateau of, treatment of medial or lateral fracture of, not being a service to which item 47546 or 47549 applies (Anaes.) **Fee:** $229.60 **Benefit:** 75% = $172.20 85% = $195.20
47546	TIBIA, plateau of, treatment of medial or lateral fracture of, by closed reduction (Anaes.) **Fee:** $344.25 **Benefit:** 75% = $258.20 85% = $292.65
47549	TIBIA, plateau of, treatment of medial or lateral fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $459.20 **Benefit:** 75% = $344.40
47552	TIBIA, plateau of, treatment of both medial and lateral fractures of, not being a service to which item 47555 or 47558 applies (Anaes.) (Assist.) **Fee:** $382.55 **Benefit:** 75% = $286.95 85% = $325.20
47555	TIBIA, plateau of, treatment of both medial and lateral fractures of, by closed reduction (Anaes.) **Fee:** $573.90 **Benefit:** 75% = $430.45
47558	TIBIA, plateau of, treatment of both medial and lateral fractures of, by open reduction (Anaes.) (Assist.) **Fee:** $765.30 **Benefit:** 75% = $574.00
47561	TIBIA, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47564, 47567, 47570 or 47573 applies (Anaes.) **Fee:** $277.30 **Benefit:** 75% = $208.00 85% = $235.75
47564	TIBIA, shaft of, treatment of fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) **Fee:** $416.10 **Benefit:** 75% = $312.10 85% = $353.70
47565	TIBIA, shaft of, treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.) **Fee:** $723.80 **Benefit:** 75% = $542.85
47566	TIBIA, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (Anaes.) (Assist.) **Fee:** $922.60 **Benefit:** 75% = $691.95
47567	TIBIA, shaft of, treatment of intra-articular fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) (Assist.) **Fee:** $482.95 **Benefit:** 75% = $362.25 85% = $410.55
47570	TIBIA, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (Anaes.) (Assist.) **Fee:** $554.75 **Benefit:** 75% = $416.10 85% = $471.55
47573	TIBIA, shaft of, treatment of intra-articular fracture of, by open reduction, with or without treatment of fibula fracture (Anaes.) (Assist.) **Fee:** $693.45 **Benefit:** 75% = $520.10

47576	FIBULA, treatment of fracture of (Anaes.) **Fee:** $114.65 **Benefit:** 75% = $86.00 85% = $97.50
47579	PATELLA, treatment of fracture of, not being a service to which item 47582 or 47585 applies (Anaes.) **Fee:** $162.60 **Benefit:** 75% = $121.95 85% = $138.25
47582	PATELLA, treatment of fracture of, by excision of patella or pole with reattachment of tendon (Anaes.) (Assist.) **Fee:** $334.85 **Benefit:** 75% = $251.15
47585	PATELLA, treatment of fracture of, by internal fixation (Anaes.) (Assist.) **Fee:** $430.55 **Benefit:** 75% = $322.95
47588	KNEE JOINT, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar or tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Anaes.) (Assist.) **Fee:** $1,338.90 **Benefit:** 75% = $1004.20
47591	KNEE JOINT, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar and tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Anaes.) (Assist.) **Fee:** $1,626.25 **Benefit:** 75% = $1219.70
47594	ANKLE JOINT, treatment of fracture of, not being a service to which item 47597 applies (Anaes.) **Fee:** $219.95 **Benefit:** 75% = $165.00 85% = $187.00
47597	ANKLE JOINT, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $330.00 **Benefit:** 75% = $247.50 85% = $280.50
47600	ANKLE JOINT, treatment of fracture of, by internal fixation of 1 of malleolus, fibula or diastasis (Anaes.) (Assist.) **Fee:** $439.90 **Benefit:** 75% = $329.95
47603	ANKLE JOINT, treatment of fracture of, by internal fixation of more than 1 of malleolus, fibula or diastasis (Anaes.) (Assist.) **Fee:** $573.90 **Benefit:** 75% = $430.45
47606	CALCANEUM OR TALUS, treatment of fracture of, not being a service to which item 47609, 47612, 47615 or 47618 applies, with or without dislocation (Anaes.) **Fee:** $239.25 **Benefit:** 75% = $179.45 85% = $203.40
47609	CALCANEUM OR TALUS, treatment of fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $358.70 **Benefit:** 75% = $269.05 85% = $304.90
47612	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $416.10 **Benefit:** 75% = $312.10 85% = $353.70
47615	CALCANEUM OR TALUS, treatment of fracture of, by open reduction, with or without dislocation

	(Anaes.) (Assist.) **Fee:** $478.25 **Benefit:** 75% = $358.70 85% = $406.55
47618	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $597.85 **Benefit:** 75% = $448.40
47621	TARSO-METATARSAL, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $416.10 **Benefit:** 75% = $312.10 85% = $353.70
47624	TARSO-METATARSAL, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $573.90 **Benefit:** 75% = $430.45
47627	TARSUS (excluding calcaneum or talus), treatment of fracture of (Anaes.) **Fee:** $162.60 **Benefit:** 75% = $121.95 85% = $138.25
47630	TARSUS (excluding calcaneum or talus), treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $344.25 **Benefit:** 75% = $258.20 85% = $292.65
47633	METATARSAL, 1 of, treatment of fracture of (Anaes.) **Fee:** $114.65 **Benefit:** 75% = $86.00 85% = $97.50
47636	METATARSAL, 1 of, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $172.20 **Benefit:** 75% = $129.15 85% = $146.40
47639	METATARSAL, 1 of, treatment of fracture of, by open reduction (Anaes.) **Fee:** $229.60 **Benefit:** 75% = $172.20 85% = $195.20
47642	METATARSALS, 2 of, treatment of fracture of (Anaes.) **Fee:** $153.15 **Benefit:** 75% = $114.90 85% = $130.20
47645	METATARSALS, 2 of, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $229.60 **Benefit:** 75% = $172.20 85% = $195.20
47648	METATARSALS, 2 of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $305.85 **Benefit:** 75% = $229.40
47651	METATARSALS, 3 or more of, treatment of fracture of (Anaes.) **Fee:** $239.25 **Benefit:** 75% = $179.45 85% = $203.40
47654	METATARSALS, 3 or more of, treatment of fracture of, by closed reduction (Anaes.) (Assist.) **Fee:** $358.70 **Benefit:** 75% = $269.05 85% = $304.90
47657	METATARSALS, 3 or more of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $478.25 **Benefit:** 75% = $358.70

47663	PHALANX OF GREAT TOE, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $143.50 **Benefit:** 75% = $107.65 85% = $122.00
47666	PHALANX OF GREAT TOE, treatment of fracture of, by open reduction (Anaes.) **Fee:** $239.25 **Benefit:** 75% = $179.45 85% = $203.40
47672	PHALANX OF TOE (other than great toe), 1 of, treatment of fracture of, by open reduction (Anaes.) **Fee:** $114.65 **Benefit:** 75% = $86.00 85% = $97.50
47678	PHALANX OF TOE (other than great toe), more than 1 of, treatment of fracture of, by open reduction (Anaes.) **Fee:** $172.20 **Benefit:** 75% = $129.15 85% = $146.40
47726	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - small quantity (Anaes.) **Fee:** $143.50 **Benefit:** 75% = $107.65
47729	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - large quantity (Anaes.) **Fee:** $239.25 **Benefit:** 75% = $179.45
47732	VASCULARISED PEDICLE BONE GRAFT, harvesting of, in conjunction with another service (Anaes.) (Assist.) **Fee:** $382.55 **Benefit:** 75% = $286.95
47735	NASAL BONES, treatment of fracture of, not being a service to which item 47738 or 47741 applies - each attendance **Fee:** $43.75 **Benefit:** 75% = $32.85 85% = $37.20
47738	NASAL BONES, treatment of fracture of, by reduction (Anaes.) **Fee:** $239.25 **Benefit:** 75% = $179.45 85% = $203.40
47741	NASAL BONES, treatment of fracture of, by open reduction involving osteotomies (Anaes.) (Assist.) **Fee:** $488.05 **Benefit:** 75% = $366.05
47753	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) **Fee:** $413.15 **Benefit:** 75% = $309.90
47756	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) **Fee:** $413.15 **Benefit:** 75% = $309.90
47762	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.) **Fee:** $242.60 **Benefit:** 75% = $181.95 85% = $206.25
47765	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.) (Assist.) **Fee:** $398.35 **Benefit:** 75% = $298.80

47768	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.) **Fee:** $488.05 **Benefit:** 75% = $366.05
47771	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.) **Fee:** $560.70 **Benefit:** 75% = $420.55
47774	MAXILLA, treatment of fracture of, requiring open operation (Anaes.) (Assist.) **Fee:** $442.60 **Benefit:** 75% = $331.95
47777	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) **Fee:** $442.60 **Benefit:** 75% = $331.95
47780	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) **Fee:** $575.40 **Benefit:** 75% = $431.55
47783	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) **Fee:** $575.40 **Benefit:** 75% = $431.55 85% = $490.70
47786	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) **Fee:** $730.25 **Benefit:** 75% = $547.70
47789	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) **Fee:** $730.25 **Benefit:** 75% = $547.70
	GENERAL
47900	BONE CYST, injection into or aspiration of (Anaes.) **Fee:** $172.20 **Benefit:** 75% = $129.15 85% = $146.40
47903	EPICONDYLITIS, open operation for (Anaes.) **Fee:** $239.25 **Benefit:** 75% = $179.45 85% = $203.40
47904	DIGITAL NAIL OF TOE, removal of, not being a service to which item 47906 applies (Anaes.) **Fee:** $57.40 **Benefit:** 75% = $43.05 85% = $48.80
47906	DIGITAL NAIL OF TOE, removal of, in the operating theatre of a hospital (Anaes.) **Fee:** $114.65 **Benefit:** 75% = $86.00
47912	PULP SPACE INFECTION, PARONYCHIA of FOOT, incision for, not being a service to which another item in this Group applies (excluding aftercare) (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $57.40 **Benefit:** 75% = $43.05 85% = $48.80
47915	INGROWING NAIL OF TOE, wedge resection for, with removal of segment of nail, ungual fold and

	portion of the nail bed (Anaes.) **Fee:** $172.20 **Benefit:** 75% = $129.15 85% = $146.40
47916	INGROWING NAIL OF TOE, partial resection of nail, with destruction of nail matrix by phenolisation, electrocautery, laser, sodium hydroxide or acid but not including excision of nail bed (Anaes.) **Fee:** $86.50 **Benefit:** 75% = $64.90 85% = $73.55
47918	INGROWING TOENAIL, radical excision of nailbed (Anaes.) **Fee:** $239.25 **Benefit:** 75% = $179.45 85% = $203.40
47920	BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.) **Fee:** $386.90 **Benefit:** 75% = $290.20
47921	ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure (Anaes.) **Fee:** $114.65 **Benefit:** 75% = $86.00 85% = $97.50
47924	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of requiring incision and suture, not being a service to which item 47927 or 47930 applies - per bone (Anaes.) **Fee:** $38.25 **Benefit:** 75% = $28.70 85% = $32.55
47927	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of, in the operating theatre of a hospital - per bone (Anaes.) **Fee:** $143.50 **Benefit:** 75% = $107.65
47930	PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all of which were inserted for internal fixation purposes, removal of, not being a service associated with a service to which item 47924 or 47927 applies - per bone (Anaes.) (Assist.) **Fee:** $267.80 **Benefit:** 75% = $200.85
47933	SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision of, or simple removal of bunion and any associated bursa, not being a service associated with a service for removal of bursa (Anaes.) (See para TN.8.112 of explanatory notes to this Category) **Fee:** $210.30 **Benefit:** 75% = $157.75 85% = $178.80
47936	LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (Anaes.) (Assist.) (See para TN.8.112 of explanatory notes to this Category) **Fee:** $258.25 **Benefit:** 75% = $193.70
47948	EXTERNAL FIXATION, removal of, in the operating theatre of a hospital (Anaes.) **Fee:** $162.60 **Benefit:** 75% = $121.95
47951	EXTERNAL FIXATION, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.) **Fee:** $191.20 **Benefit:** 75% = $143.40 85% = $162.55
47954	TENDON, repair of, as an independent procedure (Anaes.) (Assist.) **Fee:** $382.55 **Benefit:** 75% = $286.95 85% = $325.20

47957	TENDON, large, lengthening of, as an independent procedure (Anaes.) (Assist.) **Fee:** $286.85 **Benefit:** 75% = $215.15
47960	TENOTOMY, SUBCUTANEOUS, not being a service to which another item in this Group applies (Anaes.) **Fee:** $133.95 **Benefit:** 75% = $100.50 85% = $113.90
47963	TENOTOMY, OPEN, with or without tenoplasty, not being a service to which another item in this Group applies (Anaes.) **Fee:** $219.95 **Benefit:** 75% = $165.00 85% = $187.00
47966	TENDON OR LIGAMENT, TRANSFER, as an independent procedure (Anaes.) (Assist.) **Fee:** $439.90 **Benefit:** 75% = $329.95
47969	TENOSYNOVECTOMY, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $267.80 **Benefit:** 75% = $200.85
47972	TENDON SHEATH, open operation for teno-vaginitis, not being a service to which another item in this Group applies (Anaes.) **Fee:** $213.95 **Benefit:** 75% = $160.50
47975	FOREARM OR CALF, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) (Assist.) **Fee:** $375.05 **Benefit:** 75% = $281.30
47978	FOREARM OR CALF, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) **Fee:** $227.80 **Benefit:** 75% = $170.85
47981	FOREARM, CALF OR INTEROSSEOUS MUSCLE SPACE OF HAND, decompression fasciotomy of, not being a service to which another item applies (Anaes.) **Fee:** $152.95 **Benefit:** 75% = $114.75 85% = $130.05
47982	FORAGE (Drill decompression), of NECK OR HEAD of FEMUR, or BOTH (Anaes.) (Assist.) **Fee:** $370.75 **Benefit:** 75% = $278.10
	BONE GRAFTS
48200	FEMUR, bone graft to (Anaes.) (Assist.) **Fee:** $765.30 **Benefit:** 75% = $574.00
48203	FEMUR, bone graft to, with internal fixation (Anaes.) (Assist.) **Fee:** $927.85 **Benefit:** 75% = $695.90
48206	TIBIA, bone graft to (Anaes.) (Assist.) **Fee:** $574.50 **Benefit:** 75% = $430.90
48209	TIBIA, bone graft to, with internal fixation (Anaes.) (Assist.) **Fee:** $736.55 **Benefit:** 75% = $552.45

48212	HUMERUS, bone graft to (Anaes.) (Assist.) **Fee:** $574.50 **Benefit:** 75% = $430.90
48215	HUMERUS, bone graft to, with internal fixation (Anaes.) (Assist.) **Fee:** $736.55 **Benefit:** 75% = $552.45
48218	RADIUS AND ULNA, bone graft to (Anaes.) (Assist.) **Fee:** $574.50 **Benefit:** 75% = $430.90
48221	RADIUS AND ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.) **Fee:** $765.30 **Benefit:** 75% = $574.00
48224	RADIUS OR ULNA, bone graft to (Anaes.) (Assist.) **Fee:** $382.55 **Benefit:** 75% = $286.95
48227	RADIUS OR ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.) **Fee:** $497.40 **Benefit:** 75% = $373.05
48230	SCAPHOID, bone graft to, for non-union (Anaes.) (Assist.) **Fee:** $430.55 **Benefit:** 75% = $322.95
48233	SCAPHOID, bone graft to, for non-union, with internal fixation (Anaes.) (Assist.) **Fee:** $621.70 **Benefit:** 75% = $466.30
48236	SCAPHOID, bone graft to, for mal-union, including osteotomy, bone graft and internal fixation (Anaes.) (Assist.) **Fee:** $813.00 **Benefit:** 75% = $609.75
48239	BONE GRAFT, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $449.55 **Benefit:** 75% = $337.20
48242	BONE GRAFT, with internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $621.70 **Benefit:** 75% = $466.30
	OSTEOTOMY AND OSTEECTOMY
48400	PHALANX, METATARSAL, ACCESSORY BONE OR SESAMOID BONE, osteotomy or osteectomy of, excluding services to which item 49848 or 49851 applies, any of items 49848, 49851, 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $334.85 **Benefit:** 75% = $251.15
48403	PHALANX OR METATARSAL, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $526.10 **Benefit:** 75% = $394.60
48406	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $334.85 **Benefit:** 75% = $251.15

48409	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than Acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $526.10 **Benefit:** 75% = $394.60
48412	HUMERUS, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $640.75 **Benefit:** 75% = $480.60
48415	HUMERUS, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $813.00 **Benefit:** 75% = $609.75
48418	TIBIA, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $640.75 **Benefit:** 75% = $480.60
48421	TIBIA, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $813.00 **Benefit:** 75% = $609.75
48424	Femur or pelvis, osteotomy or osteectomy of, other than a service associated with surgery for femoroacetabular impingement, or to which item 47933 or 47936 applies (H) (Anaes.) (Assist.) (See para TN.8.127 of explanatory notes to this Category) **Fee:** $765.30 **Benefit:** 75% = $574.00
48427	FEMUR OR PELVIS, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $927.85 **Benefit:** 75% = $695.90
	EPIPHYSEODESIS
48500	FEMUR, epiphysiodesis of (Anaes.) (Assist.) **Fee:** $334.85 **Benefit:** 75% = $251.15
48503	TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.) **Fee:** $334.85 **Benefit:** 75% = $251.15
48506	FEMUR, TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.) **Fee:** $497.40 **Benefit:** 75% = $373.05
48509	EPIPHYSIODESIS, staple arrest of hemiepiphysis (Anaes.) **Fee:** $239.25 **Benefit:** 75% = $179.45
48512	EPIPHYSIOLYSIS, operation to prevent closure of plate (Anaes.) (Assist.) **Fee:** $908.70 **Benefit:** 75% = $681.55
	SHOULDER
48900	SHOULDER, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both (Anaes.) (Assist.)

	Fee: $286.85 **Benefit:** 75% = $215.15 85% = $243.85
48903	SHOULDER, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination (Anaes.) (Assist.) **Fee:** $573.90 **Benefit:** 75% = $430.45
48906	SHOULDER, repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff, or both - not being a service associated with a service to which item 48900 applies (Anaes.) (Assist.) **Fee:** $573.90 **Benefit:** 75% = $430.45
48909	SHOULDER, repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination, not being a service associated with a service to which item 48903 applies (Anaes.) (Assist.) **Fee:** $765.30 **Benefit:** 75% = $574.00
48912	SHOULDER, arthrotomy of (Anaes.) (Assist.) **Fee:** $334.85 **Benefit:** 75% = $251.15 85% = $284.65
48915	SHOULDER, hemi-arthroplasty of (Anaes.) (Assist.) **Fee:** $765.30 **Benefit:** 75% = $574.00
48918	SHOULDER, total replacement arthroplasty of, including any associated rotator cuff repair (Anaes.) (Assist.) **Fee:** $1,530.55 **Benefit:** 75% = $1147.95
48921	SHOULDER, total replacement arthroplasty, revision of (Anaes.) (Assist.) **Fee:** $1,578.25 **Benefit:** 75% = $1183.70
48924	SHOULDER, total replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or both (Anaes.) (Assist.) **Fee:** $1,817.45 **Benefit:** 75% = $1363.10
48927	SHOULDER prosthesis, removal of (Anaes.) (Assist.) **Fee:** $372.90 **Benefit:** 75% = $279.70
48930	SHOULDER, stabilisation procedure for recurrent anterior or posterior dislocation (Anaes.) (Assist.) **Fee:** $765.30 **Benefit:** 75% = $574.00
48933	SHOULDER, stabilisation procedure for multi-directional instability, including anterior or posterior (or both) repair when performed (Anaes.) (Assist.) **Fee:** $1,004.35 **Benefit:** 75% = $753.30
48936	SHOULDER, synovectomy of, as an independent procedure (Anaes.) (Assist.) **Fee:** $765.30 **Benefit:** 75% = $574.00
48939	SHOULDER, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $1,100.00 **Benefit:** 75% = $825.00
48942	SHOULDER, arthrodesis of, with synovectomy if performed, with removal of prosthesis, requiring bone

	grafting or internal fixation (Anaes.) (Assist.) **Fee:** $1,434.80 **Benefit:** 75% = $1076.10
48945	SHOULDER, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $277.30 **Benefit:** 75% = $208.00
48948	SHOULDER, arthroscopic surgery of, involving any 1 or more of: removal of loose bodies; decompression of calcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $621.70 **Benefit:** 75% = $466.30
48951	SHOULDER, arthroscopic division of coraco-acromial ligament including acromioplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $908.70 **Benefit:** 75% = $681.55
48954	SHOULDER, arthroscopic total synovectomy of, including release of contracture when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $956.50 **Benefit:** 75% = $717.40
48957	SHOULDER, arthroscopic stabilisation of, for recurrent instability including labral repair or reattachment when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $1,100.00 **Benefit:** 75% = $825.00
48960	SHOULDER, reconstruction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach when performed - not being a service associated with any other procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $956.50 **Benefit:** 75% = $717.40
	ELBOW
49100	ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture (Anaes.) (Assist.) **Fee:** $334.85 **Benefit:** 75% = $251.15
49103	ELBOW, ligamentous stabilisation of (Anaes.) (Assist.) **Fee:** $717.35 **Benefit:** 75% = $538.05
49106	ELBOW, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $956.50 **Benefit:** 75% = $717.40 85% = $871.80
49109	ELBOW, total synovectomy of (Anaes.) (Assist.) **Fee:** $717.35 **Benefit:** 75% = $538.05
49112	ELBOW, silastic or other replacement of radial head (Anaes.) (Assist.) **Fee:** $717.35 **Benefit:** 75% = $538.05

49115	ELBOW, total joint replacement of (Anaes.) (Assist.) **Fee:** $1,147.70 **Benefit:** 75% = $860.80
49116	ELBOW, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,515.00 **Benefit:** 75% = $1136.25
49117	ELBOW, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,818.00 **Benefit:** 75% = $1363.50
49118	ELBOW, diagnostic arthroscopy of, including biopsy and lavage, not being a service associated with any other arthroscopic procedure of the elbow (Anaes.) (Assist.) **Fee:** $277.30 **Benefit:** 75% = $208.00
49121	ELBOW, arthroscopic surgery involving any 1 or more of: drilling of defect, removal of loose body; release of contracture or adhesions; chondroplasty; or osteoplasty - not being a service associated with any other arthroscopic procedure of the elbow (Anaes.) (Assist.) **Fee:** $621.70 **Benefit:** 75% = $466.30
	WRIST
49200	WRIST, arthrodesis of, with synovectomy if performed, with or without bone graft and internal fixation of the radiocarpal joint (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $832.05 **Benefit:** 75% = $624.05
49203	WRIST, limited arthrodesis of the intercarpal joint, with synovectomy if performed, with or without bone graft (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $621.70 **Benefit:** 75% = $466.30
49206	WRIST, proximal carpectomy of, including styloidectomy when performed (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $573.90 **Benefit:** 75% = $430.45
49209	WRIST, total replacement arthroplasty of (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $765.30 **Benefit:** 75% = $574.00
49210	WRIST, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,010.20 **Benefit:** 75% = $757.65
49211	WRIST, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,212.25 **Benefit:** 75% = $909.20
49212	WRIST, arthrotomy of (Anaes.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $239.25 **Benefit:** 75% = $179.45

49215	WRIST, reconstruction of, including repair of single or multiple ligaments or capsules, including associated arthrotomy (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $660.10 **Benefit:** 75% = $495.10
49218	WRIST, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy) - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $277.30 **Benefit:** 75% = $208.00
49221	WRIST, arthroscopic surgery of, involving any 1 or more of: drilling of defect; removal of loose body; release of adhesions; local synovectomy; or debridement of one area - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $621.70 **Benefit:** 75% = $466.30
49224	WRIST, arthroscopic debridement of 2 or more distinct areas; or osteoplasty including excision of the distal ulna; or total synovectomy, not being a service associated with any other arthroscopic procedure of the wrist (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $717.35 **Benefit:** 75% = $538.05
49227	WRIST, arthroscopic pinning of osteochondral fragment or stabilisation procedure for ligamentous disruption - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.) (See para TN.8.116 of explanatory notes to this Category) **Fee:** $717.35 **Benefit:** 75% = $538.05
	HIP
49300	SACROILIAC JOINT arthrodesis of (Anaes.) (Assist.) **Fee:** $529.60 **Benefit:** 75% = $397.20
49303	Hip, arthrotomy of, including lavage, drainage or biopsy when performed, other than a service associated with surgery for femoroacetabular impingement (H) (Anaes.) (Assist.) (See para TN.8.127 of explanatory notes to this Category) **Fee:** $554.75 **Benefit:** 75% = $416.10
49306	HIP arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $1,100.00 **Benefit:** 75% = $825.00
49309	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (Austin Moore or similar (non cement)) (Anaes.) (Assist.) **Fee:** $765.30 **Benefit:** 75% = $574.00
49312	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (cemented, porous coated or similar) (Anaes.) (Assist.) **Fee:** $956.50 **Benefit:** 75% = $717.40
49315	HIP, arthroplasty of, unipolar or bipolar (Anaes.) (Assist.) **Fee:** $860.90 **Benefit:** 75% = $645.70

49318	HIP, total replacement arthroplasty of, including minor bone grafting (Anaes.) (Assist.) **Fee:** $1,338.90 **Benefit:** 75% = $1004.20
49319	HIP, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes.) (Assist.) **Fee:** $2,352.35 **Benefit:** 75% = $1764.30
49321	HIP, total replacement arthroplasty of, including major bone grafting, including obtaining of graft (Anaes.) (Assist.) **Fee:** $1,626.25 **Benefit:** 75% = $1219.70
49324	HIP, total replacement arthroplasty of, revision procedure including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,913.10 **Benefit:** 75% = $1434.85
49327	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to acetabulum, including obtaining of graft (Anaes.) (Assist.) **Fee:** $2,200.00 **Benefit:** 75% = $1650.00
49330	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (Anaes.) (Assist.) **Fee:** $2,200.00 **Benefit:** 75% = $1650.00
49333	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to both acetabulum and femur, including obtaining of graft (Anaes.) (Assist.) **Fee:** $2,487.00 **Benefit:** 75% = $1865.25
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.) **Fee:** $363.40 **Benefit:** 75% = $272.55
49339	HIP, revision total replacement of, requiring anatomic specific allograft of proximal femur greater than 5 cm in length (Anaes.) (Assist.) **Fee:** $2,821.75 **Benefit:** 75% = $2116.35
49342	HIP, revision total replacement of, requiring anatomic specific allograft of acetabulum (Anaes.) (Assist.) **Fee:** $2,821.75 **Benefit:** 75% = $2116.35
49345	HIP, revision total replacement of, requiring anatomic specific allograft of both femur and acetabulum (Anaes.) (Assist.) **Fee:** $3,347.80 **Benefit:** 75% = $2510.85
49346	HIP, revision arthroplasty with replacement of acetabular liner or ceramic head, not requiring removal of femoral component or acetabular shell (Anaes.) (Assist.) **Fee:** $860.90 **Benefit:** 75% = $645.70
49360	HIP, diagnostic arthroscopy of, not being a service associated with any other arthroscopic procedure of the hip (Anaes.) (Assist.) **Fee:** $349.45 **Benefit:** 75% = $262.10

49363	HIP, diagnostic arthroscopy of, with synovial biopsy, not being a service associated with any other arthroscopic procedure of the hip (Anaes.) (Assist.) **Fee:** $420.85 **Benefit:** 75% = $315.65 85% = $357.75
49366	Hip, arthroscopic surgery of, other than a service associated with another arthroscopic procedure of the hip, or a service associated with surgery for femoroacetabular impingement (H) (Anaes.) (Assist.) (See para TN.8.127 of explanatory notes to this Category) **Fee:** $621.70 **Benefit:** 75% = $466.30
	KNEE
49500	KNEE, arthrotomy of, involving 1 or more of; capsular release, biopsy or lavage, or removal of loose body or foreign body (Anaes.) (Assist.) **Fee:** $382.55 **Benefit:** 75% = $286.95
49503	KNEE, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon (not being a service to which another item in this Group applies) - any 1 procedure (Anaes.) (Assist.) **Fee:** $497.40 **Benefit:** 75% = $373.05
49506	KNEE, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon (not being a service to which another item in this Group applies) - any 2 or more procedures (Anaes.) (Assist.) **Fee:** $746.15 **Benefit:** 75% = $559.65
49509	KNEE, total synovectomy or arthrodesis with synovectomy if performed (Anaes.) (Assist.) **Fee:** $765.30 **Benefit:** 75% = $574.00
49512	KNEE, arthrodesis of, with synovectomy if performed, with removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,100.00 **Benefit:** 75% = $825.00
49515	KNEE, removal of prosthesis, cemented or uncemented, including associated cement, as the first stage of a 2 stage procedure (Anaes.) (Assist.) **Fee:** $860.90 **Benefit:** 75% = $645.70
49517	KNEE, hemiarthroplasty of (Anaes.) (Assist.) **Fee:** $1,225.65 **Benefit:** 75% = $919.25
49518	KNEE, total replacement arthroplasty of (Anaes.) (Assist.) **Fee:** $1,338.90 **Benefit:** 75% = $1004.20
49519	KNEE, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes.) (Assist.) **Fee:** $2,352.35 **Benefit:** 75% = $1764.30
49521	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur or tibia, including obtaining of graft (Anaes.) (Assist.) **Fee:** $1,626.25 **Benefit:** 75% = $1219.70
49524	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur and tibia, including

	obtaining of graft (Anaes.) (Assist.) **Fee:** $1,913.10 **Benefit:** 75% = $1434.85
49527	KNEE, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,626.25 **Benefit:** 75% = $1219.70
49530	KNEE, total replacement arthroplasty of, revision procedure, requiring bone grafting to femur or tibia, including obtaining of graft and including removal of prosthesis (Anaes.) (Assist.) **Fee:** $2,008.85 **Benefit:** 75% = $1506.65
49533	KNEE, total replacement arthroplasty of, revision procedure, requiring bone grafting to both femur and tibia, including obtaining of graft and including removal of prosthesis (Anaes.) (Assist.) **Fee:** $2,295.80 **Benefit:** 75% = $1721.85
49534	KNEE, patello-femoral joint of, total replacement arthroplasty as a primary procedure (Anaes.) (Assist.) **Fee:** $456.75 **Benefit:** 75% = $342.60
49536	KNEE, repair or reconstruction of, for chronic instability (open or arthroscopic, or both) involving either cruciate or collateral ligaments, including notchplasty when performed, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.) **Fee:** $956.50 **Benefit:** 75% = $717.40
49539	KNEE, reconstructive surgery of cruciate ligament or ligaments (open or arthroscopic, or both), including notchplasty when performed and surgery to other internal derangements, not being a service to which another item in this Group applies or a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.) **Fee:** $956.50 **Benefit:** 75% = $717.40
49542	KNEE, reconstructive surgery to cruciate ligament or ligaments (open or arthroscopic, or both), including notchplasty, meniscus repair, extracapsular procedure and debridement when performed, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.) **Fee:** $1,338.90 **Benefit:** 75% = $1004.20
49545	KNEE, revision arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $765.30 **Benefit:** 75% = $574.00
49548	KNEE, revision of patello-femoral stabilisation (Anaes.) (Assist.) **Fee:** $956.50 **Benefit:** 75% = $717.40
49551	KNEE, revision of procedures to which item 49536, 49539 or 49542 applies (Anaes.) (Assist.) **Fee:** $1,338.90 **Benefit:** 75% = $1004.20
49554	KNEE, revision of total replacement of, by anatomic specific allograft of tibia or femur (Anaes.) (Assist.) **Fee:** $1,913.10 **Benefit:** 75% = $1434.85
49557	KNEE, diagnostic arthroscopy of (including biopsy, simple trimming of meniscal margin or plica) - not being a service associated with autologous chondrocyte implantation or matrix-induced autologous chondrocyte implantation or any other arthroscopic procedure of the knee region (Anaes.) (Assist.)

	(See para TN.8.117 of explanatory notes to this Category) **Fee:** $277.30 **Benefit:** 75% = $208.00
49558	KNEE, arthroscopic surgery of, involving 1 or more of: debridement, osteoplasty or chondroplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $277.30 **Benefit:** 75% = $208.00
49559	KNEE, arthroscopic surgery of, involving chondroplasty requiring multiple drilling or carbon fibre (or similar) implant; including any associated debridement or oestoplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $415.25 **Benefit:** 75% = $311.45
49560	KNEE, arthroscopic surgery of, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release - not being a service associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $560.45 **Benefit:** 75% = $420.35
49561	KNEE, ARTHROSCOPIC SURGERY OF, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release; where the procedure includes associated debridement, osteoplasty or chondroplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $684.80 **Benefit:** 75% = $513.60
49562	KNEE, ARTHROSCOPIC SURGERY OF, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release; where the procedure includes chondroplasty requiring multiple drilling or carbon fibre (or similar) implant and associated debridement or osteoplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $747.25 **Benefit:** 75% = $560.45
49563	KNEE, arthroscopic surgery of, involving 1 or more of: meniscus repair; osteochondral graft; or chondral graft (excluding autologous chondrocyte implantation or matrix-induced autologous chondrocyte implantation) -not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $809.45 **Benefit:** 75% = $607.10
49564	KNEE, patello-femoral stabilisation of, combined arthroscopic and open procedure, including lateral release, medial capsulorrhaphy and tendon transfer, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.) **Fee:** $933.75 **Benefit:** 75% = $700.35
49566	KNEE, arthroscopic total synovectomy of, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.) **Fee:** $765.30 **Benefit:** 75% = $574.00
49569	KNEE, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (Anaes.) (Assist.) **Fee:** $765.30 **Benefit:** 75% = $574.00
	ANKLE
49700	ANKLE, diagnostic arthroscopy of, including biopsy (Anaes.) (Assist.)

	Fee: $277.30 **Benefit:** 75% = $208.00
49703	ANKLE, arthroscopic surgery of, not being a service associated with any other arthroscopic procedure of the ankle (Anaes.) (Assist.) **Fee:** $621.70 **Benefit:** 75% = $466.30
49706	ANKLE, arthrotomy of, involving 1 or more of: lavage, removal of loose body or division of contracture (Anaes.) (Assist.) **Fee:** $334.85 **Benefit:** 75% = $251.15
49709	ANKLE, ligamentous stabilisation of (Anaes.) (Assist.) **Fee:** $717.35 **Benefit:** 75% = $538.05
49712	ANKLE, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $765.30 **Benefit:** 75% = $574.00
49715	ANKLE, total joint replacement of (Anaes.) (Assist.) **Fee:** $1,147.70 **Benefit:** 75% = $860.80
49716	ANKLE, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,515.00 **Benefit:** 75% = $1136.25
49717	ANKLE, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,818.00 **Benefit:** 75% = $1363.50
49718	ANKLE, Achilles' tendon or other major tendon, repair of (Anaes.) (Assist.) **Fee:** $382.55 **Benefit:** 75% = $286.95
49721	ANKLE, Achilles' tendon rupture managed by non-operative treatment **Fee:** $239.25 **Benefit:** 75% = $179.45 85% = $203.40
49724	ANKLE, Achilles' tendon, secondary repair or reconstruction of (Anaes.) (Assist.) **Fee:** $669.70 **Benefit:** 75% = $502.30
49727	ANKLE, Achilles' tendon, operation for lengthening (Anaes.) (Assist.) **Fee:** $286.85 **Benefit:** 75% = $215.15
49728	ANKLE, lengthening of the gastrocnemius aponeurosis and soleus fascia, for the correction of equinus deformity in children with cerebral palsy (Anaes.) (Assist.) **Fee:** $573.75 **Benefit:** 75% = $430.35
	FOOT
49800	FOOT, flexor or extensor tendon, primary repair of (Anaes.) **Fee:** $133.95 **Benefit:** 75% = $100.50 85% = $113.90
49803	FOOT, flexor or extensor tendon, secondary repair of (Anaes.) **Fee:** $172.20 **Benefit:** 75% = $129.15 85% = $146.40

49806	FOOT, subcutaneous tenotomy of, 1 or more tendons (Anaes.) **Fee:** $133.95 **Benefit:** 75% = $100.50 85% = $113.90
49809	FOOT, open tenotomy of, with or without tenoplasty (Anaes.) **Fee:** $219.95 **Benefit:** 75% = $165.00
49812	FOOT, tendon or ligament transplantation of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $439.90 **Benefit:** 75% = $329.95
49815	FOOT, triple arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $765.30 **Benefit:** 75% = $574.00
49818	FOOT, excision of calcaneal spur (Anaes.) (Assist.) **Fee:** $277.30 **Benefit:** 75% = $208.00
49821	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - unilateral (Anaes.) (Assist.) **Fee:** $439.90 **Benefit:** 75% = $329.95
49824	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - bilateral (Anaes.) (Assist.) **Fee:** $770.10 **Benefit:** 75% = $577.60
49827	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - unilateral (Anaes.) (Assist.) **Fee:** $478.25 **Benefit:** 75% = $358.70
49830	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - bilateral (Anaes.) (Assist.) **Fee:** $836.95 **Benefit:** 75% = $627.75
49833	FOOT, correction of hallux valgus by osteotomy of first metatarsal with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - unilateral (Anaes.) (Assist.) **Fee:** $526.10 **Benefit:** 75% = $394.60
49836	FOOT, correction of hallux valgus by osteotomy of first metatarsal with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - bilateral (Anaes.) (Assist.) **Fee:** $908.70 **Benefit:** 75% = $681.55
49837	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - unilateral (Anaes.) (Assist.) **Fee:** $657.60 **Benefit:** 75% = $493.20
49838	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - bilateral (Anaes.) (Assist.) **Fee:** $1,135.65 **Benefit:** 75% = $851.75
49839	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - unilateral (Anaes.)

	(Assist.) **Fee:** $526.10 **Benefit:** 75% = $394.60
49842	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - bilateral (Anaes.) (Assist.) **Fee:** $908.70 **Benefit:** 75% = $681.55
49845	FOOT, arthrodesis of, first metatarso-phalangeal joint, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $478.25 **Benefit:** 75% = $358.70
49848	FOOT, correction of claw or hammer toe (Anaes.) **Fee:** $162.60 **Benefit:** 75% = $121.95 85% = $138.25
49851	FOOT, correction of claw or hammer toe with internal fixation (Anaes.) **Fee:** $210.30 **Benefit:** 75% = $157.75
49854	FOOT, radical plantar fasciotomy or fasciectomy of (Anaes.) (Assist.) **Fee:** $382.55 **Benefit:** 75% = $286.95
49857	FOOT, metatarso-phalangeal joint replacement (Anaes.) (Assist.) **Fee:** $353.90 **Benefit:** 75% = $265.45
49860	FOOT, synovectomy of metatarso-phalangeal joint, single joint (Anaes.) (Assist.) **Fee:** $286.85 **Benefit:** 75% = $215.15
49863	FOOT, synovectomy of metatarso-phalangeal joint, 2 or more joints (Anaes.) (Assist.) **Fee:** $430.55 **Benefit:** 75% = $322.95
49866	FOOT, neurectomy for plantar or digital neuritis (Morton's or Bett's syndrome) (Anaes.) (Assist.) **Fee:** $305.85 **Benefit:** 75% = $229.40
49878	TALIPES EQUINOVARUS, calcaneo valgus or metatarus varus, treatment by cast, splint or manipulation - each attendance (Anaes.) **Fee:** $57.40 **Benefit:** 75% = $43.05 85% = $48.80
	OTHER JOINTS
50100	JOINT, diagnostic arthroscopy of (including biopsy), not being a service to which another item in this Group applies and not being a service associated with any other arthroscopic procedure (Anaes.) (Assist.) **Fee:** $277.30 **Benefit:** 75% = $208.00 85% = $235.75
50102	JOINT, arthroscopic surgery of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $621.70 **Benefit:** 75% = $466.30
50103	JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $334.85 **Benefit:** 75% = $251.15
50104	JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes.)

	(Assist.) **Fee:** $317.30 **Benefit:** 75% = $238.00 85% = $269.75
50106	JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $478.25 **Benefit:** 75% = $358.70
50109	JOINT, arthrodesis of, not being a service to which another item in this Group applies, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $478.25 **Benefit:** 75% = $358.70
50112	CICATRICIAL FLEXION OR EXTENSION CONTRACTION OF JOINT, correction of, involving tissues deeper than skin and subcutaneous tissue, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $366.85 **Benefit:** 75% = $275.15
50115	JOINT or JOINTS, manipulation of, performed in the operating theatre of a hospital, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $145.25 **Benefit:** 75% = $108.95
50118	SUBTALAR JOINT, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $439.90 **Benefit:** 75% = $329.95
50121	GREATER TROCHANTER, transplantation of ileopsoas tendon to (Anaes.) (Assist.) **Fee:** $860.90 **Benefit:** 75% = $645.70
50127	JOINT OR JOINTS, arthroplasty of, by any technique not being a service to which another item applies (Anaes.) (Assist.) **Fee:** $713.75 **Benefit:** 75% = $535.35
50130	JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) **Fee:** $317.30 **Benefit:** 75% = $238.00
	MALIGNANT DISEASE
50200	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, biopsy of (not including aftercare) (Anaes.) **Fee:** $191.20 **Benefit:** 75% = $143.40 85% = $162.55
50201	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, involving neurovascular structures, open biopsy of (not including aftercare) (Anaes.) (Assist.) **Fee:** $334.75 **Benefit:** 75% = $251.10
50203	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes.) (Assist.) **Fee:** $420.90 **Benefit:** 75% = $315.70 85% = $357.80
50206	BONE TUMOUR, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) **Fee:** $621.70 **Benefit:** 75% = $466.30

50209	BONE TUMOUR, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) **Fee:** $765.30 **Benefit:** 75% = $574.00
50212	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, without reconstruction (Anaes.) (Assist.) **Fee:** $1,673.90 **Benefit:** 75% = $1255.45
50215	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, with intercalary reconstruction (prosthesis, allograft or autograft) (Anaes.) (Assist.) **Fee:** $2,104.35 **Benefit:** 75% = $1578.30
50218	MALIGNANT TUMOUR of LONG BONE, enbloc resection of, with replacement or arthrodesis of adjacent joint, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $2,774.00 **Benefit:** 75% = $2080.50
50221	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of (Anaes.) (Assist.) **Fee:** $2,582.50 **Benefit:** 75% = $1936.90
50224	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of, with reconstruction by prosthesis, allograft or autograft (Anaes.) (Assist.) **Fee:** $2,869.55 **Benefit:** 75% = $2152.20 85% = $2784.85
50227	MALIGNANT BONE TUMOUR, enbloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement (Anaes.) (Assist.) **Fee:** $3,347.80 **Benefit:** 75% = $2510.85
50230	BENIGN TUMOUR, resection of, requiring anatomic specific allograft, with or without internal fixation (Anaes.) (Assist.) **Fee:** $1,721.70 **Benefit:** 75% = $1291.30
50233	MALIGNANT TUMOUR, amputation for, hemipelvectomy or interscapulo-thoracic (Anaes.) (Assist.) **Fee:** $2,200.00 **Benefit:** 75% = $1650.00
50236	MALIGNANT TUMOUR, amputation for, hip disarticulation, shoulder disarticulation or proximal third femur (Anaes.) (Assist.) **Fee:** $1,721.70 **Benefit:** 75% = $1291.30
50239	MALIGNANT TUMOUR, amputation for, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $1,147.70 **Benefit:** 75% = $860.80
	LIMB LENGTHENING AND DEFORMITY CORRECTION
50300	JOINT DEFORMITY, slow correction of, using ring fixator or similar device, including all associated attendances - payable only once in any 12 month period (Anaes.) (Assist.) **Fee:** $1,176.20 **Benefit:** 75% = $882.15

50303	LIMB LENGTHENING, 5cm or less, by gradual distraction, with application of an external fixator or intra-medullary device, in the operating theatre of a hospital - payable only once per limb in any 12 month period (Anaes.) (Assist.) **Fee:** $1,605.90 **Benefit:** 75% = $1204.45
50306	LIMB LENGTHENING , where the lengthening is bipolar, or bone transport is performed or where the fixator is extended to correct an adjacent joint deformity, or where the lengthening is greater than 5cm (Anaes.) (Assist.) **Fee:** $2,507.40 **Benefit:** 75% = $1880.55 85% = $2422.70
50309	RING FIXATOR OR SIMILAR DEVICE, adjustment of, with or without insertion or removal of fixation pins, performed under general anaesthesia in the operating theatre of a hospital, not being a service to which item 50303 or 50306 applies (Anaes.) (Assist.) **Fee:** $309.95 **Benefit:** 75% = $232.50
50312	ANKLE, synovectomy of, by arthroscopic or open means - not associated with any other arthroscopic procedure of the ankle (Anaes.) (Assist.) **Fee:** $711.30 **Benefit:** 75% = $533.50
50315	TALIPES EQUINOVARUS, posterior release of (Anaes.) (Assist.) **Fee:** $704.40 **Benefit:** 75% = $528.30
50318	TALIPES EQUINOVARUS, medial release of (Anaes.) (Assist.) **Fee:** $704.40 **Benefit:** 75% = $528.30
50321	TALIPES EQUINOVARUS, combined postero-medial release of (Anaes.) (Assist.) **Fee:** $943.70 **Benefit:** 75% = $707.80
50324	TALIPES EQUINOVARUS, combined postero-medial release of, revision procedure (Anaes.) (Assist.) **Fee:** $1,345.35 **Benefit:** 75% = $1009.05
50327	TALIPES EQUINOVARUS, bilateral procedures (Anaes.) (Assist.) **Fee:** $1,641.00 **Benefit:** 75% = $1230.75
50330	TALIPES EQUINOVARUS, or talus, vertical congenital - post operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital, not being a service to which item 50315, 50318, 50321, 50324 or 50327 applies (Anaes.) **Fee:** $232.35 **Benefit:** 75% = $174.30
50333	TARSAL COALITION, excision of, with interposition of muscle, fat graft or similar graft (Anaes.) (Assist.) **Fee:** $626.70 **Benefit:** 75% = $470.05
50336	TALUS, VERTICAL, CONGENITAL, combined anterior and posterior reconstruction (Anaes.) (Assist.) **Fee:** $936.80 **Benefit:** 75% = $702.60
50339	FOOT AND ANKLE, tibialis anterior tendon (split or whole) transfer to lateral column (Anaes.) (Assist.) **Fee:** $570.55 **Benefit:** 75% = $427.95

50342	FOOT AND ANKLE, tibialis or tibialis posterior tendon transfer, through the interosseous membrane to anterior or posterior aspect of foot (Anaes.) (Assist.) **Fee:** $662.05 **Benefit:** 75% = $496.55
50345	HYPEREXTENSION DEFORMITY OF TOE, release incorporating V-Y plasty of skin, lengthening of extensor tendons and release of capsule contracture (Anaes.) (Assist.) **Fee:** $352.20 **Benefit:** 75% = $264.15
50348	*HIP, KNEE AND LEG PROCEDURES* KNEE, deformity of, post-operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital (Anaes.) **Fee:** $232.35 **Benefit:** 75% = $174.30
50349	HIP, congenital dislocation of, treatment of, by closed reduction (Anaes.) **Fee:** $325.25 **Benefit:** 75% = $243.95 85% = $276.50
50351	HIP, developmental dislocation of, open reduction of (Anaes.) (Assist.) **Fee:** $1,622.80 **Benefit:** 75% = $1217.10
50352	HIP, congenital dislocation of, treatment of, involving supervision of splint, harness or cast - each attendance (Anaes.) **Fee:** $57.40 **Benefit:** 75% = $43.05 85% = $48.80
50353	HIP SPICA, initial application of, for congenital dislocation of hip (excluding aftercare) (Anaes.) (Assist.) **Fee:** $360.50 **Benefit:** 75% = $270.40
50354	TIBIA, pseudarthrosis of, congenital, resection and internal fixation (Anaes.) (Assist.) **Fee:** $1,331.10 **Benefit:** 75% = $998.35 85% = $1246.40
50357	KNEE, LEG OR THIGH, rectus femoris tendon transfer, or medial or lateral hamstring tendon transfer (Anaes.) (Assist.) **Fee:** $570.55 **Benefit:** 75% = $427.95
50360	KNEE, LEG OR THIGH, combined medial and lateral hamstring tendon transfer (Anaes.) (Assist.) **Fee:** $662.05 **Benefit:** 75% = $496.55
50363	KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, unilateral (Anaes.) (Assist.) **Fee:** $507.05 **Benefit:** 75% = $380.30
50366	KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, bilateral (Anaes.) (Assist.) **Fee:** $887.45 **Benefit:** 75% = $665.60
50369	KNEE, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, unilateral (Anaes.) (Assist.)

	Fee: $662.05 **Benefit:** 75% = $496.55
50372	KNEE, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, bilateral (Anaes.) (Assist.) **Fee:** $1,162.10 **Benefit:** 75% = $871.60
50375	HIP, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, unilateral (Anaes.) (Assist.) **Fee:** $507.05 **Benefit:** 75% = $380.30
50378	HIP, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, bilateral (Anaes.) (Assist.) **Fee:** $887.45 **Benefit:** 75% = $665.60
50381	HIP, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, unilateral (Anaes.) (Assist.) **Fee:** $662.05 **Benefit:** 75% = $496.55
50384	HIP, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, bilateral (Anaes.) (Assist.) **Fee:** $1,162.10 **Benefit:** 75% = $871.60
50387	HIP, iliopsoas tendon transfer to greater trochanter, or transfer of abdominal musculature to greater trochanter, or transfer of adductors to ischium (Anaes.) (Assist.) **Fee:** $662.05 **Benefit:** 75% = $496.55
50390	PERTHES, CEREBRAL PALSY, or other neuromuscular conditions, affecting hips or knees, application of cast under general anaesthesia, performed in the operating theatre of a hospital (Anaes.) **Fee:** $232.35 **Benefit:** 75% = $174.30
50393	PELVIS, bone graft or shelf procedures for acetabular dysplasia (Anaes.) (Assist.) **Fee:** $859.15 **Benefit:** 75% = $644.40
50394	ACETABULAR DYSPLASIA, treatment of, by multiple peri-acetabular osteotomy, including internal fixation where performed (Anaes.) (Assist.) **Fee:** $2,821.75 **Benefit:** 75% = $2116.35
	SHOULDER, ARM AND FOREARM PROCEDURES
50396	HAND, congenital abnormalities or duplication of digits, amputation or splitting of phalanx or phalanges, with ligament or joint reconstruction (Anaes.) (Assist.) **Fee:** $472.00 **Benefit:** 75% = $354.00
50399	FOREARM, RADIAL APLASIA OR DYSPLASIA (radial club hand), centralisation or radialisation of (Anaes.) (Assist.) **Fee:** $936.80 **Benefit:** 75% = $702.60
50402	TORTICOLLIS, bipolar release of sternocleidomastoid muscle and associated soft tissue (Anaes.) (Assist.)

	Fee: $429.70 **Benefit:** 75% = $322.30
50405	ELBOW, flexorplasty, or tendon transfer to restore elbow function (Anaes.) (Assist.) **Fee:** $584.60 **Benefit:** 75% = $438.45
50408	SHOULDER, congenital or developmental dislocation, open reduction of (Anaes.) (Assist.) **Fee:** $1,014.20 **Benefit:** 75% = $760.65
50411	AMPUTATIONS OR RECONSTRUCTIONS FOR CONGENITAL DEFORMITIES LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion (Anaes.) (Assist.) **Fee:** $1,331.10 **Benefit:** 75% = $998.35 85% = $1246.40
50414	LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion and rotationplasty (Anaes.) (Assist.) **Fee:** $1,795.90 **Benefit:** 75% = $1346.95 85% = $1711.20
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.) **Fee:** $1,331.10 **Benefit:** 75% = $998.35 85% = $1246.40
50420	PATELLA, congenital dislocation of, reconstruction of the quadriceps (Anaes.) (Assist.) **Fee:** $1,098.65 **Benefit:** 75% = $824.00
50423	TIBIA, FIBULA OR BOTH, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (Anaes.) (Assist.) **Fee:** $1,014.20 **Benefit:** 75% = $760.65 85% = $929.50
	TUMOROUS CONDITIONS
50426	DIAPHYSEAL ACLASIA, removal of lesion or lesions from bone - 1 approach (Anaes.) (Assist.) **Fee:** $472.00 **Benefit:** 75% = $354.00
	SINGLE EVEN MULTILEVEL SURGERY FOR CHILDREN WITH CEREBRAL PALSY
50450	UNILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with hemiplegic cerebral palsy comprising three or more of the following: (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of femoral torsion by rotational osteotomy of the femur. (d) Correction of tibial torsion by rotational osteotomy of the tibia. (e) Correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis, with synovectomy if performed, or os calcis lengthening. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)

	(See para TN.8.118 of explanatory notes to this Category) **Fee:** $1,246.55 **Benefit:** 75% = $934.95
50451	UNILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with hemiplegic cerebral palsy comprising three or more of the following: (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of femoral torsion by rotational osteotomy of the femur. (d) Correction of tibial torsion by rotational osteotomy of the tibia. (e) Correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis, with synovectomy if performed, or os calcis lengthening. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $1,246.55 **Benefit:** 75% = $934.95
50455	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises: (`) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.  (`) Correction of muscle imbalance by tendon transfer/transfers. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $1,411.65 **Benefit:** 75% = $1058.75
50456	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises: (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $1,411.65 **Benefit:** 75% = $1058.75
50460	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral femoral osteotomies. (`) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.  (`) Correction of muscle imbalance by tendon transfer/transfers.

	(`) Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $2,107.65 **Benefit:** 75% = $1580.75
50461	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral femoral osteotomies. (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $2,107.65 **Benefit:** 75% = $1580.75
50465	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies. (`) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.  (`) Correction of muscle imbalance by tendon transfer/transfers. (`) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation.  (`) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $2,968.55 **Benefit:** 75% = $2226.45
50466	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies. (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation. (d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category)

	Fee: $2,968.55 **Benefit:** 75% = $2226.45
50470	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation. (`) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.  (`) Correction of muscle imbalance by tendon transfer/transfers. (`) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation.  (`) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. (`) Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,764.85 **Benefit:** 75% = $2823.65
50471	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation. (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation. (d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. (e) Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,764.85 **Benefit:** 75% = $2823.65
50475	SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including: (`) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.  (`) Correction of muscle imbalance by tendon transfer/transfers. (`) Correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation.  (`) Correction of patella alta and quadriceps insufficiency by patella tendon shortening/reconstruction. (`) Correction of tibial torsion by rotational osteotomy of the tibia with internal fixation.

	(`) Correction of foot instability by os calcis lengthening or subtalar fusion. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,344.25 **Benefit:** 75% = $3258.20
50476	SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including: (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation. (d) Correction of patella alta and quadriceps insufficiency by patella tendon shortening/reconstruction. (e) Correction of tibial torsion by rotational osteotomy of the tibia with internal fixation. (f) Correction of foot instability by os calcis lengthening or subtalar fusion. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,344.25 **Benefit:** 75% = $3258.20
	TREATMENT OF FRACTURES IN PAEDIATRIC PATIENTS
50500	RADIUS OR ULNA, distal end of, *with open growth plate*, treatment of fracture of, by closed reduction (Anaes.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $281.10 **Benefit:** 75% = $210.85 85% = $238.95
50504	RADIUS OR ULNA, distal end of, *with open growth plate*, treatment of fracture of, by open reduction (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $374.95 **Benefit:** 75% = $281.25 85% = $318.75
50508	RADIUS, distal end of, *with open growth plate*, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $401.55 **Benefit:** 75% = $301.20 85% = $341.35
50512	RADIUS, distal end of, *with open growth plate*, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $535.75 **Benefit:** 75% = $401.85
50516	RADIUS OR ULNA, shaft of, *with open growth plate*, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $361.55 **Benefit:** 75% = $271.20

50520	RADIUS OR ULNA, shaft of, *with open growth plate*, treatment of fracture of, by open reduction (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $482.00 **Benefit:** 75% = $361.50
50524	RADIUS OR ULNA, shaft of, *with open growth plate*, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction undertaken in the operating theatre of a hospital (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $415.05 **Benefit:** 75% = $311.30
50528	RADIUS OR ULNA, shaft of, *with open growth plate*, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $669.55 **Benefit:** 75% = $502.20
50532	RADIUS AND ULNA, shafts of, *with open growth plates*, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $582.55 **Benefit:** 75% = $436.95
50536	RADIUS AND ULNA, shafts of, *with open growth plates*, treatment of fracture of, by open reduction (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $776.65 **Benefit:** 75% = $582.50
50540	OLECRANON, *with open growth plate*, treatment of fracture of, by open reduction (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $535.75 **Benefit:** 75% = $401.85
50544	RADIUS, *with open growth plate*, treatment of fracture of head or neck of, by closed reduction of (Anaes.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $267.80 **Benefit:** 75% = $200.85 85% = $227.65
50548	RADIUS, *with open growth plate*, treatment of fracture of head or neck of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $535.75 **Benefit:** 75% = $401.85
50552	HUMERUS, proximal, *with open growth plate*, treatment of fracture of, by closed reduction, undertaken in the operating theatre, neonatal unit or nursery of a hospital (Anaes.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $462.05 **Benefit:** 75% = $346.55
50556	HUMERUS, proximal, *with open growth plate*, treatment of fracture of, by open reduction (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $615.90 **Benefit:** 75% = $461.95
50560	HUMERUS, shaft of, *with open growth plate*, treatment of fracture of, by closed reduction, undertaken

	in the operating theatre, neonatal unit or nursery of a hospital (Anaes.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $482.00 **Benefit:** 75% = $361.50
50564	HUMERUS, shaft of, *with open growth plate*, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $642.75 **Benefit:** 75% = $482.10
50568	HUMERUS, *with open growth plate*, supracondylar or condylar, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $562.45 **Benefit:** 75% = $421.85
50572	HUMERUS, *with open growth plate*, supracondylar or condylar, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means, undertaken in the operating theatre of a hospital (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $749.90 **Benefit:** 75% = $562.45
50576	FEMUR, *with open growth plate*, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $615.90 **Benefit:** 75% = $461.95 85% = $531.20
50580	TIBIA, *with open growth plate*, plateau or condyles, medial or lateral, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $642.75 **Benefit:** 75% = $482.10
50584	TIBIA, distal, *with open growth plate*, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $615.90 **Benefit:** 75% = $461.95
50588	TIBIA AND FIBULA, *with open growth plates*, treatment of fracture of, by internal fixation (Anaes.) (Assist.) (See para TN.8.119, TN.8.118 of explanatory notes to this Category) **Fee:** $803.35 **Benefit:** 75% = $602.55
	SPINE SURGERY FOR SCOLIOSIS AND KYPHOSIS IN PAEDIATRIC PATIENTS
50600	SCOLIOSIS OR KYPHOSIS, in a growing child, manipulation of deformity and application of a localiser cast, under general anaesthesia, in a hospital (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $441.65 **Benefit:** 75% = $331.25
50604	SCOLIOSIS or KYPHOSIS, in a child or adolescent, spinal fusion for (without instrumentation) (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $1,874.55 **Benefit:** 75% = $1405.95
50608	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, treatment by segmental instrumentation and

	fusion of the spine, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,481.80 **Benefit:** 75% = $2611.35
50612	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, with spinal deformity, treatment by segmental instrumentation, utilising separate anterior and posterior approaches, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,952.50 **Benefit:** 75% = $3714.40
50616	SCOLIOSIS, in a child or adolescent, re-exploration for adjustment or removal of segmental instrumentation used for correction of spine deformity (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $629.25 **Benefit:** 75% = $471.95
50620	SCOLIOSIS, in a child or adolescent, revision of failed scoliosis surgery, involving more than 1 of osteotomy, fusion, removal of instrumentation or instrumentation, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,481.80 **Benefit:** 75% = $2611.35
50624	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - not more than 4 levels (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,481.80 **Benefit:** 75% = $2611.35
50628	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,300.95 **Benefit:** 75% = $3225.75
50632	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, requiring segmental instrumentation and fusion of the spine down to and including the pelvis or sacrum, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,615.60 **Benefit:** 75% = $2711.70
50636	SCOLIOSIS, in a child or adolescent, requiring anterior decompression of the spinal cord with vertebral resection and instrumentation in the presence of spinal cord involvement, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,017.35 **Benefit:** 75% = $3013.05
50640	SCOLIOSIS, in a child or adolescent, congenital, resection and fusion of abnormal vertebra via an anterior or posterior approach, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $2,220.75 **Benefit:** 75% = $1665.60
50644	SPINE, bone graft to, for a child or adolescent, associated with surgery for correction of scoliosis or kyphosis or both (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category)

	Fee: $2,142.70 **Benefit:** 75% = $1607.05
	TREATMENT OF HIP DYSPLASIA OR DISLOCATION IN PAEDIATRIC PATIENTS
50650	HIP DYSPLASIA or DISLOCATION, in a child, examination, manipulation and arthrography of the hip under anaesthesia (Anaes.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $421.40 **Benefit:** 75% = $316.05 85% = $358.20
50654	HIP DYSPLASIA or DISLOCATION, in a child, application or reapplication of a hip spica, including examination of the hip (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $504.60 **Benefit:** 75% = $378.45
50658	HIP DYSPLASIA or DISLOCATION, in a child, examination and manipulation of the hip under anaesthesia (Anaes.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $200.90 **Benefit:** 75% = $150.70 85% = $170.80

	Group T8. Surgical Operations
	Subgroup 16. Radiofrequency And Microwave Tissue Ablation
50950	Unresectable primary malignant tumour of the liver, destruction of, by percutaneous radiofrequency ablation or percutaneous microwave tissue ablation (including any associated imaging services), other than a service associated with a service to which item 30419 or 50952 applies (Anaes.) **Fee:** $830.15 **Benefit:** 75% = $622.65 85% = $745.45
50952	Unresectable primary malignant tumour of the liver, destruction of, by open or laparoscopic radiofrequency ablation or open or laparoscopic microwave tissue ablation (including any associated imaging services), if a multi-disciplinary team has assessed that percutaneous radiofrequency ablation or percutaneous microwave tissue ablation cannot be performed or is not practical because of one or more of the following clinical circumstances: (a) percutaneous access cannot be achieved; (b) vital organs or tissues are at risk of damage from the percutaneous radiofrequency ablation or percutaneous microwave tissue ablation procedure; (c) resection of one part of the liver is possible, however there is at least one primary liver tumour in an unresectable portion of the liver that is suitable for radiofrequency ablation or microwave tissue ablation; other than a service associated with a service to which item 30419 or 50950 applies. (Anaes.) (See para TN.8.120 of explanatory notes to this Category)

	Fee: $830.15 **Benefit:** 75% = $622.65 85% = $745.45

	Group T8. Surgical Operations
	Subgroup 17. Spinal Surgery
51011	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, one motion segment, not being a service associated with a service to which item 51012, 51013, 51014 or 51015 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.142 of explanatory notes to this Category) **Fee:** $1,458.45 **Benefit:** 75% = $1093.85
51012	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, 2 motion segments, not being a service associated with a service to which item 51011, 51013, 51014 or 51015 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.142 of explanatory notes to this Category) **Fee:** $1,944.40 **Benefit:** 75% = $1458.30
51013	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, 3 motion segments, not being a service associated with a service to which item 51011, 51012, 51014 or 51015 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.142 of explanatory notes to this Category) **Fee:** $2,430.55 **Benefit:** 75% = $1822.95
51014	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, 4 motion segments, not being a service associated with a service to which item 51011, 51012, 51013 or 51015 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.142 of explanatory notes to this Category) **Fee:** $2,916.65 **Benefit:** 75% = $2187.50
51015	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, more than 4 motion segments, not being a service associated with a service to which item 51011, 51012, 51013 or 51014 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.142 of explanatory notes to this Category) **Fee:** $3,402.75 **Benefit:** 75% = $2552.10
51020	Simple fixation of part of one vertebra (not motion segment) including pars interarticularis, spinous process or pedicle, or simple interspinous wiring between 2 adjacent vertebral levels, not being a service associated with: (a) interspinous dynamic stabilisation devices; or (b) a service to which item 51021, 51022, 51023, 51024, 51025 or 51026 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.143 of explanatory notes to this Category) **Fee:** $777.70 **Benefit:** 75% = $583.30
51021	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, one motion segment, not being a service associated with a service to which item 51020, 51022, 51023, 51024, 51025 or 51026 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.143 of explanatory notes to this Category)

	Fee: $1,301.70 **Benefit:** 75% = $976.30
51022	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 2 motion segments, not being a service associated with a service to which item 51020, 51021, 51023, 51024, 51025 or 51026 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.143 of explanatory notes to this Category) **Fee:** $1,619.20 **Benefit:** 75% = $1214.40
51023	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 3 or 4 motion segments, not being a service associated with a service to which item 51020, 51021, 51022, 51024, 51025 or 51026 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.143 of explanatory notes to this Category) **Fee:** $1,926.95 **Benefit:** 75% = $1445.25
51024	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 5 or 6 motion segments, not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51025 or 51026 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.143 of explanatory notes to this Category) **Fee:** $2,224.65 **Benefit:** 75% = $1668.50
51025	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 7 to 12 motion segments, not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51024 or 51026 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.143 of explanatory notes to this Category) **Fee:** $2,600.15 **Benefit:** 75% = $1950.15
51026	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, more than 12 motion segments, not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51024 or 51025 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.143 of explanatory notes to this Category) **Fee:** $2,846.75 **Benefit:** 75% = $2135.10
51031	Spine, posterior and/or posterolateral bone graft to, one motion segment, not being a service associated with a service to which item 51032, 51033, 51034, 51035 or 51036 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.144 of explanatory notes to this Category) **Fee:** $956.50 **Benefit:** 75% = $717.40
51032	Spine, posterior and/or posterolateral bone graft to, 2 motion segments, not being a service associated with a service to which item 51031, 51033, 51034, 51035 or 51036 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.144 of explanatory notes to this Category) **Fee:** $1,147.85 **Benefit:** 75% = $860.90
51033	Spine, posterior and/or posterolateral bone graft to, 3 motion segments, not being a service associated with a service to which item 51031, 51032, 51034, 51035 or 51036 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.144 of explanatory notes to this Category) **Fee:** $1,339.15 **Benefit:** 75% = $1004.40
51034	Spine, posterior and/or posterolateral bone graft to, 4 to 7 motion segments, not being a service associated with a service to which item 51031, 51032, 51033, 51035 or 51036 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.144 of explanatory notes to this Category) **Fee:** $1,434.80 **Benefit:** 75% = $1076.10
51035	Spine, posterior and/or posterolateral bone graft to, 8 to 11 motion segments, not being a service

	associated with a service to which item 51031, 51032, 51033, 51034 or 51036 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.144 of explanatory notes to this Category) **Fee:** $1,530.40 **Benefit:** 75% = $1147.80
51036	Spine, posterior and/or posterolateral bone graft to, 12 or more motion segments, not being a service associated with a service to which item 51031, 51032, 51033, 51034 or 51035 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.144 of explanatory notes to this Category) **Fee:** $1,626.10 **Benefit:** 75% = $1219.60
51041	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), one motion segment, not being a service associated with a service to which item 51042, 51043, 51044 or 51045 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.145 of explanatory notes to this Category) **Fee:** $1,100.00 **Benefit:** 75% = $825.00
51042	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 2 motion segments, not being a service associated with a service to which item 51041, 51043, 51044 or 51045 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.145 of explanatory notes to this Category) **Fee:** $1,540.05 **Benefit:** 75% = $1155.05
51043	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 3 motion segments, not being a service associated with a service to which item 51041, 51042, 51044 or 51045 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.145 of explanatory notes to this Category) **Fee:** $1,925.05 **Benefit:** 75% = $1443.80
51044	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 4 motion segments, not being a service associated with a service to which item 51041, 51042, 51043 or 51045 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.145 of explanatory notes to this Category) **Fee:** $2,090.05 **Benefit:** 75% = $1567.55
51045	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 5 or more motion segments, not being a service associated with a service to which item 51041, 51042, 51043 or 51044 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.145 of explanatory notes to this Category) **Fee:** $2,200.05 **Benefit:** 75% = $1650.05
Amend 51051	Pedicle subtraction osteotomy, one vertebra, not being a service associated with a service to which item 51052, 51053, 51054, 51055, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $1,879.60 **Benefit:** 75% = $1409.70
Amend 51052	Pedicle subtraction osteotomy, 2 vertebrae, not being a service associated with a service to which item 51051, 51053, 51054, 51055, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $2,286.00 **Benefit:** 75% = $1714.50
Amend 51053	Vertebral column resection osteotomy performed through single posterior approach, one vertebra, not being a service associated with a service to which item 51051, 51052, 51054, 51055, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.)

	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $2,600.95 **Benefit:** 75% = $1950.75
51054	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtotal excision is defined as removal of more than 50% of the vertebral body), one vertebra, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51055, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $1,386.85 **Benefit:** 75% = $1040.15
51055	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtotal excision is defined as removal of more than 50% of the vertebral body), 2 vertebrae, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $2,080.25 **Benefit:** 75% = $1560.20
51056	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtotal excision is defined as removal of more than 50% of the vertebral body), 3 or more vertebrae, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51055, 51057, 51058 or 51059 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $2,426.95 **Benefit:** 75% = $1820.25
51057	Vertebral body, en bloc excision of (complete spondylectomy), one vertebra, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51058 or 51059 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $2,438.40 **Benefit:** 75% = $1828.80
51058	Vertebral body, en bloc excision of (complete spondylectomy), 2 vertebrae, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51057 or 51059 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $2,743.70 **Benefit:** 75% = $2057.80
51059	Vertebral body, en bloc excision of (complete spondylectomy), 3 or more vertebrae, not being a service

	associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51057 or 51058 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.146 of explanatory notes to this Category) **Fee:** $3,352.80 **Benefit:** 75% = $2514.60
Amend 51061	Spinal fusion, anterior and posterior, including spinal instrumentation at one motion segment, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51062, 51063, 51064, 51065 or 51066 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.147 of explanatory notes to this Category) **Fee:** $2,880.00 **Benefit:** 75% = $2160.00
Amend 51062	Spinal fusion, anterior and posterior, including spinal instrumentation at 2 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51063, 51064, 51065 or 51066 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.147 of explanatory notes to this Category) **Fee:** $3,733.15 **Benefit:** 75% = $2799.90
Amend 51063	Spinal fusion, anterior and posterior, including spinal instrumentation at 3 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51062, 51064, 51065 or 51066 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.147 of explanatory notes to this Category) **Fee:** $4,521.55 **Benefit:** 75% = $3391.20
Amend 51064	Spinal fusion, anterior and posterior, including spinal instrumentation at 4 to 7 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51062, 51063, 51065 or 51066 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.147 of explanatory notes to this Category) **Fee:** $5,032.10 **Benefit:** 75% = $3774.10
Amend 51065	Spinal fusion, anterior and posterior, including spinal instrumentation at 8 to 11 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51062, 51063, 51064 or 51066 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.147 of explanatory notes to this Category) **Fee:** $5,565.45 **Benefit:** 75% = $4174.10
Amend 51066	Spinal fusion, anterior and posterior, including spinal instrumentation at 12 or more motion segments, posterior and/or posterolateral bone graft, and anterior column fusion not being a service associated with a service to which item 51061, 51062, 51063, 51064 or 51065 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.147 of explanatory notes to this Category) **Fee:** $5,859.80 **Benefit:** 75% = $4394.85
51071	Removal of intradural lesion, not being a service associated with a service to which item 51072 or 51073 applies (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $2,540.00 **Benefit:** 75% = $1905.00
51072	Craniocervical junction lesion, transoral approach for, not being a service associated with a service to which item 51071 or 51073 applies (Anaes.) (Assist.)

	(See para TN.8.141 of explanatory notes to this Category) **Fee:** $2,641.60 **Benefit:** 75% = $1981.20
51073	Removal of intramedullary tumour or arteriovenous malformation, not being a service associated with a service to which item 51071 or 51072 applies (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $3,352.80 **Benefit:** 75% = $2514.60
51102	Thoracoplasty in combination with thoracic scoliosis correction—3 or more ribs (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $1,202.35 **Benefit:** 75% = $901.80
51103	Odontoid screw fixation (Anaes.) (Assist.) (See para TN.8.141, TN.8.148 of explanatory notes to this Category) **Fee:** $2,113.05 **Benefit:** 75% = $1584.80
51110	Spine, treatment of fracture, dislocation or fracture dislocation, with immobilisation by calipers or halo, not including application of skull tongs or calipers as part of operative positioning (Anaes.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $765.30 **Benefit:** 75% = $574.00 85% = $680.60
51111	Skull calipers or halo, insertion of, as an independent procedure (Anaes.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $325.25 **Benefit:** 75% = $243.95
51112	Plaster jacket, application of, as an independent procedure (Anaes.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $219.95 **Benefit:** 75% = $165.00 85% = $187.00
51113	Halo, application of, in addition to spinal fusion for scoliosis, or other conditions (Anaes.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $243.90 **Benefit:** 75% = $182.95
51114	Halo thoracic orthosis—application of both halo and thoracic jacket (Anaes.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $430.55 **Benefit:** 75% = $322.95
51115	Halo femoral traction, as an independent procedure (Anaes.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $430.55 **Benefit:** 75% = $322.95 85% = $366.00
51120	Bone graft, harvesting of autogenous graft, via separate incision or via subcutaneous approach, in conjunction with spinal fusion, other than for the purposes of bone graft obtained from the cervical, thoracic, lumbar or sacral spine (Anaes.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $239.25 **Benefit:** 75% = $179.45
51130	Lumbar artificial intervertebral total disc replacement, at one motion segment only, including removal of disc and marginal osteophytes: (a) for a patient who:

	(i) has not had prior spinal fusion surgery at the same lumbar level; and (ii) does not have vertebral osteoporosis; and (iii) has failed conservative therapy; and (b) not being a service associated with a service to which item 51011, 51012, 51013, 51014 or 51015 applies (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $1,822.35 **Benefit:** 75% = $1366.80
51131	Cervical artificial intervertebral total disc replacement, at one motion segment only, including removal of disc and marginal osteophytes, for a patient who: (a) has not had prior spinal surgery at the same cervical level; and (b) is skeletally mature; and (c) has symptomatic degenerative disc disease with radiculopathy; and (d) does not have vertebral osteoporosis; and (e) has failed conservative therapy (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $1,100.00 **Benefit:** 75% = $825.00
51140	Previous spinal fusion, re-exploration for, involving adjustment or removal of instrumentation up to 3 motion segments, not being a service associated with a service to which item 51141 applies (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $449.55 **Benefit:** 75% = $337.20
51141	Previous spinal fusion, re-exploration for, involving adjustment or removal of instrumentation more than 3 motion segments, not being a service associated with a service to which item 51140 applies (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $831.65 **Benefit:** 75% = $623.75
51145	Wound debridement or excision for post operative infection or haematoma following spinal surgery (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $449.55 **Benefit:** 75% = $337.20
51150	Coccyx, excision of (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $452.55 **Benefit:** 75% = $339.45
51160	Anterior exposure of thoracic or lumbar spine, one motion segment, not being a service to which item 51165 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.149 of explanatory notes to this Category) **Fee:** $1,168.40 **Benefit:** 75% = $876.30
51165	Anterior exposure of thoracic or lumbar spine, more than one motion segment, not being a service to

	which item 51160 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.149 of explanatory notes to this Category) **Fee:** $1,473.20 **Benefit:** 75% = $1104.90
51170	Syringomyelia or hydromyelia, craniotomy for, with or without duraplasty, intradural dissection, plugging of obex or local cerebrospinal fluid shunt (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $2,219.55 **Benefit:** 75% = $1664.70
51171	Syringomyelia or hydromyelia, treatment by direct cerebrospinal fluid shunt (for example, syringosubarachnoid shunt, syringopleural shunt or syringoperitoneal shunt) (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $932.10 **Benefit:** 75% = $699.10

T9. ASSISTANCE AT OPERATIONS

	Group T9. Assistance At Operations
51300	Assistance at any operation identified by the word "Assist." for which the fee does not exceed $567.25 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed $567.25 (See para TN.9.2, TN.9.1 of explanatory notes to this Category) **Fee:** $87.70 **Benefit:** 75% = $65.80 85% = $74.55
51303	Assistance at any operation identified by the word "Assist." for which the fee exceeds $567.25 or at a series of operations identified by the word "Assist." for which the aggregate fee exceeds $567.25. (See para TN.9.1, TN.9.3 of explanatory notes to this Category) **Derived Fee:** one fifth of the established fee for the operation or combination of operations
51306	Assistance at a birth involving Caesarean section (See para TN.9.1 of explanatory notes to this Category) **Fee:** $126.65 **Benefit:** 75% = $95.00 85% = $107.70
51309	Assistance at a series or combination of operations that include “(Assist.)” and assistance at a birth involving Caesarean section (See para TN.9.1, TN.9.4 of explanatory notes to this Category) **Derived Fee:** one fifth of the established fee for the operation or combination of operations (the fee for item 16520 being the Schedule fee for the Caesarean section component in the calculation of the established fee)
51312	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615 and 16627 (See para TN.4.11, TN.9.1 of explanatory notes to this Category) **Derived Fee:** one fifth of the established fee for the procedure or combination of procedures
51315	Assistance at cataract and intraocular lens surgery covered by item 42698, 42701, 42702, 42704 or 42707, when performed in association with services covered by item 42551 to 42569, 42653, 42656, 42725, 42746, 42749, 42752, 42776 or 42779 (See para TN.9.1 of explanatory notes to this Category) **Fee:** $276.75 **Benefit:** 75% = $207.60 85% = $235.25
51318	Assistance at cataract and intraocular lens surgery where patient has:

	- total loss of vision, including no potential for central vision, in the fellow eye; or - previous significant surgical complication in the fellow eye; or - pseudo exfoliation, subluxed lens, iridodonesis, phacodonesis, retinal detachment, corneal scarring, pre-existing uveitis, bound down miosed pupil, nanophthalmos, spherophakia, Marfan's syndrome, homocysteinuria or previous blunt trauma causing intraocular damage (See para TN.9.5, TN.9.1 of explanatory notes to this Category) **Fee:** $182.65 **Benefit:** 75% = $137.00 85% = $155.30

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

1. HEAD

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 1. Head
20100	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, subcutaneous tissue, muscles, salivary glands or superficial vessels of the head including biopsy, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20102	INITIATION OF MANAGEMENT OF ANAESTHESIA for plastic repair of cleft lip (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
20104	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroconvulsive therapy (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20120	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on external, middle or inner ear, including biopsy, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20124	INITIATION OF MANAGEMENT OF ANAESTHESIA for otoscopy (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20140	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on eye, not being a service to which another item in this Group applies (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
Fee 20142	INITIATION OF MANAGEMENT OF ANAESTHESIA for lens surgery (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45 **Extended Medicare Safety Net Cap:** $80.40
20143	INITIATION OF MANAGEMENT OF ANAESTHESIA for retinal surgery (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
Fee 20144	INITIATION OF MANAGEMENT OF ANAESTHESIA for corneal transplant (7 basic units)

	Fee: $140.70 **Benefit:** 75% = $105.55 85% = $119.60
Fee 20145	INITIATION OF MANAGEMENT OF ANAESTHESIA for vitrectomy (7 basic units) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60
20146	INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of conjunctiva (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20147	INITIATION OF MANAGEMENT OF ANAESTHESIA for squint repair (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
20148	INITIATION OF MANAGEMENT OF ANAESTHESIA for ophthalmoscopy (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
Amend 20160	Initiation of the management of anaesthesia for intranasal or accessory sinuses, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
Amend 20162	Initiation of the management of anaesthesia for intranasal surgery for malignancy or for intranasal ablation (7 basic units) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60
20164	INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of soft tissue of the nose and accessory sinuses (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20170	INITIATION OF MANAGEMENT OF ANAESTHESIA for intraoral procedures, including biopsy, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
20172	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of cleft palate (7 basic units) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60
20174	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision of retropharyngeal tumour (9 basic units) **Fee:** $180.90 **Benefit:** 75% = $135.70 85% = $153.80
20176	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical intraoral surgery (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20190	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on facial bones, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20192	INITIATION OF MANAGEMENT OF ANAESTHESIA for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction) (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	1. HEAD
20210	INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial procedures, not being a service to which another item in this Subgroup applies (15 basic units) **Fee:** $301.50 **Benefit:** 75% = $226.15 85% = $256.30
20212	INITIATION OF MANAGEMENT OF ANAESTHESIA for subdural taps (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20214	INITIATION OF MANAGEMENT OF ANAESTHESIA for burr holes of the cranium (9 basic units) **Fee:** $180.90 **Benefit:** 75% = $135.70 85% = $153.80
20216	INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial vascular procedures including those for aneurysms or arterio-venous abnormalities (20 basic units) **Fee:** $402.00 **Benefit:** 75% = $301.50 85% = $341.70
20220	INITIATION OF MANAGEMENT OF ANAESTHESIA for spinal fluid shunt procedures (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20222	INITIATION OF MANAGEMENT OF ANAESTHESIA for ablation of an intracranial nerve (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
20225	INITIATION OF MANAGEMENT OF ANAESTHESIA for all cranial bone procedures (12 basic units) **Fee:** $241.20 **Benefit:** 75% = $180.90 85% = $205.05
20230	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the head or face (12 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $241.20 **Benefit:** 75% = $180.90 85% = $205.05

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	2. NECK
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 2. Neck
20300	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the neck not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20305	INITIATION OF MANAGEMENT OF ANAESTHESIA for incision and drainage of large haematoma, large abscess, cellulitis or similar lesion or epiglottitis causing life threatening airway obstruction (15

	basic units) **Fee:** $301.50 **Benefit:** 75% = $226.15 85% = $256.30
20320	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on oesophagus, thyroid, larynx, trachea, lymphatic system, muscles, nerves or other deep tissues of the neck, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
20321	INITIATION OF MANAGEMENT OF ANAESTHESIA for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20330	INITIATION OF MANAGEMENT OF ANAESTHESIA for laser surgery to the airway (excluding nose and mouth) (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70
20350	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major vessels of neck, not being a service to which another item in this Subgroup applies (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20352	INITIATION OF MANAGEMENT OF ANAESTHESIA for simple ligation of major vessels of neck (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20355	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the neck (12 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $241.20 **Benefit:** 75% = $180.90 85% = $205.05

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 3. Thorax
20400	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
20401	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the breast, not being a service to which another item in this Subgroup applies (4 basic units)

	Fee: $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20402	INITIATION OF MANAGEMENT OF ANAESTHESIA for reconstructive procedures on breast (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20403	INITIATION OF MANAGEMENT OF ANAESTHESIA for removal of breast lump or for breast segmentectomy where axillary node dissection is performed (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20404	INITIATION OF MANAGEMENT OF ANAESTHESIA for mastectomy (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
20405	INITIATION OF MANAGEMENT OF ANAESTHESIA for reconstructive procedures on the breast using myocutaneous flaps (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70
20406	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical or modified radical procedures on breast with internal mammary node dissection (13 basic units) **Fee:** $261.30 **Benefit:** 75% = $196.00 85% = $222.15
Fee 20410	INITIATION OF MANAGEMENT OF ANAESTHESIA for electrical conversion of arrhythmias (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20420	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the posterior part of the chest not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20440	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the sternum (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20450	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on clavicle, scapula or sternum, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20452	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical surgery on clavicle, scapula or sternum (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
20470	INITIATION OF MANAGEMENT OF ANAESTHESIA for partial rib resection, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
20472	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracoplasty (10 basic units)

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	3. THORAX
	Fee: $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20474	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures on chest wall (13 basic units) (See para TN.10.22 of explanatory notes to this Category) **Fee:** $261.30 **Benefit:** 75% = $196.00 85% = $222.15
20475	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior thorax (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	4. INTRATHORACIC
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 4. Intrathoracic
20500	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the oesophagus (15 basic units) **Fee:** $301.50 **Benefit:** 75% = $226.15 85% = $256.30
20520	INITIATION OF MANAGEMENT OF ANAESTHESIA for all closed chest procedures (including rigid oesophagoscopy or bronchoscopy), not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
20522	INITIATION OF MANAGEMENT OF ANAESTHESIA for needle biopsy of pleura (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20524	INITIATION OF MANAGEMENT OF ANAESTHESIA for pneumocentesis (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20526	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracoscopy (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20528	INITIATION OF MANAGEMENT OF ANAESTHESIA for mediastinoscopy (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70
20540	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracotomy procedures involving lungs, pleura, diaphragm, or mediastinum, not being a service to which another item in this Subgroup applies (13 basic units) **Fee:** $261.30 **Benefit:** 75% = $196.00 85% = $222.15

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	4. INTRATHORACIC
20542	INITIATION OF MANAGEMENT OF ANAESTHESIA for pulmonary decortication (15 basic units) **Fee:** $301.50 **Benefit:** 75% = $226.15 85% = $256.30
20546	INITIATION OF MANAGEMENT OF ANAESTHESIA for pulmonary resection with thoracoplasty (15 basic units) **Fee:** $301.50 **Benefit:** 75% = $226.15 85% = $256.30
20548	INITIATION OF MANAGEMENT OF ANAESTHESIA for intrathoracic repair of trauma to trachea and bronchi (15 basic units) **Fee:** $301.50 **Benefit:** 75% = $226.15 85% = $256.30
20560	Initiation of the management of anaesthesia for: (a) open procedures on the heart, pericardium or great vessels of the chest; or (b) percutaneous insertion of a valvular prosthesis (20 basic units) **Fee:** $402.00 **Benefit:** 75% = $301.50 85% = $341.70

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	5. SPINE AND SPINAL CORD
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 5. Spine And Spinal Cord
20600	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on cervical spine and/or cord, not being a service to which another item in this Subgroup applies (for myelography and discography see Items 21908 and 21914) (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20604	INITIATION OF MANAGEMENT OF ANAESTHESIA for posterior cervical laminectomy with the patient in the sitting position (13 basic units) **Fee:** $261.30 **Benefit:** 75% = $196.00 85% = $222.15
20620	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on thoracic spine and/or cord, not being a service to which another item in this Subgroup applies (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20622	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracolumbar sympathectomy (13 basic units) **Fee:** $261.30 **Benefit:** 75% = $196.00 85% = $222.15
20630	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures in lumbar region, not being a

	service to which another item in this Subgroup applies (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70
20632	INITIATION OF MANAGEMENT OF ANAESTHESIA for lumbar sympathectomy (7 basic units) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60
20634	INITIATION OF MANAGEMENT OF ANAESTHESIA for chemonucleolysis (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20670	INITIATION OF MANAGEMENT OF ANAESTHESIA for extensive spine and/or spinal cord procedures (13 basic units) (See para TN.10.23 of explanatory notes to this Category) **Fee:** $261.30 **Benefit:** 75% = $196.00 85% = $222.15
20680	INITIATION OF MANAGEMENT OF ANAESTHESIA for manipulation of spine when performed in the operating theatre of a hospital (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
20690	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous spinal procedures, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 6. Upper Abdomen
20700	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper anterior abdominal wall, not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
20702	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20703	INITIATION OF MANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, tendons and fascia of the upper abdominal wall, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20704	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery

	involving the anterior or posterior upper abdomen (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
Amend 20706	Initiation of the management of anaesthesia for laparoscopic procedures in the upper abdomen, including laparoscopic cholecystectomy, not being a service to which another item in this Subgroup applies (7 basic units) (See para TN.10.27 of explanatory notes to this Category) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60
20730	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper posterior abdominal wall, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20740	INITIATION OF MANAGEMENT OF ANAESTHESIA for upper gastrointestinal endoscopic procedures (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
Amend Fee 20745	Initiation of the management of anaesthesia for either or both of the following: (a) upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage; (b) endoscopic retrograde cholangiopancreatography (7 basic units) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60
Amend Fee 20750	Initiation of the management of anaesthesia for hernia repairs to the upper abdominal wall, other than a service to which another item in this Subgroup applies. (5 basic units) (See para TN.10.27 of explanatory notes to this Category) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20752	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional hernia and/or wound dehiscence (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
20754	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on an omphalocele (7 basic units) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60
20756	INITIATION OF MANAGEMENT OF ANAESTHESIA for transabdominal repair of diaphragmatic hernia (9 basic units) **Fee:** $180.90 **Benefit:** 75% = $135.70 85% = $153.80
20770	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major upper abdominal blood vessels (15 basic units) **Fee:** $301.50 **Benefit:** 75% = $226.15 85% = $256.30
Amend 20790	Initiation of the management of anaesthesia for procedures within the peritoneal cavity in upper abdomen, including any of the following: (a) open cholecystectomy;

	(b) gastrectomy; (c) laparoscopically assisted nephrectomy; (d) bowel shunts (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70
20791	Initiation of the management of anaesthesia for bariatric surgery in a patient with clinically severe obesity (10 basic units) (See para TN.8.29 of explanatory notes to this Category) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20792	INITIATION OF MANAGEMENT OF ANAESTHESIA for partial hepatectomy (excluding liver biopsy) (13 basic units) **Fee:** $261.30 **Benefit:** 75% = $196.00 85% = $222.15
20793	INITIATION OF MANAGEMENT OF ANAESTHESIA for extended or trisegmental hepatectomy (15 basic units) **Fee:** $301.50 **Benefit:** 75% = $226.15 85% = $256.30
20794	INITIATION OF MANAGEMENT OF ANAESTHESIA for pancreatectomy, partial or total (12 basic units) **Fee:** $241.20 **Benefit:** 75% = $180.90 85% = $205.05
20798	INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the upper abdomen (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20799	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra-abdominal organ in the upper abdomen (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 7. Lower Abdomen
20800	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the lower anterior abdominal walls, not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
20802	INITIATION OF MANAGEMENT OF ANAESTHESIA for lipectomy of the lower abdomen (5 basic

	units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20803	INITIATION OF MANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, tendons and fascia of the lower abdominal wall, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20804	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20806	INITIATION OF MANAGEMENT OF ANAESTHESIA for laparoscopic procedures in the lower abdomen (7 basic units) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60
20810	INITIATION OF MANAGEMENT OF ANAESTHESIA for lower intestinal endoscopic procedures (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20815	INITIATION OF MANAGEMENT OF ANAESTHESIA for extracorporeal shock wave lithotripsy to urinary tract (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
20820	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or subcutaneous tissue of the lower posterior abdominal wall (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20830	INITIATION OF MANAGEMENT OF ANAESTHESIA for hernia repairs in lower abdomen, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20832	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional herniae and/or wound dehiscence of the lower abdomen (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
Amend 20840	Initiation of the management of anaesthesia for all open procedures within the lower abdominal peritoneal cavity, including appendicectomy, not being a service to which another item in this Subgroup applies (6 basic units) (See para TN.10.27 of explanatory notes to this Category) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
20841	INITIATION OF MANAGEMENT OF ANAESTHESIA for bowel resection, including laparoscopic bowel resection not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70

20842	INITIATION OF MANAGEMENT OF ANAESTHESIA for amniocentesis (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20844	INITIATION OF MANAGEMENT OF ANAESTHESIA for abdominoperineal resection, including pull through procedures, ultra low anterior resection and formation of bowel reservoir (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20845	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical prostatectomy (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20846	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical hysterectomy (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20847	INITIATION OF MANAGEMENT OF ANAESTHESIA for ovarian malignancy (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20848	INITIATION OF MANAGEMENT OF ANAESTHESIA for pelvic exenteration (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20850	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean section (12 basic units) **Fee:** $241.20 **Benefit:** 75% = $180.90 85% = $205.05
20855	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean hysterectomy or hysterectomy within 24 hours of birth (15 basic units) **Fee:** $301.50 **Benefit:** 75% = $226.15 85% = $256.30
20860	INITIATION OF MANAGEMENT OF ANAESTHESIA for extraperitoneal procedures in lower abdomen, including those on the urinary tract, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
20862	INITIATION OF MANAGEMENT OF ANAESTHESIA for renal procedures, including upper 1/3 of ureter (7 basic units) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60
20863	INITIATION OF MANAGEMENT OF ANAESTHESIA for nephrectomy (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20864	INITIATION OF MANAGEMENT OF ANAESTHESIA for total cystectomy (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20866	INITIATION OF MANAGEMENT OF ANAESTHESIA for adrenalectomy (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20867	INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the lower abdomen (10 basic units)

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	7. LOWER ABDOMEN
	Fee: $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20868	INITIATION OF MANAGEMENT OF ANAESTHESIA for renal transplantation (donor or recipient) (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20880	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major lower abdominal vessels, not being a service to which another item in this subgroup applies (15 basic units) **Fee:** $301.50 **Benefit:** 75% = $226.15 85% = $256.30
20882	INITIATION OF MANAGEMENT OF ANAESTHESIA for inferior vena cava ligation (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
20884	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous umbrella insertion (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20886	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra-abdominal organ in the lower abdomen (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	8. PERINEUM
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 8. Perineum
20900	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the perineum not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
Amend 20902	Initiation of the management of anaesthesia for anorectal procedures (including surgical haemorrhoidectomy, but not banding of haemorrhoids) (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20904	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical perineal procedures including radical perineal prostatectomy or radical vulvectomy (7 basic units) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60
20905	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the perineum (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85

20906	INITIATION OF MANAGEMENT OF ANAESTHESIA for vulvectomy (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20910	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral procedures (including urethrocystoscopy), not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20911	INITIATION OF MANAGEMENT OF ANAESTHESIA for endoscopic ureteroscopic surgery including laser procedures (5 basic units) (See para TN.10.29 of explanatory notes to this Category) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20912	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral resection of bladder tumour(s) (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20914	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral resection of prostate (7 basic units) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60
20916	INITIATION OF MANAGEMENT OF ANAESTHESIA for bleeding post-transurethral resection (7 basic units) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60
20920	Initiation of management of anaesthesia for procedures on external genitalia, not being a service to which another item in this Subgroup applies. (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20924	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on undescended testis, unilateral or bilateral (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20926	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, inguinal approach (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20928	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, abdominal approach (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
20930	INITIATION OF MANAGEMENT OF ANAESTHESIA for orchiopexy, unilateral or bilateral (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20932	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis (4 basic units)

	Fee: $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20934	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal lymphadenectomy (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
20936	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70
20938	INITIATION OF MANAGEMENT OF ANAESTHESIA for insertion of penile prosthesis (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20940	INITIATION OF MANAGEMENT OF ANAESTHESIA for per vagina and vaginal procedures (including biopsy of vagina, cervix or endometrium), not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20942	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal procedures including repair operations and urinary incontinence procedures (perineal) (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20943	INITIATION OF MANAGEMENT OF ANAESTHESIA for transvaginal assisted reproductive services (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20944	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal hysterectomy (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
20946	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal birth (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70
20948	INITIATION OF MANAGEMENT OF ANAESTHESIA for purse string ligation of cervix, or removal of purse string ligature (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20950	INITIATION OF MANAGEMENT OF ANAESTHESIA for culdoscopy (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20952	INITIATION OF MANAGEMENT OF ANAESTHESIA for hysteroscopy (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20954	INITIATION OF MANAGEMENT OF ANAESTHESIA for correction of inverted uterus (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	8. PERINEUM
20956	INITIATION OF MANAGEMENT OF ANAESTHESIA for evacuation of retained products of conception, as a complication of confinement (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
20958	INITIATION OF MANAGEMENT OF ANAESTHESIA for manual removal of retained placenta or for repair of vaginal or perineal tear following birth (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
20960	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of post partum haemorrhage (blood loss > 500mls) (7 basic units) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	9. PELVIS (EXCEPT HIP)
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 9. Pelvis (Except Hip)
21100	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior pelvic region (anterior to iliac crest), except external genitalia (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21110	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21112	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21114	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21116	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow harvesting from the pelvis (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
21120	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the bony pelvis (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
21130	INITIATION OF MANAGEMENT OF ANAESTHESIA for body cast application or revision when

	performed in the operating theatre of a hospital (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21140	INITIATION OF MANAGEMENT OF ANAESTHESIA for interpelviabdominal (hind-quarter) amputation (15 basic units) **Fee:** $301.50 **Benefit:** 75% = $226.15 85% = $256.30
21150	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures for tumour of the pelvis, except hind-quarter amputation (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
21155	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior pelvis (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
21160	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving symphysis pubis or sacroiliac joint when performed in the operating theatre of a hospital (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21170	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving symphysis pubis or sacroiliac joint (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 10. Upper Leg (Except Knee)
21195	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper leg (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21199	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21200	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving hip joint when performed in the operating theatre of a hospital (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21202	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the hip joint (4

	basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21210	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving hip joint, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
21212	INITIATION OF MANAGEMENT OF ANAESTHESIA for hip disarticulation (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
21214	INITIATION OF MANAGEMENT OF ANAESTHESIA for total hip replacement or revision (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
21216	INITIATION OF MANAGEMENT OF ANAESTHESIA for bilateral total hip replacement (14 basic units) **Fee:** $281.40 **Benefit:** 75% = $211.05 85% = $239.20
21220	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving upper 2/3 of femur when performed in the operating theatre of a hospital (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21230	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving upper 2/3 of femur, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
21232	INITIATION OF MANAGEMENT OF ANAESTHESIA for above knee amputation (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21234	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection of the upper 2/3 of femur (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70
21260	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures involving veins of upper leg, including exploration (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21270	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures involving arteries of upper leg, including bypass graft, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70
21272	INITIATION OF MANAGEMENT OF ANAESTHESIA for femoral artery ligation (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21274	INITIATION OF MANAGEMENT OF ANAESTHESIA for femoral artery embolectomy (6 basic units) (See para TN.10.24 of explanatory notes to this Category)

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	10. UPPER LEG (EXCEPT KNEE)
	Fee: $120.60 **Benefit:** 75% = $90.45 85% = $102.55
21275	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the upper leg (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
21280	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper leg (15 basic units) **Fee:** $301.50 **Benefit:** 75% = $226.15 85% = $256.30

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	11. KNEE AND POPLITEAL AREA
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 11. Knee And Popliteal Area
21300	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the knee and/or popliteal area (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21321	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of knee and/or popliteal area (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21340	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on lower 1/3 of femur when performed in the operating theatre of a hospital (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21360	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on lower 1/3 of femur (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21380	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on knee joint when performed in the operating theatre of a hospital (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21382	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of knee joint (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21390	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on upper ends of tibia, fibula, and/or patella when performed in the operating theatre of a hospital (3 basic units)

	Fee: $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21392	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on upper ends of tibia, fibula, and/or patella (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21400	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on knee joint, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21402	INITIATION OF MANAGEMENT OF ANAESTHESIA for knee replacement (7 basic units) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60
21403	INITIATION OF MANAGEMENT OF ANAESTHESIA for bilateral knee replacement (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
21404	INITIATION OF MANAGEMENT OF ANAESTHESIA for disarticulation of knee (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21420	INITIATION OF MANAGEMENT OF ANAESTHESIA for cast application, removal, or repair involving knee joint, undertaken in a hospital (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21430	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of knee or popliteal area, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21432	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of arteriovenous fistula of knee or popliteal area (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21440	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of knee or popliteal area, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70
21445	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the knee and/or popliteal area (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service

	Subgroup 12. Lower Leg (Below Knee)
21460	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of lower leg, ankle, or foot (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21461	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, or fascia of lower leg, ankle, or foot, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21462	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on lower leg, ankle, or foot (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21464	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedure of ankle joint (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21472	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of Achilles tendon (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21474	INITIATION OF MANAGEMENT OF ANAESTHESIA for gastrocnemius recession (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21480	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on bones of lower leg, ankle, or foot, including amputation, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21482	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection of bone involving lower leg, ankle or foot (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21484	INITIATION OF MANAGEMENT OF ANAESTHESIA for osteotomy or osteoplasty of tibia or fibula (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21486	INITIATION OF MANAGEMENT OF ANAESTHESIA for total ankle replacement (7 basic units) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60
21490	INITIATION OF MANAGEMENT OF ANAESTHESIA for lower leg cast application, removal or repair, undertaken in a hospital (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21500	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of lower leg,

	including bypass graft, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70
21502	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of the lower leg (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
21520	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of lower leg, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21522	INITIATION OF MANAGEMENT OF ANAESTHESIA for venous thrombectomy of the lower leg (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21530	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of lower leg, ankle or foot (15 basic units) **Fee:** $301.50 **Benefit:** 75% = $226.15 85% = $256.30
21532	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of toe (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70
21535	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the lower leg (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 13. Shoulder And Axilla
21600	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the shoulder or axilla (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21610	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla including axillary dissection (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21620	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on humeral head and

	neck, sternoclavicular joint, acromioclavicular joint, or shoulder joint when performed in the operating theatre of a hospital (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21622	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of shoulder joint (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21630	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21632	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection involving humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
21634	INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder disarticulation (9 basic units) **Fee:** $180.90 **Benefit:** 75% = $135.70 85% = $153.80
21636	INITIATION OF MANAGEMENT OF ANAESTHESIA for interthoracoscapular (forequarter) amputation (15 basic units) **Fee:** $301.50 **Benefit:** 75% = $226.15 85% = $256.30
21638	INITIATION OF MANAGEMENT OF ANAESTHESIA for total shoulder replacement (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
21650	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of shoulder or axilla, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70
21652	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures for axillary-brachial aneurysm (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
21654	INITIATION OF MANAGEMENT OF ANAESTHESIA for bypass graft of arteries of shoulder or axilla (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70
21656	INITIATION OF MANAGEMENT OF ANAESTHESIA for axillary-femoral bypass graft (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
21670	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of shoulder or axilla (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	13. SHOULDER AND AXILLA
21680	INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder cast application, removal or repair, not being a service to which another item in this Subgroup applies, when undertaken in a hospital (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21682	INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder spica application when undertaken in a hospital (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21685	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the shoulder or the axilla (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	14. UPPER ARM AND ELBOW
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 14. Upper Arm And Elbow
21700	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper arm or elbow (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21710	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of upper arm or elbow, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21712	INITIATION OF MANAGEMENT OF ANAESTHESIA for open tenotomy of the upper arm or elbow (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21714	INITIATION OF MANAGEMENT OF ANAESTHESIA for tenoplasty of the upper arm or elbow (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21716	INITIATION OF MANAGEMENT OF ANAESTHESIA for tenodesis for rupture of long tendon of biceps (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21730	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on the upper arm

	or elbow when performed in the operating theatre of a hospital (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21732	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of elbow joint (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21740	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the upper arm or elbow, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21756	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures on the upper arm or elbow (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
21760	INITIATION OF MANAGEMENT OF ANAESTHESIA for total elbow replacement (7 basic units) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60
21770	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of upper arm, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70
21772	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of arteries of the upper arm (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
21780	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of upper arm, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21785	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the upper arm or elbow (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
21790	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper arm (15 basic units) **Fee:** $301.50 **Benefit:** 75% = $226.15 85% = $256.30

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service

	Subgroup 15. Forearm Wrist And Hand
21800	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the forearm, wrist or hand (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21810	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the nerves, muscles, tendons, fascia, or bursae of the forearm, wrist or hand (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21820	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on the radius, ulna, wrist, or hand bones when performed in the operating theatre of a hospital (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21830	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the radius, ulna, wrist, or hand bones, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21832	INITIATION OF MANAGEMENT OF ANAESTHESIA for total wrist replacement (7 basic units) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60
21834	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the wrist joint (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21840	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the arteries of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70
21842	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of artery of forearm, wrist or hand (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
21850	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the veins of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21860	INITIATION OF MANAGEMENT OF ANAESTHESIA for forearm, wrist, or hand cast application, removal, or repair when rendered to a patient as part of an episode of hospital treatment (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21865	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the forearm, wrist or hand (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
21870	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of forearm,

	wrist or hand (15 basic units) **Fee:** $301.50 **Benefit:** 75% = $226.15 85% = $256.30
21872	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of a finger (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 16. Anaesthesia For Burns
21878	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting where the area of burn involves not more than 3% of total body surface (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21879	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting,where the area of burn involves more than 3% but less than 10% of total body surface (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21880	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 10% or more but less than 20% of total body surface (7 basic units) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60
21881	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 20% or more but less than 30% of total body surface (9 basic units) **Fee:** $180.90 **Benefit:** 75% = $135.70 85% = $153.80
21882	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 30% or more but less than 40% of total body surface (11 basic units) **Fee:** $221.10 **Benefit:** 75% = $165.85 85% = $187.95
21883	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 40% or more but less than 50% of total body surface (13 basic units) **Fee:** $261.30 **Benefit:** 75% = $196.00 85% = $222.15

21884	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 50% or more but less than 60% of total body surface (15 basic units) **Fee:** $301.50 **Benefit:** 75% = $226.15 85% = $256.30
21885	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 60% or more but less than 70% of total body surface (17 basic units) **Fee:** $341.70 **Benefit:** 75% = $256.30 85% = $290.45
21886	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 70% or more but less than 80% of total body surface (19 basic units) **Fee:** $381.90 **Benefit:** 75% = $286.45 85% = $324.65
21887	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 80% or more of total body surface (21 basic units) **Fee:** $422.10 **Benefit:** 75% = $316.60 85% = $358.80

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 17. Anaesthesia For Radiological Or Other Diagnostic Or Therapeutic Procedures
21900	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for hysterosalpingography (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21906	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: lumbar or thoracic (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21908	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: cervical (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
21910	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: posterior fossa (9 basic units) **Fee:** $180.90 **Benefit:** 75% = $135.70 85% = $153.80
21912	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography:

	lumbar or thoracic (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21914	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography: cervical (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
21915	INITIATION OF MANAGEMENT OF ANAESTHESIA for peripheral arteriogram (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21916	INITIATION OF MANAGEMENT OF ANAESTHESIA for arteriograms: cerebral, carotid or vertebral (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21918	INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde arteriogram: brachial or femoral (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
Fee 21922	INITIATION OF MANAGEMENT OF ANAESTHESIA for computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
21925	INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde cystography, retrograde urethrography or retrograde cystourethrography (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
Fee 21926	INITIATION OF MANAGEMENT OF ANAESTHESIA for fluoroscopy (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21930	INITIATION OF MANAGEMENT OF ANAESTHESIA for bronchography (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
21935	INITIATION OF MANAGEMENT OF ANAESTHESIA for phlebography (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
Fee 21936	INITIATION OF MANAGEMENT OF ANAESTHESIA for heart, 2 dimensional real time transoesophageal examination (5 basic units) (See para TN.10.26 of explanatory notes to this Category) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21939	INITIATION OF MANAGEMENT OF ANAESTHESIA for peripheral venous cannulation (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21941	INITIATION OF MANAGEMENT OF ANAESTHESIA for cardiac catheterisation including coronary arteriography, ventriculography, cardiac mapping, insertion of automatic defibrillator or transvenous

	pacemaker (7 basic units) (See para TN.10.25 of explanatory notes to this Category) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60
21942	INITIATION OF MANAGEMENT OF ANAESTHESIA for cardiac electrophysiological procedures including radio frequency ablation (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
21943	INITIATION OF MANAGEMENT OF ANAESTHESIA for central vein catheterisation or insertion of right heart balloon catheter (via jugular, subclavian or femoral vein) by percutaneous or open exposure (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21945	INITIATION OF MANAGEMENT OF ANAESTHESIA for lumbar puncture, cisternal puncture, or epidural injection (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21949	INITIATION OF MANAGEMENT OF ANAESTHESIA for harvesting of bone marrow for the purpose of transplantation (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
Amend Fee 21952	Initiation of the management of anaesthesia for diagnostic muscle biopsy to assess for malignant hyperpyrexia (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21955	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroencephalography (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21959	INITIATION OF MANAGEMENT OF ANAESTHESIA for brain stem evoked response audiometry (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21962	INITIATION OF MANAGEMENT OF ANAESTHESIA for electrocochleography by extratympanic method or transtympanic membrane insertion method (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21965	INITIATION OF MANAGEMENT OF ANAESTHESIA as a therapeutic procedure if there is a clinical need for anaesthesia, not for headache of any etiology (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21969	INITIATION OF MANAGEMENT OF ANAESTHESIA during hyperbaric therapy where the medical practitioner is not confined in the chamber (including the administration of oxygen) (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70
21970	INITIATION OF MANAGEMENT OF ANAESTHESIA during hyperbaric therapy where the medical practitioner is confined in the chamber (including the administration of oxygen) (15 basic units)

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES
	Fee: $301.50 **Benefit:** 75% = $226.15 85% = $256.30
21973	INITIATION OF MANAGEMENT OF ANAESTHESIA for brachytherapy using radioactive sealed sources (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21976	INITIATION OF MANAGEMENT OF ANAESTHESIA for therapeutic nuclear medicine (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
21980	INITIATION OF MANAGEMENT OF ANAESTHESIA for radiotherapy (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	18. MISCELLANEOUS
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 18. Miscellaneous
21990	INITIATION OF MANAGEMENT OF ANAESTHESIA when no procedure ensues (3 basic units) (See para TN.10.12 of explanatory notes to this Category) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
21992	INITIATION OF MANAGEMENT OF ANAESTHESIA performed on a person under the age of 10 years in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
21997	INITIATION OF MANAGEMENT OF ANAESTHESIA in connection with a procedure covered by an item that does not include the word "(Anaes.)", other than a service to which item 21965 or 21992 applies, if there is a clinical need for anaesthesia (4 basic units) (See para TN.10.13 of explanatory notes to this Category) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	19. THERAPEUTIC AND DIAGNOSTIC SERVICES
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 19. Therapeutic And Diagnostic Services

Amend 22002	Administration of homologous blood or bone marrow already collected, when performed in association with the management of anaesthesia (4 basic units) (See para TN.10.8 of explanatory notes to this Category) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
22007	ENDOTRACHEAL INTUBATION with flexible fibreoptic scope associated with difficult airway when performed in association with the administration of anaesthesia (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
22008	DOUBLE LUMEN ENDOBRONCHIAL TUBE OR BRONCHIAL BLOCKER, insertion of when performed in association with the administration of anaesthesia (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
Amend 22012	Central venous, pulmonary arterial, systemic arterial or cardiac intracavity blood pressure monitoring by indwelling catheter—once per day for each type of pressure for a patient: (a) when performed in association with the management of anaesthesia for the patient; and (b) other than a service to which item 13876 applies (c) is categorised as having a high risk of complications or during the procedure develops either complications or a high risk of complications (3 basic units) (See para TN.10.8 of explanatory notes to this Category) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
Amend 22014	Central venous, pulmonary arterial, systemic arterial or cardiac intracavity blood pressure monitoring by indwelling catheter—once per day for each type of pressure for a patient: (a) when performed in association with the management of anaesthesia for the patient; and (b) relating to another discrete operation on the same day for the patient; and (c) other than a service to which item 13876 applies (d) who is categorised as having a high risk of complications or develops during the current procedure either complications or a high risk of complications (3 basic units) (See para TN.10.8 of explanatory notes to this Category) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
22015	RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and cardiac output measurement, when performed in association with the administration of anaesthesia (6 basic units) (See para TN.10.8 of explanatory notes to this Category) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
22020	CENTRAL VEIN CATHETERISATION by percutaneous or open exposure, not being a service to which item 13318 applies, when performed in association with the administration of anaesthesia (4 basic units) (See para TN.1.6, TN.10.8 of explanatory notes to this Category) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
Amend 22025	Intra-arterial cannulation when performed in association with the management of anaesthesia in a patient who: (a) is categorised as having a high risk of complications; or (b) develops a high risk of complications during the procedure (4 basic units)

	(See para TN.10.8 of explanatory notes to this Category) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
Amend 22031	Intrathecal or epidural injection (initial) of a therapeutic substance or substances, with or without insertion of a catheter, in association with anaesthesia and surgery, for post-operative pain management, not being a service to which 22036 applies (5 basic units) (See para TN.10.17 of explanatory notes to this Category) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
22036	INTRATHECAL or EPIDURAL INJECTION (subsequent) of a therapeutic substance or substances, using an in-situ catheter, in association with anaesthesia and surgery, for postoperative pain management, not being a service associated with a service to which 22031 applies (3 basic units) (See para TN.10.17 of explanatory notes to this Category) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
New 22041	Perioperative introduction of a plexus or nerve block proximal to the lower leg or forearm for post operative pain management (2 basic units) (See para TN.10.17 of explanatory notes to this Category) **Fee:** $40.20 **Benefit:** 75% = $30.15 85% = $34.20
New 22042	Introduction of a nerve block performed via a retrobulbar, peribulbar, or sub Tenon's approach, or other complex eye block, when administered by an anaesthetist perioperatively (1 basic units) (See para TN.10.8 of explanatory notes to this Category) **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10
22051	INTRA-OPERATIVE TRANSOESOPHAGEAL ECHOCARDIOGRAPHY - Monitoring in real time of the structure and function of the heart chambers, valves and surrounding structures, including assessment of blood flow, with appropriate permanent recording during procedures on the heart, pericardium or great vessels of the chest (not in association with items 55130, 55135 or 21936) (9 basic units) (See para TN.10.30 of explanatory notes to this Category) **Fee:** $180.90 **Benefit:** 75% = $135.70 85% = $153.80
22055	PERFUSION OF LIMB OR ORGAN using heart-lung machine or equivalent, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (12 basic units) (See para TN.10.10 of explanatory notes to this Category) **Fee:** $241.20 **Benefit:** 75% = $180.90 85% = $205.05
22060	WHOLE BODY PERFUSION, CARDIAC BYPASS, where the heart-lung machine or equivalent is continuously operated by a medical perfusionist, other than a service associated with anaesthesia to which an item in Subgroup 21 applies. (20 basic units) (20 basic units) (See para TN.10.10, TN.10.3 of explanatory notes to this Category) **Fee:** $402.00 **Benefit:** 75% = $301.50 85% = $341.70
22065	INDUCED CONTROLLED HYPOTHERMIA total body, being a service to which item 22060 applies, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (5 basic units) (See para TN.10.10 of explanatory notes to this Category) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
22075	DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22°c, including

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	19. THERAPEUTIC AND DIAGNOSTIC SERVICES
	management of retrograde cerebral perfusion if performed, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (15 basic units) (See para TN.10.10 of explanatory notes to this Category) **Fee:** $301.50 **Benefit:** 75% = $226.15 85% = $256.30

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	20. ADMINISTRATION OF ANAESTHESIA IN CONNECTION WITH A DENTAL SERVICE
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 20. Administration Of Anaesthesia In Connection With A Dental Service
22900	INITIATION OF MANAGEMENT BY A MEDICAL PRACTITIONER OF ANAESTHESIA for extraction of tooth or teeth with or without incision of soft tissue or removal of bone (6 basic units) (See para TN.10.14 of explanatory notes to this Category) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
22905	INITIATION OF MANAGEMENT OF ANAESTHESIA for restorative dental work (6 basic units) (See para TN.10.14 of explanatory notes to this Category) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	21. ANAESTHESIA/PERFUSION TIME UNITS
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 21. Anaesthesia/Perfusion Time Units
23010	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA (a) administration of anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or (b) perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 25205 For a period of:

	(FIFTEEN MINUTES OR LESS) (1 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10
New 23025	16 MINUTES TO 30 MINUTES (2 basic units) **Fee:** $40.20 **Benefit:** 75% = $30.15 85% = $34.20
New 23035	31 MINUTES to 45 MINUTES (3 basic units) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
New 23045	46 MINUTES to 1:00 HOUR (4 basic units) **Fee:** $80.40 **Benefit:** 75% = $60.30 85% = $68.35
New 23055	1:01 HOURS to 1:15 HOURS (5 basic units) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
New 23065	1:16 HOURS to 1:30 HOURS (6 basic units) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
New 23075	1:31 HOURS to 1:45 HOURS (7 basic units) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60
New 23085	1:46 HOURS to 2:00 HOURS (8 basic units) **Fee:** $160.80 **Benefit:** 75% = $120.60 85% = $136.70
23091	2:01 HOURS TO 2:10 HOURS (9 basic units) **Fee:** $180.90 **Benefit:** 75% = $135.70 85% = $153.80
23101	2:11 HOURS TO 2:20 HOURS (10 basic units) **Fee:** $201.00 **Benefit:** 75% = $150.75 85% = $170.85
23111	2:21 HOURS TO 2:30 HOURS (11 basic units) **Fee:** $221.10 **Benefit:** 75% = $165.85 85% = $187.95
23112	2:31 HOURS TO 2:40 HOURS (12 basic units) **Fee:** $241.20 **Benefit:** 75% = $180.90 85% = $205.05
23113	2:41 HOURS TO 2:50 HOURS (13 basic units) **Fee:** $261.30 **Benefit:** 75% = $196.00 85% = $222.15
23114	2:51 HOURS TO 3:00 HOURS (14 basic units) **Fee:** $281.40 **Benefit:** 75% = $211.05 85% = $239.20
23115	3:01 HOURS TO 3:10 HOURS (15 basic units) **Fee:** $301.50 **Benefit:** 75% = $226.15 85% = $256.30

23116	3:11 HOURS TO 3:20 HOURS (16 basic units) **Fee:** $321.60 **Benefit:** 75% = $241.20 85% = $273.40
23117	3:21 HOURS TO 3:30 HOURS (17 basic units) **Fee:** $341.70 **Benefit:** 75% = $256.30 85% = $290.45
23118	3:31 HOURS TO 3:40 HOURS (18 basic units) **Fee:** $361.80 **Benefit:** 75% = $271.35 85% = $307.55
23119	3:41 HOURS TO 3:50 HOURS (19 basic units) **Fee:** $381.90 **Benefit:** 75% = $286.45 85% = $324.65
23121	3:51 HOURS TO 4:00 HOURS (20 basic units) **Fee:** $402.00 **Benefit:** 75% = $301.50 85% = $341.70
23170	4:01 HOURS TO 4:10 HOURS (21 basic units) **Fee:** $422.10 **Benefit:** 75% = $316.60 85% = $358.80
23180	4:11 HOURS TO 4:20 HOURS (22 basic units) **Fee:** $442.20 **Benefit:** 75% = $331.65 85% = $375.90
23190	4:21 HOURS TO 4:30 HOURS (23 basic units) **Fee:** $462.30 **Benefit:** 75% = $346.75 85% = $393.00
23200	4:31 HOURS TO 4:40 HOURS (24 basic units) **Fee:** $482.40 **Benefit:** 75% = $361.80 85% = $410.05
23210	4:41 HOURS TO 4:50 HOURS (25 basic units) **Fee:** $502.50 **Benefit:** 75% = $376.90 85% = $427.15
23220	4:51 HOURS TO 5:00 HOURS (26 basic units) **Fee:** $522.60 **Benefit:** 75% = $391.95 85% = $444.25
23230	5:01 HOURS TO 5:10 HOURS (27 basic units) **Fee:** $542.70 **Benefit:** 75% = $407.05 85% = $461.30
23240	5:11 HOURS TO 5:20 HOURS (28 basic units) **Fee:** $562.80 **Benefit:** 75% = $422.10 85% = $478.40
23250	5:21 HOURS TO 5:30 HOURS (29 basic units) **Fee:** $582.90 **Benefit:** 75% = $437.20 85% = $498.20
23260	5:31 HOURS TO 5:40 HOURS (30 basic units) **Fee:** $603.00 **Benefit:** 75% = $452.25 85% = $518.30

23270	5:41 HOURS TO 5:50 HOURS (31 basic units) **Fee:** $623.10 **Benefit:** 75% = $467.35 85% = $538.40
23280	(5:51 HOURS TO 6:00 HOURS (32 basic units) **Fee:** $643.20 **Benefit:** 75% = $482.40 85% = $558.50
23290	6:01 HOURS TO 6:10 HOURS (33 basic units) **Fee:** $663.30 **Benefit:** 75% = $497.50 85% = $578.60
23300	6:11 HOURS TO 6:20 HOURS (34 basic units) **Fee:** $683.40 **Benefit:** 75% = $512.55 85% = $598.70
23310	6:21 HOURS TO 6:30 HOURS (35 basic units) **Fee:** $703.50 **Benefit:** 75% = $527.65 85% = $618.80
23320	6:31 HOURS TO 6:40 HOURS (36 basic units) **Fee:** $723.60 **Benefit:** 75% = $542.70 85% = $638.90
23330	6:41 HOURS TO 6:50 HOURS (37 basic units) **Fee:** $743.70 **Benefit:** 75% = $557.80 85% = $659.00
23340	6:51 HOURS TO 7:00 HOURS (38 basic units) **Fee:** $763.80 **Benefit:** 75% = $572.85 85% = $679.10
23350	7:01 HOURS TO 7:10 HOURS (39 basic units) **Fee:** $783.90 **Benefit:** 75% = $587.95 85% = $699.20
23360	7:11 HOURS TO 7:20 HOURS (40 basic units) **Fee:** $804.00 **Benefit:** 75% = $603.00 85% = $719.30
23370	7:21 HOURS TO 7:30 HOURS (41 basic units) **Fee:** $824.10 **Benefit:** 75% = $618.10 85% = $739.40
23380	7:31 HOURS TO 7:40 HOURS (42 basic units) **Fee:** $844.20 **Benefit:** 75% = $633.15 85% = $759.50
23390	7:41 HOURS TO 7:50 HOURS (43 basic units) **Fee:** $864.30 **Benefit:** 75% = $648.25 85% = $779.60
23400	7:51 HOURS TO 8:00 HOURS (44 basic units) **Fee:** $884.40 **Benefit:** 75% = $663.30 85% = $799.70
23410	8:01 HOURS TO 8:10 HOURS (45 basic units) **Fee:** $904.50 **Benefit:** 75% = $678.40 85% = $819.80

23420	8:11 HOURS TO 8:20 HOURS (46 basic units) **Fee:** $924.60 **Benefit:** 75% = $693.45 85% = $839.90
23430	8:21 HOURS TO 8:30 HOURS (47 basic units) **Fee:** $944.70 **Benefit:** 75% = $708.55 85% = $860.00
23440	8:31 HOURS TO 8:40 HOURS (48 basic units) **Fee:** $964.80 **Benefit:** 75% = $723.60 85% = $880.10
23450	8:41 HOURS TO 8:50 HOURS (49 basic units) **Fee:** $984.90 **Benefit:** 75% = $738.70 85% = $900.20
23460	8:51 HOURS TO 9:00 HOURS (50 basic units) **Fee:** $1,005.00 **Benefit:** 75% = $753.75 85% = $920.30
23470	9:01 HOURS TO 9:10 HOURS (51 basic units) **Fee:** $1,025.10 **Benefit:** 75% = $768.85 85% = $940.40
23480	9:11 HOURS TO 9:20 HOURS (52 basic units) **Fee:** $1,045.20 **Benefit:** 75% = $783.90 85% = $960.50
23490	9:21 HOURS TO 9:30 HOURS (53 basic units) **Fee:** $1,065.30 **Benefit:** 75% = $799.00 85% = $980.60
23500	9:31 HOURS TO 9:40 HOURS (54 basic units) **Fee:** $1,085.40 **Benefit:** 75% = $814.05 85% = $1000.70
23510	9:41 HOURS TO 9:50 HOURS (55 basic units) **Fee:** $1,105.50 **Benefit:** 75% = $829.15 85% = $1020.80
23520	9:51 HOURS TO 10:00 HOURS (56 basic units) **Fee:** $1,125.60 **Benefit:** 75% = $844.20 85% = $1040.90
23530	10:01 HOURS TO 10:10 HOURS (57 basic units) **Fee:** $1,145.70 **Benefit:** 75% = $859.30 85% = $1061.00
23540	10:11 HOURS TO 10:20 HOURS (58 basic units) **Fee:** $1,165.80 **Benefit:** 75% = $874.35 85% = $1081.10
23550	10:21 HOURS TO 10:30 HOURS (59 basic units) **Fee:** $1,185.90 **Benefit:** 75% = $889.45 85% = $1101.20
23560	10:31 HOURS TO 10:40 HOURS (60 basic units) **Fee:** $1,206.00 **Benefit:** 75% = $904.50 85% = $1121.30

23570	10:41 HOURS TO 10:50 HOURS (61 basic units) **Fee:** $1,226.10 **Benefit:** 75% = $919.60 85% = $1141.40
23580	10:51 HOURS TO 11:00 HOURS (62 basic units) **Fee:** $1,246.20 **Benefit:** 75% = $934.65 85% = $1161.50
23590	11:01 HOURS TO 11:10 HOURS (63 basic units) **Fee:** $1,266.30 **Benefit:** 75% = $949.75 85% = $1181.60
23600	11:11 HOURS TO 11:20 HOURS (64 basic units) **Fee:** $1,286.40 **Benefit:** 75% = $964.80 85% = $1201.70
23610	11:21 HOURS TO 11:30 HOURS (65 basic units) **Fee:** $1,306.50 **Benefit:** 75% = $979.90 85% = $1221.80
23620	11:31 HOURS TO 11:40 HOURS (66 basic units) **Fee:** $1,326.60 **Benefit:** 75% = $994.95 85% = $1241.90
23630	11:41 HOURS TO 11:50 HOURS (67 basic units) **Fee:** $1,346.70 **Benefit:** 75% = $1010.05 85% = $1262.00
23640	11:51 HOURS TO 12:00 HOURS (68 basic units) **Fee:** $1,366.80 **Benefit:** 75% = $1025.10 85% = $1282.10
23650	12:01 HOURS TO 12:10 HOURS (69 basic units) **Fee:** $1,386.90 **Benefit:** 75% = $1040.20 85% = $1302.20
23660	12:11 HOURS TO 12:20 HOURS (70 basic units) **Fee:** $1,407.00 **Benefit:** 75% = $1055.25 85% = $1322.30
23670	12:21 HOURS TO 12:30 HOURS (71 basic units) **Fee:** $1,427.10 **Benefit:** 75% = $1070.35 85% = $1342.40
23680	12:31 HOURS TO 12:40 HOURS (72 basic units) **Fee:** $1,447.20 **Benefit:** 75% = $1085.40 85% = $1362.50
23690	12:41 HOURS TO 12:50 HOURS (73 basic units) **Fee:** $1,467.30 **Benefit:** 75% = $1100.50 85% = $1382.60
23700	12:51 HOURS TO 13:00 HOURS (74 basic units) **Fee:** $1,487.40 **Benefit:** 75% = $1115.55 85% = $1402.70
23710	13:01 HOURS TO 13:10 HOURS (75 basic units) **Fee:** $1,507.50 **Benefit:** 75% = $1130.65 85% = $1422.80

23720	13:11 HOURS TO 13:20 HOURS (76 basic units) **Fee:** $1,527.60 **Benefit:** 75% = $1145.70 85% = $1442.90
23730	13:21 HOURS TO 13:30 HOURS (77 basic units) **Fee:** $1,547.70 **Benefit:** 75% = $1160.80 85% = $1463.00
23740	13:31 HOURS TO 13:40 HOURS (78 basic units) **Fee:** $1,567.80 **Benefit:** 75% = $1175.85 85% = $1483.10
23750	13:41 HOURS TO 13:50 HOURS (79 basic units) **Fee:** $1,587.90 **Benefit:** 75% = $1190.95 85% = $1503.20
23760	13:51 HOURS TO 14:00 HOURS (80 basic units) **Fee:** $1,608.00 **Benefit:** 75% = $1206.00 85% = $1523.30
23770	14:01 HOURS TO 14:10 HOURS (81 basic units) **Fee:** $1,628.10 **Benefit:** 75% = $1221.10 85% = $1543.40
23780	14:11 HOURS TO 14:20 HOURS (82 basic units) **Fee:** $1,648.20 **Benefit:** 75% = $1236.15 85% = $1563.50
23790	14:21 HOURS TO 14:30 HOURS (83 basic units) **Fee:** $1,668.30 **Benefit:** 75% = $1251.25 85% = $1583.60
23800	14:31 HOURS TO 14:40 HOURS (84 basic units) **Fee:** $1,688.40 **Benefit:** 75% = $1266.30 85% = $1603.70
23810	14:41 HOURS TO 14:50 HOURS (85 basic units) **Fee:** $1,708.50 **Benefit:** 75% = $1281.40 85% = $1623.80
23820	14:51 HOURS TO 15:00 HOURS (86 basic units) **Fee:** $1,728.60 **Benefit:** 75% = $1296.45 85% = $1643.90
23830	15:01 HOURS TO 15:10 HOURS (87 basic units) **Fee:** $1,748.70 **Benefit:** 75% = $1311.55 85% = $1664.00
23840	15:11 HOURS TO 15:20 HOURS (88 basic units) **Fee:** $1,768.80 **Benefit:** 75% = $1326.60 85% = $1684.10
23850	15:21 HOURS TO 15:30 HOURS (89 basic units) **Fee:** $1,788.90 **Benefit:** 75% = $1341.70 85% = $1704.20
23860	15:31 HOURS TO 15:40 HOURS (90 basic units) **Fee:** $1,809.00 **Benefit:** 75% = $1356.75 85% = $1724.30

23870	15:41 HOURS TO 15:50 HOURS (91 basic units) **Fee:** $1,829.10 **Benefit:** 75% = $1371.85 85% = $1744.40
23880	15:51 HOURS TO 16:00 HOURS (92 basic units) **Fee:** $1,849.20 **Benefit:** 75% = $1386.90 85% = $1764.50
23890	16:01 HOURS TO 16:10 HOURS (93 basic units) **Fee:** $1,869.30 **Benefit:** 75% = $1402.00 85% = $1784.60
23900	16:11 HOURS TO 16:20 HOURS (94 basic units) **Fee:** $1,889.40 **Benefit:** 75% = $1417.05 85% = $1804.70
23910	16:21 HOURS TO 16:30 HOURS (95 basic units) **Fee:** $1,909.50 **Benefit:** 75% = $1432.15 85% = $1824.80
23920	16:31 HOURS TO 16:40 HOURS (96 basic units) **Fee:** $1,929.60 **Benefit:** 75% = $1447.20 85% = $1844.90
23930	16:41 HOURS TO 16:50 HOURS (97 basic units) **Fee:** $1,949.70 **Benefit:** 75% = $1462.30 85% = $1865.00
23940	16:51 HOURS TO 17:00 HOURS (98 basic units) **Fee:** $1,969.80 **Benefit:** 75% = $1477.35 85% = $1885.10
23950	17:01 HOURS TO 17:10 HOURS (99 basic units) **Fee:** $1,989.90 **Benefit:** 75% = $1492.45 85% = $1905.20
23960	17:11 HOURS TO 17:20 HOURS (100 basic units) **Fee:** $2,010.00 **Benefit:** 75% = $1507.50 85% = $1925.30
23970	17:21 HOURS TO 17:30 HOURS (101 basic units) **Fee:** $2,030.10 **Benefit:** 75% = $1522.60 85% = $1945.40
23980	17:31 HOURS TO 17:40 HOURS (102 basic units) **Fee:** $2,050.20 **Benefit:** 75% = $1537.65 85% = $1965.50
23990	17:41 HOURS TO 17:50 HOURS (103 basic units) **Fee:** $2,070.30 **Benefit:** 75% = $1552.75 85% = $1985.60
24100	17:51 HOURS TO 18:00 HOURS (104 basic units) **Fee:** $2,090.40 **Benefit:** 75% = $1567.80 85% = $2005.70
24101	18:01 HOURS TO 18:10 HOURS (105 basic units) **Fee:** $2,110.50 **Benefit:** 75% = $1582.90 85% = $2025.80

24102	18:11 HOURS TO 18:20 HOURS (106 basic units) **Fee:** $2,130.60 **Benefit:** 75% = $1597.95 85% = $2045.90
24103	18:21 HOURS TO 18:30 HOURS (107 basic units) **Fee:** $2,150.70 **Benefit:** 75% = $1613.05 85% = $2066.00
24104	18:31 HOURS TO 18:40 HOURS (108 basic units) **Fee:** $2,170.80 **Benefit:** 75% = $1628.10 85% = $2086.10
24105	18:41 HOURS TO 18:50 HOURS (109 basic units) **Fee:** $2,190.90 **Benefit:** 75% = $1643.20 85% = $2106.20
24106	18:51 HOURS TO 19:00 HOURS (110 basic units) **Fee:** $2,211.00 **Benefit:** 75% = $1658.25 85% = $2126.30
24107	19:01 HOURS TO 19:10 HOURS (111 basic units) **Fee:** $2,231.10 **Benefit:** 75% = $1673.35 85% = $2146.40
24108	19:11 HOURS TO 19:20 HOURS (112 basic units) **Fee:** $2,251.20 **Benefit:** 75% = $1688.40 85% = $2166.50
24109	19:21 HOURS TO 19:30 HOURS (113 basic units) **Fee:** $2,271.30 **Benefit:** 75% = $1703.50 85% = $2186.60
24110	19:31 HOURS TO 19:40 HOURS (114 basic units) **Fee:** $2,291.40 **Benefit:** 75% = $1718.55 85% = $2206.70
24111	19:41 HOURS TO 19:50 HOURS (115 basic units) **Fee:** $2,311.50 **Benefit:** 75% = $1733.65 85% = $2226.80
24112	19:51 HOURS TO 20:00 HOURS (116 basic units) **Fee:** $2,331.60 **Benefit:** 75% = $1748.70 85% = $2246.90
24113	20:01 HOURS TO 20:10 HOURS (117 basic units) **Fee:** $2,351.70 **Benefit:** 75% = $1763.80 85% = $2267.00
24114	20:11 HOURS TO 20:20 HOURS (118 basic units) **Fee:** $2,371.80 **Benefit:** 75% = $1778.85 85% = $2287.10
24115	20:21 HOURS TO 20:30 HOURS (119 basic units) **Fee:** $2,391.90 **Benefit:** 75% = $1793.95 85% = $2307.20
24116	20:31 HOURS TO 20:40 HOURS (120 basic units) **Fee:** $2,412.00 **Benefit:** 75% = $1809.00 85% = $2327.30

24117	20:41 HOURS TO 20:50 HOURS (121 basic units) **Fee:** $2,432.10 **Benefit:** 75% = $1824.10 85% = $2347.40
24118	20:51 HOURS TO 21:00 HOURS (122 basic units) **Fee:** $2,452.20 **Benefit:** 75% = $1839.15 85% = $2367.50
24119	21:01 HOURS TO 21:10 HOURS (123 basic units) **Fee:** $2,472.30 **Benefit:** 75% = $1854.25 85% = $2387.60
24120	21:11 HOURS TO 21:20 HOURS (124 basic units) **Fee:** $2,492.40 **Benefit:** 75% = $1869.30 85% = $2407.70
24121	21:21 HOURS TO 21:30 HOURS (125 basic units) **Fee:** $2,512.50 **Benefit:** 75% = $1884.40 85% = $2427.80
24122	21:31 HOURS TO 21:40 HOURS (126 basic units) **Fee:** $2,532.60 **Benefit:** 75% = $1899.45 85% = $2447.90
24123	21:41 HOURS TO 21:50 HOURS (127 basic units) **Fee:** $2,552.70 **Benefit:** 75% = $1914.55 85% = $2468.00
24124	21:51 HOURS TO 22:00 HOURS (128 basic units) **Fee:** $2,572.80 **Benefit:** 75% = $1929.60 85% = $2488.10
24125	22:01 HOURS TO 22:10 HOURS (129 basic units) **Fee:** $2,592.90 **Benefit:** 75% = $1944.70 85% = $2508.20
24126	22:11 HOURS TO 22:20 HOURS (130 basic units) **Fee:** $2,613.00 **Benefit:** 75% = $1959.75 85% = $2528.30
24127	22:21 HOURS TO 22:30 HOURS (131 basic units) **Fee:** $2,633.10 **Benefit:** 75% = $1974.85 85% = $2548.40
24128	22:31 HOURS TO 22:40 HOURS (132 basic units) **Fee:** $2,653.20 **Benefit:** 75% = $1989.90 85% = $2568.50
24129	22:41 HOURS TO 22:50 HOURS (133 basic units) **Fee:** $2,673.30 **Benefit:** 75% = $2005.00 85% = $2588.60
24130	22:51 HOURS TO 23:00 HOURS (134 basic units) **Fee:** $2,693.40 **Benefit:** 75% = $2020.05 85% = $2608.70
24131	23:01 HOURS TO 23:10 HOURS (135 basic units) **Fee:** $2,713.50 **Benefit:** 75% = $2035.15 85% = $2628.80

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	21. ANAESTHESIA/PERFUSION TIME UNITS
24132	23:11 HOURS TO 23:20 HOURS (136 basic units) **Fee:** $2,733.60 **Benefit:** 75% = $2050.20 85% = $2648.90
24133	23:21 HOURS TO 23:30 HOURS (137 basic units) **Fee:** $2,753.70 **Benefit:** 75% = $2065.30 85% = $2669.00
24134	23:31 HOURS TO 23:40 HOURS (138 basic units) **Fee:** $2,773.80 **Benefit:** 75% = $2080.35 85% = $2689.10
24135	23:41 HOURS TO 23:50 HOURS (139 basic units) **Fee:** $2,793.90 **Benefit:** 75% = $2095.45 85% = $2709.20
24136	23:51 HOURS TO 24:00 HOURS (140 basic units) **Fee:** $2,814.00 **Benefit:** 75% = $2110.50 85% = $2729.30

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	22. ANAESTHESIA/PERFUSION MODIFYING UNITS - PHYSICAL STATUS
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 22. Anaesthesia/Perfusion Modifying Units - Physical Status
25000	ANAESTHESIA, PERFUSION or ASSISTANCE AT ANAESTHESIA (a) for anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or (b) for perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 25205 Where the patient has severe systemic disease equivalent to ASA physical status indicator 3 (1 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10
25005	Where the patient has severe systemic disease which is a constant threat to life equivalent to ASA physical status indicator 4 (2 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $40.20 **Benefit:** 75% = $30.15 85% = $34.20
25010	For a patient who is not expected to survive for 24 hours with or without the operation, equivalent to ASA physical status indicator 5 (3 basic units) (See para TN.10.3 of explanatory notes to this Category)

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	22. ANAESTHESIA/PERFUSION MODIFYING UNITS - PHYSICAL STATUS
	Fee: $60.30 **Benefit:** 75% = $45.25 85% = $51.30

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	23. ANAESTHESIA/PERFUSION MODIFYING UNITS - OTHER
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 23. Anaesthesia/Perfusion Modifying Units - Other
Amend 25015	Anaesthesia, perfusion or assistance in the management of anaesthesia, for a patient less than 4 years or 75 years or older (1 basic units) **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10
25020	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA - where the patient requires immediate treatment without which there would be significant threat to life or body part - not being a service associated with a service to which item 25025 or 25030 or 25050 applies (2 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $40.20 **Benefit:** 75% = $30.15 85% = $34.20

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	24. ANAESTHESIA AFTER HOURS EMERGENCY MODIFIER
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 24. Anaesthesia After Hours Emergency Modifier
25025	EMERGENCY ANAESTHESIA performed in the after hours period where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for the emergency anaesthesia service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25030 or 25050 applies (0 basic units) (See para TN.10.3 of explanatory notes to this Category) **Derived Fee:** An additional amount of 50% of the fee for the anaesthetic service. That is: (a) an anaesthesia item/s in the range 20100 - 21997 or 22900, plus (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000-25015, plus (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001-22051
25030	ASSISTANCE AT AFTER HOURS EMERGENCY ANAESTHESIA where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for which the assistant is in professional attendance on the patient is provided in

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	24. ANAESTHESIA AFTER HOURS EMERGENCY MODIFIER
	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 (0 basic units) (See para TN.10.3 of explanatory notes to this Category) **Derived Fee:** An additional amount of 50% of the fee for assistance at anaesthesia. That is: (a) an assistant anaesthesia item in the range 25200 - 25205, plus (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000-25015, plus (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001-22051

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	25. PERFUSION AFTER HOURS EMERGENCY MODIFIER
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 25. Perfusion After Hours Emergency Modifier
25050	AFTER HOURS EMERGENCY PERFUSION where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the perfusion service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25025 or 25030 applies (0 basic units) (See para TN.10.3 of explanatory notes to this Category) **Derived Fee:** An additional amount of 50% of the fee for the perfusion service. That is: (a) item 22060, plus (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000 - 25015, plus (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001-22051 or 22065-22075

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	26. ASSISTANCE AT ANAESTHESIA
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 26. Assistance At Anaesthesia
25200	ASSISTANCE IN THE ADMINISTRATION OF ANAESTHESIA on a patient in imminent danger of death requiring continuous life saving emergency treatment, to the exclusion of all other patients (5 basic units) (See para TN.10.9 of explanatory notes to this Category) **Derived Fee:** An amount of $100.50 (5 basic units) plus an item in the range 23010 - 24136 plus, where applicable - an item in the range 25000 - 25020 plus, where performed, any associated therapeutic or diagnostic service/s in the

	range 22001 - 22051
25205	ASSISTANCE IN THE ADMINISTRATION OF ELECTIVE ANAESTHESIA where: (i) the patient has complex airway problems; or (ii) the patient is a neonate or a complex paediatric case; or (iii) there is anticipated to be massive blood loss (greater than 50% of blood volume) during the procedure; or (iv) the patient is critically ill, with multiple organ failure; or (v) where the anaesthesia time exceeds 6 hours and the assistance is provided to the exclusion of all other patients (5 basic units) (See para TN.10.9 of explanatory notes to this Category) **Derived Fee:** An amount of $100.50 (5 basic units) plus an item in the range 23010 - 24136 plus, where applicable - an item in the range 25000 - 25020 plus, where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22051

T11. BOTULINUM TOXIN INJECTIONS

	Group T11. Botulinum Toxin Injections
18350	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of hemifacial spasm in a patient who is at least 12 years of age, including all such injections on any one day (See para TN.11.1 of explanatory notes to this Category) **Fee:** $126.85 **Benefit:** 75% = $95.15 85% = $107.85
18351	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport), injection of, for the treatment of hemifacial spasm in a patient who is at least 18 years of age, including all such injections on any one day (See para TN.11.1 of explanatory notes to this Category) **Fee:** $126.85 **Benefit:** 75% = $95.15 85% = $107.85
18353	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of cervical dystonia (spasmodic torticollis), including all such injections on any one day (See para TN.11.1 of explanatory notes to this Category) **Fee:** $253.75 **Benefit:** 75% = $190.35 85% = $215.70
18354	Botulinum Toxin Type A Purified Neurotixin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport), injection of, for the treatment of dynamic equinus foot deformity (including equinovarus and equinovalgus) due to spasticity in an ambulant cerebral palsy patient, if: (a) the patient is at least 2 years of age; and (b) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum

T11. BOTULINUM TOXIN INJECTIONS	
	of 2 sets of injections for each lower limb), including all injections per set (Anaes.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $126.85 **Benefit:** 75% = $95.15 85% = $107.85
18360	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), or Clostridium Botulinum Type A Toxin Haemagglutinin Complex (Dysport), injection of, for the treatment of moderate to severe focal spasticity, if: (a) the patient is at least 18 years of age; and (b) the spasticity is associated with a previously diagnosed neurological disorder; and (c) treatment is provided as: (i) second line therapy when standard treatment for the conditions has failed; or (ii) an adjunct to physical therapy; and (d) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each limb), including all injections per set; and (e) the treatment is not provided on the same occasion as a service mentioned in item 18365 (See para TN.11.1 of explanatory notes to this Category) **Fee:** $126.85 **Benefit:** 75% = $95.15 85% = $107.85
18361	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of moderate to severe upper limb spasticity due to cerebral palsy if: (a) the patient is at least 2 years of age, and (b) for a patient who is at least 18 years of age - before the patient turned 18, the patient had commenced treatment for the spasticity with botulinum toxin supplied under the pharmaceutical benefits scheme; and (c) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set (Anaes.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $126.85 **Benefit:** 75% = $95.15 85% = $107.85
18362	Botulinum Toxin type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of severe primary axillary hyperhidrosis, including all injections on any one day, if: (a) the patient is at least 12 years of age; and (b) the patient has been intolerant of, or has not responded to, topical aluminium chloride hexahydrate; and (c) the patient has not had treatment with botulinum toxin within the immediately preceding 4 months; and (d) if the patient has had treatment with botulinum toxin within the previous 12 months - the patient had treatment on no more than 2 separate occasions (Anaes.)

T11. BOTULINUM TOXIN INJECTIONS	
	(See para TN.11.1 of explanatory notes to this Category) **Fee:** $250.65 **Benefit:** 75% = $188.00 85% = $213.10
18365	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of moderate to severe spasticity of the upper limb following a stroke, if: (a) the patient is at least 18 years of age; and (b) treatment is provided as: (i) second line therapy when standard treatment for the condition has failed; or (ii) an adjunct to physical therapy; and (c) the patient does not have established severe contracture in the limb that is to be treated; and (d) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set; and (e) for a patient who has received treatment on 2 previous separate occasions - the patient has responded to the treatment (See para TN.11.1 of explanatory notes to this Category) **Fee:** $126.85 **Benefit:** 75% = $95.15 85% = $107.85
18366	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of strabismus, including all such injections on any one day and associated electromyography (Anaes.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $158.90 **Benefit:** 75% = $119.20 85% = $135.10
18368	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of spasmodic dysphonia, including all such injections on any one day (See para TN.11.1 of explanatory notes to this Category) **Fee:** $271.30 **Benefit:** 75% = $203.50 85% = $230.65
18369	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of unilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $45.75 **Benefit:** 75% = $34.35 85% = $38.90
18370	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of unilateral blepharospasm in a patient who is at least 12 years of age, including all such injections on any one day (Anaes.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $45.75 **Benefit:** 75% = $34.35 85% = $38.90
18372	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of bilateral blepharospasm, in a patient who is at least 12 years of age; including all such injections on any one day (Anaes.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $126.85 **Benefit:** 75% = $95.15 85% = $107.85

T11. BOTULINUM TOXIN INJECTIONS	
18374	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of bilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $126.85 **Benefit:** 75% = $95.15 85% = $107.85
18375	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), intravesical injection of, with cystoscopy, for the treatment of urinary incontinence, including all such injections on any one day, if: (a) the urinary incontinence is due to neurogenic detrusor overactivity as demonstrated by urodynamic study of a patient with: (i) multiple sclerosis; or (ii) spinal cord injury; or (iii) spina bifida and who is at least 18 years of age; and (b) the patient has urinary incontinence that is inadequately controlled by anti-cholinergic therapy, as manifested by having experienced at least 14 episodes of urinary incontinence per week before commencement of treatment with botulinum toxin type A; and (c) the patient is willing and able to self-catheterise; and (d) the requirements relating to botulinum toxin type A under the Pharmaceutical Benefits Scheme are complied with; and (e) treatment is not provided on the same occasion as a service described in item 104, 105, 110, 116, 119, 11900 or 11919 For each patient - applicable not more than once except if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment (Anaes.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $233.55 **Benefit:** 75% = $175.20

T11. BOTULINUM TOXIN INJECTIONS	
18377	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of chronic migraine, including all injections in 1 day, if: (a) the patient is at least 18 years of age; and (b) the patient has experienced an inadequate response, intolerance or contraindication to at least 3 prophylactic migraine medications before commencement of treatment with botulinum toxin, as manifested by an average of 15 or more headache days per month, with at least 8 days of migraine, over a period of at least 6 months, before commencement of treatment with botulinum toxin; and (c) the requirements relating to botulinum toxin type A under the Pharmaceutical Benefits Scheme are complied with For each patient-applicable not more than twice except if the patient achieves and maintains at least a 50% reduction in the number of headache days per month from baseline after 2 treatment cycles (each of 12 weeks duration) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $126.85 **Benefit:** 75% = $95.15 85% = $107.85
18379	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), intravesical injection of, with cystoscopy, for the treatment of urinary incontinence, including all such injections on any one day, if: (a) the urinary incontinence is due to idiopathic overactive bladder in a patient: and (b) the patient is at least 18 years of age; and (c) the patient has urinary incontinence that is inadequately controlled by at least 2 alternative anti- cholinergic agents, as manifested by having experienced at least 14 episodes of urinary incontinence per week before commencement of treatment with botulinum toxin; and (d) the patient is willing and able to self-catheterise; and (e) treatment is not provided on the same occasion as a service mentioned in item 104, 105, 110, 116, 119, 11900 or 11919 For each patient-applicable not more than once except if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment (H) (Anaes.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $233.55 **Benefit:** 75% = $175.20

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CATEGORY 4: ORAL AND MAXILLOFACIAL SERVICES

SUMMARY OF CHANGES FROM 01/11/2019

The 01/11/2019 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

Description Amended

52027

Minor amendments to items 30075, 30078, 30275, 30329, 30330, 35551, 35664, 35670 and 52027

Terminology for these items has been improved by replacing references to "lymph gland/s" with the term “lymph node/s”.

ORAL AND MAXILLOFACIAL SERVICES NOTES

ON.1.1 Benefits for Medical Services Performed by Approved Dental Practitioners

Under the provisions of the *Health Insurance Act 1973* (the Act), Medicare benefits are payable where an eligible person incurs medical expenses in respect of certain professional services rendered by a approved dental practitioner approved before 1 November 2004.

Category 4 is restricted to those dental practitioners who were approved by the Minister prior to 1November2004 for the provision of oral and maxillofacial surgery services and relevant attendances.

Approved dental practitioners may also request certain diagnostic imaging services - refer to Category 5 - Diagnostic Imaging Services for more information.

ON.1.2 Changes to the Scheme Effective from 1 November 2004

From 1 November 2004, access to Category 4 is restricted to those dental practitioners who were approved by the Minister prior to 1 November 2004. No new approvals will be granted after that date.

Background

Since 2000, practitioners performing oral and maxillofacial surgery in Australia are required to have both dental and medical qualifications in order to sit for their FRACDS(OMS) exam. This effectively means that since then, any practitioner who has obtained an FRACDS(OMS) or equivalent can access Category 3 of the MBS because they are medically qualified. The Government, in consultation with the Australian and New Zealand Association of Oral and Maxillofacial Surgeons, the Australian Dental Association, the Royal Australian College of Surgeons, the Royal Australian College of Dental Surgeons and the Australian Medical Association, has agreed that access by new practitioners to Category 4 will be withdrawn from 1November2004. Practitioners who were approved prior to that date will continue to have access to Category 4. The long-term proposal is that once all practitioners who currently access Category 4 have left the workforce, Category 4 will be removed from the Medicare Benefits Schedule.

Details of the services attracting Medicare benefits are set out in the Medicare Benefits Schedule.

ON.2.1 Definition of Oral and Maxillofacial Surgery

Oral and Maxillofacial Surgery is defined as the surgical specialty which deals with the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects of the oral and maxillofacial region.

ON.2.2 Services That Can Be Provided

Dental practitioners holding the FRACDS (OMS) or equivalent who were approved by the Minister prior to 1November2004 may perform prescribed oral and maxillofacial services listed in this category. All dental practitioners approved for the purposes of subsection 3(1) of the Act are also recognised to perform those items of oral and maxillofacial surgery listed in Group C2 of the booklet "Medicare Benefits for Treatment of Cleft Lip and Cleft Palate Conditions".

It is emphasised that -

- the sole purpose of granting approval to dental practitioners is to enable payment of Medicare benefits;

- the services set out in Groups 01 to 011 of the Medicare Benefits Schedule book, and in the Cleft Lip and Cleft Palate Schedule are the only ones for which Medicare benefits are payable when the services are performed by an eligible dental practitioner.

ON.3.1 Principles of Interpretation

Each professional service listed in the Schedule is a complete medical service in itself. Where a service is rendered partly by one practitioner and partly by another, only the one amount of benefit is payable.

ON.3.2 Multiple Operation Rule

The Schedule fees for two or more operations performed on a patient on the one occasion are calculated by the following rule:-

100% for the item with the greatest Schedule fee, plus 50% for the item with the next greatest Schedule fee, plus 25% for each other item.

NOTE:

1. Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents

2. Where two or more operations performed on the one occasion have fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.

3. The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

The above rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient by different dental practitioners unless either practitioner assists the other. In this case, the fees and benefits specified in the Schedule apply. For these purposes the term "operation" includes all services in Groups O3 to O9.

If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

ON.3.3 After Care (Post-operative Treatment)

The fee specified for each of the operations listed in the Schedule contains a component for the consequential after-care customarily provided unless otherwise indicated. After-care is deemed to include all post-operative treatment rendered by practitioners and need not necessarily be limited to treatment given by the approved dental practitioner or to treatment given by any one practitioner. This does not preclude, however, the payment of benefit for professional services for the treatment by a dental practitioner of an intercurrent condition or an unusual complication arising from the operation.

Some minor operations are merely stages in the treatment of a particular condition. Professional services by dental practitioners subsequent to such operations should not be regarded as after-care but rather as continuation of the treatment of the original condition and should attract benefit. Item 52057 is a service to which this policy applies.

ON.3.4 Administration of Anaesthetics by Medical Practitioners

When a medical practitioner administers an anaesthetic in connection with a procedure prescribed for the payment of Medicare benefits (and the procedure has been performed by an approved dental practitioner), Medicare benefits are payable for the administration of the anaesthetic on the same basis as if the procedure had been rendered by a medical practitioner.

The Schedule fee for anaesthesia is established using the RVG schedule at Category 3 - Group T10.

Before the payment of benefits for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of additional details are required on the anaesthetist's account:

- The anaesthetist's account must show the name/s of the medical practitioner/s who performed the associated operation/s. Also, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and the total time of the anaesthesia;

- The assistant anaesthetist's account must show the name/s of the medical practitioners who performed the associated operation/s, as well as the name of the principle anaesthetist. In addition, where the after hours

emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthesia.

ON.4.1 Consultations - (Items 51700 and 51703)

The consultation item numbers (51700 and 51703) are to be used by approved dental practitioners in the practice of oral and maxillofacial surgery.

The referral must be from a registered dental practitioner or a medical practitioner.

ON.4.2 Assistance at Operations - (Items 51800 and 51803)

Items covering operations which are eligible for benefits for assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery or surgical assistance have been identified by the inclusion of the word "Assist" in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

The assistance must be rendered by a practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.

Where more than one practitioner provides assistance to an approved dental practitioner no additional benefits are payable. The assistance benefit is the same irrespective of the number of practitioners providing assistance.

Benefits payable under item 51800

Medicare benefits are payable under Item 51800 for assistance rendered at the following procedures:

51900, 51904, 52010, 52018, 52039, 52048, 52051, 52062, 52063, 52066, 52078, 52090, 52092, 52095, 52105, 52108, 52111, 52130, 52138, 52141, 52144, 52147, 52182, 52300, 52303, 52312, 52315, 52321, 52324, 52336, 52339, 52424, 52440, 52452, 52480, 52482, 52600, 52603, 52609, 52612, 52615, 52624, 52626, 52627, 52800, 52803, 52806, 52809, 52818, 52824, 52828, 52830, 53006, 53009, 53016, 53215, 53220, 53225, 53226, 53236, 53239, 53242, 53406, 53409, 53412, 53413, 53415, 53416, 53453, 53460.

Where assistance with any of the above procedures is provided by a medical practitioner, benefits are payable under item 51300.

Benefits payable under Item 51803

Medicare benefits are payable under Item 51803 for assistance rendered at the following procedures:

51906, 52054, 52094, 52114, 52117, 52120, 52122, 52123, 52126, 52129, 52131, 52148, 52158, 52184, 52186, 52306, 52330, 52333, 52337, 52342, 52345, 52348, 52351, 52354, 52357, 52360, 52363, 52366, 52369, 52372, 52375, 52378, 52379, 52380, 52382, 52430, 52442, 52444, 52446, 52456, 52484, 52618, 52621, 52812, 52815, 52821, 52832, 53015, 53017, 53019, 53209, 53212, 53218, 53221, 53224, 53227, 53230, 53233, 53414, 53418, 53419, 53422, 53423, 53424, 53425, 53427, 53429, 53455.

or at a combination of procedures (including those identified as payable under item 51800 above) for which the aggregate fee exceeds the amount specified in the item.

Where assistance with any of the above procedures is provided by a medical practitioner, benefits are payable under Item 51303.

Assistance at multiple operations

Where assistance is provided at two or more operations performed on a patient on the one occasion the multi operation formula is applied to all the operations to determine the surgical fee payable to each approved dental practitioner. The multi-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for assistance is payable to determine the abated fee level for assistance. The abated fee is

used to determine the appropriate Schedule item covering the surgical assistance (ie either Items 51800/51300 or 51803/51303).

The derived fee applicable to Item 51803/51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery.

ON.4.3 Repair of Wound - (Item 51900)

Item 51900 covers debridement of "deep and extensively contaminated" wound. Benefits are not payable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures.

ON.4.4 Lipectomy, Wedge Excision - Two or More Excisions - (Item 51906)

Multiple lipectomies attract benefits under Item 51906 once only, i.e. the multiple operation rule does not apply.

Medicare benefits are not payable in respect of liposuction.

ON.4.5 Upper Aerodigestive Tract Endoscopic Procedure - (Item 52035)

The following are guidelines of appropriate minimum standards for the performance of GI endoscopy in relation to (a) cleaning, disinfection and sterilisation procedures, and (b) anaesthetic and resuscitation equipment. These guidelines are based on the advice of the Gastroenterological Society of Australia, the Sections of HPB and Upper GI and of Colon and Rectal Surgery of the Royal Australasian College of Surgeons, and the Colorectal Surgical Society of Australia.

Cleaning, disinfection and sterilisation procedures

Endoscopic procedures should be performed in facilities where endoscope and accessory reprocessing protocols follow procedures outlined in:-

(i) 'Infection and Endoscopy' (3rd edition), Gastroenterological Society of Australia;

(ii) 'Infection control in the health care setting - Guidelines for the prevention of transmission of infectious diseases', National Health and Medical Research Council; and

(iii) Australian Standard AS 4187-1994 (and Amendments), Standards Association of Australia.

Anaesthetic and resuscitation equipment

Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post operative and resuscitation facilities should conform to the standards outlined in 'Sedation for Endoscopy', Australian & New Zealand College of Anaesthetists, Gastroenterological Society of Australia and Royal Australasian College of Surgeons. These guidelines will be taken into account in determining appropriate practice in the context of the Professional Services Review process.

ON.4.6 Tumour, cyst, Ulcer or Scar - (Items 52036 to 52054)

It is recognised that odontogenic keratocysts, although not neoplastic, often require the surgical management of benign tumours.

ON.4.7 Aspiration of Haematoma - (Item 52056)

Aspiration of haematoma is indicated in clinical situations where incision may leave an unsightly scar or where access is difficult for conventional drainage.

ON.4.8 Osteotomy of Jaw - (Items 52342 to 52375)

The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site.

Bone grafts taken from a separate site, e.g. iliac crest, would attract additional benefit under Item 52318 or 52319 for the harvesting, plus item 52130 or 52131 for the grafting.

Where the site of grafting under item 52131 requires closure by single stage local flap, item 52300 may be claimed where clinically appropriate. Clinically appropriate in this instance means that the flap is required to close defects because the defect cannot be closed directly.

A local skin flap is an area of skin or subcutaneous tissue designed to be elevated from the skin adjoining a defect requiring closure. The flap remains partially attached by pedicle and is moved to the defect by rotation, advancement or transposition, or a combination of these manoeuvres.

Benefits are only payable where the flap is required for adequate wound closure. A secondary defect will be created which may be closed by direct suture, skin grafting or sometimes a further local skin flap. This latter procedure will also attract benefit if closed by graft or flap repair but not been closed by direct suture.

By definition, direct wound closure (e.g. by suture) does not constitute skin flap. Similarly, angled, curved or trapdoor incisions which are used for exposure and which are sutured back into the same position relative to the adjacent tissues are not skin flap repairs. Undermining of the edges of the wound prior to suturing is considered a normal part of wound closure and is not considered to skin flap repair.

For the purposes of these items, a reference to maxilla includes the zygoma.

ON.4.9 Genioplasty - (Item 52378)

Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

ON.4.10 Fracture of Mandible or Maxilla - (Items 53400 to 53439)

There are two maxillae in the skull and for the purpose of these items the mandible is regarded as comprising two bones.

Hence a bilateral fracture of the mandible would be assessed as:

· Item 53409 x 1½;

· two maxillae and one side of the mandible as Item 53406 x 1½ + 53409 x ¼.

Splinting in Item 53406 or 53409 refers to cap splints, arch bars, silver (cast metal) or acrylic splints.

ON.4.12 Destruction of Nerve Branch by Neurolytic Agent - (Item 53706)

Item 53706 includes the use of botulinum toxin as a neurolytic agent.

ORAL AND MAXILLOFACIAL SERVICES ITEMS

O1. CONSULTATIONS	
	Group O1. Consultations
	APPROVED DENTAL PRACTITIONER, REFERRED CONSULTATION - SURGERY, HOSPITAL OR RESIDENTIAL AGED CARE FACILITY
51700	Professional attendance (other than a second or subsequent attendance in a single course of treatment) by an approved dental practitioner, at consulting rooms, hospital or residential aged care facility where the patient is referred to him or her (See para ON.4.1 of explanatory notes to this Category) **Fee:** $86.90 **Benefit:** 75% = $65.20 85% = $73.90
51703	Professional attendance by an approved dental practitioner, each attendance subsequent to the first in a single course of treatment at consulting rooms, hospital or residential aged care facility where the patient is referred to him or her (See para ON.4.1 of explanatory notes to this Category) **Fee:** $43.70 **Benefit:** 75% = $32.80 85% = $37.15
O2. ASSISTANCE AT OPERATION	
	Group O2. Assistance At Operation
51800	Assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery at any operation identified by the word "Assist." for which the fee does not exceed $567.25 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed $567.25 (See para ON.4.2 of explanatory notes to this Category) **Fee:** $87.70 **Benefit:** 75% = $65.80 85% = $74.55
51803	Assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery at any operation specified in an item that includes '(Assist.)' for which the fee exceeds $567.25 or at a series or combination of operations specified in items that include '(Assist)' if the aggregate fee exceeds $567.25 (See para ON.4.2 of explanatory notes to this Category) **Derived Fee:** one fifth of the established fee for the operation or combination of operations
O3. GENERAL SURGERY	
	Group O3. General Surgery
51900	WOUND OF SOFT TISSUE, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.) (See para ON.4.3 of explanatory notes to this Category) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60
51902	WOUNDS, DRESSING OF, under general anaesthesia, with or without removal of sutures, not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.) **Fee:** $75.10 **Benefit:** 75% = $56.35 85% = $63.85
51904	LIPECTOMY - wedge excision of skin or fat - 1 EXCISION (Anaes.) (Assist.) **Fee:** $462.15 **Benefit:** 75% = $346.65 85% = $392.85
51906	LIPECTOMY - wedge excision of skin or fat - 2 OR MORE EXCISIONS (Anaes.) (Assist.) (See para ON.4.4 of explanatory notes to this Category)

O3. GENERAL SURGERY	
	Fee: $702.80 **Benefit:** 75% = $527.10 85% = $618.10
52000	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes.) **Fee:** $83.80 **Benefit:** 75% = $62.85 85% = $71.25
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.) **Fee:** $119.45 **Benefit:** 75% = $89.60 85% = $101.55
52006	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes.) **Fee:** $119.45 **Benefit:** 75% = $89.60 85% = $101.55
52009	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) **Fee:** $188.55 **Benefit:** 75% = $141.45 85% = $160.30
52010	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.) **Fee:** $258.05 **Benefit:** 75% = $193.55 85% = $219.35
52012	SUPERFICIAL FOREIGN BODY, removal of, as an independent procedure (Anaes.) **Fee:** $23.90 **Benefit:** 75% = $17.95 85% = $20.35
52015	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and suture, as an independent procedure (Anaes.) **Fee:** $111.65 **Benefit:** 75% = $83.75 85% = $94.95
52018	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.) **Fee:** $281.25 **Benefit:** 75% = $210.95 85% = $239.10
52021	ASPIRATION BIOPSY of 1 or MORE JAW CYSTS as an independent procedure to obtain material for diagnostic purposes and not being a service associated with an operative procedure on the same day (Anaes.) **Fee:** $29.90 **Benefit:** 75% = $22.45 85% = $25.45
52024	BIOPSY OF SKIN OR MUCOUS MEMBRANE, as an independent procedure (Anaes.) **Fee:** $53.05 **Benefit:** 75% = $39.80 85% = $45.10
52025	LYMPH NODE OF NECK, biopsy of (Anaes.) **Fee:** $186.85 **Benefit:** 75% = $140.15 85% = $158.85
Amend 52027	BIOPSY OF LYMPH NODE, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure and not being a service to which item 52025 applies (Anaes.) **Fee:** $152.15 **Benefit:** 75% = $114.15 85% = $129.35
52030	SINUS, excision of, involving superficial tissue only (Anaes.) **Fee:** $91.45 **Benefit:** 75% = $68.60 85% = $77.75
52033	SINUS, excision of, involving muscle and deep tissue (Anaes.) **Fee:** $186.85 **Benefit:** 75% = $140.15 85% = $158.85
52034	PREMALIGNANT LESIONS of the oral mucous, treatment by cryotherapy, diathermy or carbon

	dioxide laser **Fee:** $43.70 **Benefit:** 75% = $32.80 85% = $37.15
52035	ENDOSCOPIC LASER THERAPY for neoplasia and benign vascular lesions of the oral cavity (Anaes.) (See para ON.4.5 of explanatory notes to this Category) **Fee:** $483.70 **Benefit:** 75% = $362.80 85% = $411.15
52036	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 52039 applies (Anaes.) (See para ON.4.6 of explanatory notes to this Category) **Fee:** $128.95 **Benefit:** 75% = $96.75 85% = $109.65
52039	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes.) (Assist.) (See para ON.4.6 of explanatory notes to this Category) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60
52042	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.) (See para ON.4.6 of explanatory notes to this Category) **Fee:** $175.25 **Benefit:** 75% = $131.45 85% = $149.00
52045	TUMOUR, CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), removal of, not being a service to which another item in Groups O3 to O9 applies, involving muscle, bone, or other deep tissue (Anaes.) (See para ON.4.6 of explanatory notes to this Category) **Fee:** $250.45 **Benefit:** 75% = $187.85 85% = $212.90
52048	TUMOUR OR DEEP CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), removal of, requiring wide excision, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) (See para ON.4.6 of explanatory notes to this Category) **Fee:** $377.45 **Benefit:** 75% = $283.10 85% = $320.85
52051	TUMOUR, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.) (See para ON.4.6 of explanatory notes to this Category) **Fee:** $510.30 **Benefit:** 75% = $382.75 85% = $433.80
52054	TUMOUR, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.) (See para ON.4.6 of explanatory notes to this Category) **Fee:** $597.00 **Benefit:** 75% = $447.75 85% = $512.30
52055	HAEMATOMA, SMALL ABSCESS OR CELLULITIS, not requiring admission to a hospital,

O3. GENERAL SURGERY	
	INCISION WITH DRAINAGE OF (excluding after care) **Fee:** $27.80 **Benefit:** 75% = $20.85 85% = $23.65
52056	HAEMATOMA, aspiration of (Anaes.) (See para ON.4.7 of explanatory notes to this Category) **Fee:** $27.80 **Benefit:** 75% = $20.85 85% = $23.65
52057	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.) (See para ON.3.3 of explanatory notes to this Category) **Fee:** $165.55 **Benefit:** 75% = $124.20 85% = $140.75
52058	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS, using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $241.40 **Benefit:** 75% = $181.05 85% = $205.20
52059	ABSCESS, DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $271.95 **Benefit:** 75% = $204.00 85% = $231.20
52060	MUSCLE, excision of (Anaes.) **Fee:** $192.45 **Benefit:** 75% = $144.35 85% = $163.60
52061	MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.) **Fee:** $227.20 **Benefit:** 75% = $170.40 85% = $193.15
52062	MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.) **Fee:** $300.45 **Benefit:** 75% = $225.35 85% = $255.40
52063	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) **Fee:** $362.05 **Benefit:** 75% = $271.55 85% = $307.75
52064	BONE CYST, injection into or aspiration of (Anaes.) **Fee:** $172.20 **Benefit:** 75% = $129.15 85% = $146.40
52066	SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.) **Fee:** $452.55 **Benefit:** 75% = $339.45 85% = $384.70
52069	SUBLINGUAL GLAND, extirpation of (Anaes.) **Fee:** $201.70 **Benefit:** 75% = $151.30 85% = $171.45
52072	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.) **Fee:** $59.75 **Benefit:** 75% = $44.85 85% = $50.80
52073	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes.) **Fee:** $152.15 **Benefit:** 75% = $114.15 85% = $129.35
52075	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures (Anaes.) **Fee:** $152.15 **Benefit:** 75% = $114.15 85% = $129.35
52078	TONGUE, partial excision of (Anaes.) (Assist.) **Fee:** $300.45 **Benefit:** 75% = $225.35 85% = $255.40

O3. GENERAL SURGERY	
52081	TONGUE TIE, division or excision of frenulum (Anaes.) **Fee:** $47.25 **Benefit:** 75% = $35.45 85% = $40.20
52084	TONGUE TIE, MANDIBULAR FRENULUM OR MAXILLARY FRENULUM, division or excision of frenulum, in a person aged not less than 2 years (Anaes.) **Fee:** $121.40 **Benefit:** 75% = $91.05 85% = $103.20
52087	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.) **Fee:** $208.00 **Benefit:** 75% = $156.00 85% = $176.80
52090	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.) (Assist.) **Fee:** $362.05 **Benefit:** 75% = $271.55 85% = $307.75
52092	OPERATION on SKULL for OSTEOMYELITIS (Anaes.) (Assist.) **Fee:** $471.95 **Benefit:** 75% = $354.00 85% = $401.20
52094	OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 52092 (Anaes.) (Assist.) **Fee:** $596.95 **Benefit:** 75% = $447.75 85% = $512.25
52095	BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.) **Fee:** $386.90 **Benefit:** 75% = $290.20 85% = $328.90
52096	ORTHOPAEDIC PIN OR WIRE, insertion of, into maxilla or mandible or zygoma, as an independent procedure (Anaes.) **Fee:** $114.65 **Benefit:** 75% = $86.00 85% = $97.50
52097	EXTERNAL FIXATION, removal of, in the operating theatre of a hospital (Anaes.) **Fee:** $162.60 **Benefit:** 75% = $121.95
52098	EXTERNAL FIXATION, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.) **Fee:** $191.20 **Benefit:** 75% = $143.40 85% = $162.55
52099	BURIED WIRE, PIN or SCREW, 1 or more, which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, per bone, not being a service associated with a service to which item 52102 or 52105 applies (Anaes.) **Fee:** $143.50 **Benefit:** 75% = $107.65 85% = $122.00
52102	BURIED WIRE, PIN or SCREW, 1 or more, which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, where undertaken in the operating theatre of a hospital, per bone (Anaes.) **Fee:** $143.50 **Benefit:** 75% = $107.65 85% = $122.00
52105	PLATE, 1 or more of, and associated screw and wire which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, per bone, not being a service associated with a service to which item 52099 or 52102 applies (Anaes.) (Assist.) **Fee:** $267.80 **Benefit:** 75% = $200.85 85% = $227.65
52106	ARCH BARS, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia where undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $110.65 **Benefit:** 75% = $83.00

O3. GENERAL SURGERY	
52108	LIP, full thickness wedge excision of, with repair by direct sutures (Anaes.) (Assist.) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60
52111	VERMILIONECTOMY (Anaes.) (Assist.) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60
52114	MANDIBLE or MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.) **Fee:** $597.00 **Benefit:** 75% = $447.75 85% = $512.30
52117	MANDIBLE, including lower border, or MAXILLA, sub-total resection of (Anaes.) (Assist.) **Fee:** $710.65 **Benefit:** 75% = $533.00 85% = $625.95
52120	MANDIBLE, hemimandiblectomy of, including condylectomy where performed (Anaes.) (Assist.) **Fee:** $840.55 **Benefit:** 75% = $630.45 85% = $755.85
52122	MANDIBLE, hemi-mandibular reconstruction of, OR MAXILLA, reconstruction of, with BONE GRAFT, PLATE, TRAY OR ALLOPLAST, not being a service associated with a service to which item 52123 applies (Anaes.) (Assist.) **Fee:** $840.55 **Benefit:** 75% = $630.45 85% = $755.85
52123	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.) **Fee:** $951.55 **Benefit:** 75% = $713.70 85% = $866.85
52126	MAXILLA, total resection of (Anaes.) (Assist.) **Fee:** $914.85 **Benefit:** 75% = $686.15 85% = $830.15
52129	MAXILLA, total resection of both maxillae (Anaes.) (Assist.) **Fee:** $1,224.70 **Benefit:** 75% = $918.55 85% = $1140.00
52130	BONE GRAFT, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) **Fee:** $449.55 **Benefit:** 75% = $337.20 85% = $382.15
52131	BONE GRAFT WITH INTERNAL FIXATION, not being a service to which an item in the range (a) 51900 to 52186; or (b) 52303 to 53460 applies (Anaes.) (Assist.) **Fee:** $621.70 **Benefit:** 75% = $466.30 85% = $537.00
52132	TRACHEOSTOMY (Anaes.) **Fee:** $252.95 **Benefit:** 75% = $189.75 85% = $215.05
52133	CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.) **Fee:** $92.50 **Benefit:** 75% = $69.40 85% = $78.65
52135	POST-OPERATIVE or POST-NASAL HAEMORRHAGE, or both, control of, where undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $146.65 **Benefit:** 75% = $110.00
52138	MAXILLARY ARTERY, ligation of (Anaes.) (Assist.) **Fee:** $455.75 **Benefit:** 75% = $341.85 85% = $387.40
52141	FACIAL, MANDIBULAR or LINGUAL ARTERY or VEIN or ARTERY and VEIN, ligation of, not

O3. GENERAL SURGERY	
	being a service to which item 52138 applies (Anaes.) (Assist.) **Fee:** $450.80 **Benefit:** 75% = $338.10 85% = $383.20
52144	FOREIGN BODY, deep, removal of using interventional imaging techniques (Anaes.) (Assist.) **Fee:** $420.15 **Benefit:** 75% = $315.15 85% = $357.15
52147	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.) **Fee:** $396.50 **Benefit:** 75% = $297.40 85% = $337.05
52148	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.) **Fee:** $700.85 **Benefit:** 75% = $525.65 85% = $616.15
52158	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.) **Fee:** $1,128.40 **Benefit:** 75% = $846.30 85% = $1043.70
	MALIGNANT DISEASE
52180	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, biopsy of (not including aftercare) (Anaes.) **Fee:** $191.20 **Benefit:** 75% = $143.40 85% = $162.55
52182	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes.) (Assist.) **Fee:** $420.90 **Benefit:** 75% = $315.70 85% = $357.80
52184	BONE TUMOUR, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) **Fee:** $621.70 **Benefit:** 75% = $466.30 85% = $537.00
52186	BONE TUMOUR, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) **Fee:** $765.30 **Benefit:** 75% = $574.00 85% = $680.60
O4. PLASTIC & RECONSTRUCTIVE	
	Group O4. Plastic & Reconstructive
52300	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, with skin or mucosa (Anaes.) (Assist.) **Fee:** $288.90 **Benefit:** 75% = $216.70 85% = $245.60
52303	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, with buccal pad of fat (Anaes.) (Assist.) **Fee:** $412.55 **Benefit:** 75% = $309.45 85% = $350.70
52306	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.) **Fee:** $612.10 **Benefit:** 75% = $459.10 85% = $527.40
52309	FREE GRAFTING (mucosa or split skin) of a granulating area (Anaes.) **Fee:** $208.00 **Benefit:** 75% = $156.00 85% = $176.80
52312	FREE GRAFTING (mucosa, split skin or connective tissue) to 1 defect, including elective dissection (Anaes.) (Assist.)

O4. PLASTIC & RECONSTRUCTIVE	
	Fee: $288.90 **Benefit:** 75% = $216.70 85% = $245.60
52315	FREE GRAFTING, FULL THICKNESS, to 1 defect (mucosa or skin) (Anaes.) (Assist.) **Fee:** $481.35 **Benefit:** 75% = $361.05 85% = $409.15
52318	BONE GRAFT, harvesting of, via separate incision, being a service associated with a service to which another item in Groups O3 to O9 applies - Autogenous - small quantity (Anaes.) **Fee:** $143.50 **Benefit:** 75% = $107.65 85% = $122.00
52319	BONE GRAFT, harvesting of, via separate incision, being a service associated with a service to which another item in Groups O3 to O9 applies - Autogenous - large quantity (Anaes.) **Fee:** $239.25 **Benefit:** 75% = $179.45 85% = $203.40
52321	FOREIGN IMPLANT (NON-BIOLOGICAL), insertion of, for CONTOUR RECONSTRUCTION of pathological deformity, not being a service associated with a service to which item 52624 applies (Anaes.) (Assist.) **Fee:** $481.35 **Benefit:** 75% = $361.05 85% = $409.15
52324	DIRECT FLAP REPAIR, using tongue, first stage (Anaes.) (Assist.) **Fee:** $481.35 **Benefit:** 75% = $361.05 85% = $409.15
52327	DIRECT FLAP REPAIR, using tongue, second stage (Anaes.) **Fee:** $238.80 **Benefit:** 75% = $179.10 85% = $203.00
52330	PALATAL DEFECT (oro-nasal fistula), plastic closure of, including services to which item 52300, 52303, 52306 or 52324 applies (Anaes.) (Assist.) **Fee:** $794.45 **Benefit:** 75% = $595.85 85% = $709.75
52333	CLEFT PALATE, primary repair (Anaes.) (Assist.) **Fee:** $794.45 **Benefit:** 75% = $595.85 85% = $709.75
52336	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.) (Assist.) **Fee:** $496.55 **Benefit:** 75% = $372.45 85% = $422.10
52337	ALVEOLAR CLEFT (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes.) (Assist.) **Fee:** $1,086.20 **Benefit:** 75% = $814.65 85% = $1001.50
52339	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.) **Fee:** $565.50 **Benefit:** 75% = $424.15 85% = $480.80
52342	MANDIBLE or MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $982.25 **Benefit:** 75% = $736.70
52345	MANDIBLE or MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,107.80 **Benefit:** 75% = $830.85
52348	MANDIBLE or MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,251.75 **Benefit:** 75% = $938.85

O4. PLASTIC & RECONSTRUCTIVE	
52351	MANDIBLE or MAXILLA, bilateral osteotomy of osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,405.80 **Benefit:** 75% = $1054.35
52354	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,425.15 **Benefit:** 75% = $1068.90
52357	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,604.45 **Benefit:** 75% = $1203.35
52360	MANDIBLE and MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,636.85 **Benefit:** 75% = $1227.65
52363	MANDIBLE and MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,841.40 **Benefit:** 75% = $1381.05
52366	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,800.65 **Benefit:** 75% = $1350.50
52369	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $2,024.60 **Benefit:** 75% = $1518.45
52372	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,964.50 **Benefit:** 75% = $1473.40
52375	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (H) (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $2,200.40 **Benefit:** 75% = $1650.30
52378	GENIOPLASTY including transposition of nerves and vessels and bone grafts taken from the same site

	(Anaes.) (Assist.) (See para ON.4.9 of explanatory notes to this Category) **Fee:** $760.65 **Benefit:** 75% = $570.50 85% = $675.95
52379	FACE, contour reconstruction of 1 region, using autogenous bone or cartilage graft (Anaes.) (Assist.) **Fee:** $1,299.90 **Benefit:** 75% = $974.95 85% = $1215.20
52380	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) **Fee:** $2,213.45 **Benefit:** 75% = $1660.10 85% = $2128.75
52382	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) **Fee:** $2,653.40 **Benefit:** 75% = $1990.05 85% = $2568.70
52420	MANDIBLE, fixation by intermaxillary wiring, excluding wiring for obesity **Fee:** $245.00 **Benefit:** 75% = $183.75 85% = $208.25
52424	DERMIS, DERMOFAT OR FASCIA GRAFT (excluding transfer of fat by injection) (Anaes.) (Assist.) **Fee:** $481.25 **Benefit:** 75% = $360.95 85% = $409.10
52430	MICROVASCULAR REPAIR OF, using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.) **Fee:** $1,107.80 **Benefit:** 75% = $830.85 85% = $1023.10
52440	CLEFT LIP, unilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) **Fee:** $550.00 **Benefit:** 75% = $412.50 85% = $467.50
52442	CLEFT LIP, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) **Fee:** $687.65 **Benefit:** 75% = $515.75 85% = $602.95
52444	CLEFT LIP, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) **Fee:** $763.90 **Benefit:** 75% = $572.95 85% = $679.20
52446	CLEFT LIP, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) **Fee:** $901.70 **Benefit:** 75% = $676.30 85% = $817.00
52450	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.) **Fee:** $305.55 **Benefit:** 75% = $229.20 85% = $259.75
52452	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.) **Fee:** $496.55 **Benefit:** 75% = $372.45 85% = $422.10
52456	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) **Fee:** $840.55 **Benefit:** 75% = $630.45 85% = $755.85
52458	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) **Fee:** $305.55 **Benefit:** 75% = $229.20 85% = $259.75

O4. PLASTIC & RECONSTRUCTIVE	
52460	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.) **Fee:** $794.45 **Benefit:** 75% = $595.85 85% = $709.75
52480	COMPOSITE GRAFT (Chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (Anaes.) (Assist.) **Fee:** $510.30 **Benefit:** 75% = $382.75 85% = $433.80
52482	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.) **Fee:** $491.00 **Benefit:** 75% = $368.25 85% = $417.35
52484	MACROSTOMIA, operation for (Anaes.) (Assist.) **Fee:** $584.50 **Benefit:** 75% = $438.40 85% = $499.80
O5. PREPROSTHETIC	
	Group O5. Preprosthetic
52600	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) **Fee:** $343.75 **Benefit:** 75% = $257.85 85% = $292.20
52603	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.) **Fee:** $328.55 **Benefit:** 75% = $246.45 85% = $279.30
52606	MAXILLARY TUBEROSITY, reduction of (Anaes.) **Fee:** $250.65 **Benefit:** 75% = $188.00 85% = $213.10
52609	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.) **Fee:** $328.55 **Benefit:** 75% = $246.45 85% = $279.30
52612	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.) **Fee:** $412.55 **Benefit:** 75% = $309.45 85% = $350.70
52615	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - more than 20 lesions (Anaes.) (Assist.) **Fee:** $511.90 **Benefit:** 75% = $383.95 85% = $435.15
52618	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.) **Fee:** $595.90 **Benefit:** 75% = $446.95 85% = $511.20
52621	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.) (Assist.) **Fee:** $595.90 **Benefit:** 75% = $446.95 85% = $511.20
52624	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.) **Fee:** $481.25 **Benefit:** 75% = $360.95 85% = $409.10
52626	ALVEOLAR RIDGE AUGMENTATION - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.) **Fee:** $295.15 **Benefit:** 75% = $221.40 85% = $250.90
52627	OSSEO-INTEGRATION PROCEDURE - in the practice of oral and maxillofacial surgery, extra oral implantation of titanium fixture (Anaes.) (Assist.) **Fee:** $511.90 **Benefit:** 75% = $383.95 85% = $435.15
52630	OSSEO-INTEGRATION PROCEDURE - in the practice of oral and maxillofacial surgery, fixation of transcutaneous abutment (Anaes.) **Fee:** $189.50 **Benefit:** 75% = $142.15 85% = $161.10

O5. PREPROSTHETIC	
52633	OSSEO-INTEGRATION PROCEDURE - intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) **Fee:** $511.90 **Benefit:** 75% = $383.95 85% = $435.15
52636	OSSEO-INTEGRATION PROCEDURE - fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) **Fee:** $189.50 **Benefit:** 75% = $142.15 85% = $161.10
O6. NEUROSURGICAL	
	Group O6. Neurosurgical
52800	NEUROLYSIS BY OPEN OPERATION, without transposition, not being a service associated with a service to which item 52803 applies (Anaes.) (Assist.) **Fee:** $281.25 **Benefit:** 75% = $210.95 85% = $239.10
52803	NERVE TRUNK, internal (interfascicular), NEUROLYSIS of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $404.95 **Benefit:** 75% = $303.75 85% = $344.25
52806	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from superficial peripheral nerve (Anaes.) (Assist.) **Fee:** $281.25 **Benefit:** 75% = $210.95 85% = $239.10
52809	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from deep peripheral nerve (Anaes.) (Assist.) **Fee:** $481.35 **Benefit:** 75% = $361.05 85% = $409.15
52812	NERVE TRUNK, PRIMARY repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $687.65 **Benefit:** 75% = $515.75 85% = $602.95
52815	NERVE TRUNK, SECONDARY repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $725.80 **Benefit:** 75% = $544.35 85% = $641.10
52818	NERVE, TRANSPOSITION OF (Anaes.) (Assist.) **Fee:** $481.35 **Benefit:** 75% = $361.05 85% = $409.15
52821	NERVE GRAFT TO NERVE TRUNK, (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,046.70 **Benefit:** 75% = $785.05 85% = $962.00
52824	PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.) **Fee:** $450.80 **Benefit:** 75% = $338.10 85% = $383.20
52826	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.) **Fee:** $241.40 **Benefit:** 75% = $181.05 85% = $205.20
52828	CUTANEOUS NERVE, primary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $359.00 **Benefit:** 75% = $269.25 85% = $305.15
52830	CUTANEOUS NERVE, secondary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $473.55 **Benefit:** 75% = $355.20 85% = $402.55

O6. NEUROSURGICAL	
52832	CUTANEOUS NERVE, nerve graft to, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $649.45 **Benefit:** 75% = $487.10 85% = $564.75
O7. EAR, NOSE & THROAT	
	Group O7. Ear, Nose & Throat
53000	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.) **Fee:** $33.05 **Benefit:** 75% = $24.80 85% = $28.10
53003	MAXILLARY ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission to hospital) not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.) **Fee:** $93.35 **Benefit:** 75% = $70.05 85% = $79.35
53004	MAXILLARY ANTRUM, LAVAGE OF - each attendance at which the procedure is performed, including any associated consultation (Anaes.) **Fee:** $36.15 **Benefit:** 75% = $27.15 85% = $30.75
53006	ANTROSTOMY (RADICAL) (Anaes.) (Assist.) **Fee:** $529.60 **Benefit:** 75% = $397.20 85% = $450.20
53009	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.) **Fee:** $300.45 **Benefit:** 75% = $225.35 85% = $255.40
53012	ANTRUM, drainage of, through tooth socket (Anaes.) **Fee:** $119.45 **Benefit:** 75% = $89.60 85% = $101.55
53015	ORO-ANTRAL FISTULA, plastic closure of (Anaes.) (Assist.) **Fee:** $597.00 **Benefit:** 75% = $447.75 85% = $512.30
53016	NASAL SEPTUM, septoplasty, submucous resection or closure of septal perforation (Anaes.) (Assist.) **Fee:** $491.00 **Benefit:** 75% = $368.25 85% = $417.35
53017	NASAL SEPTUM, reconstruction of (Anaes.) (Assist.) **Fee:** $612.50 **Benefit:** 75% = $459.40 85% = $527.80
53019	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.) **Fee:** $590.20 **Benefit:** 75% = $442.65 85% = $505.50
53052	POST-NASAL SPACE, direct examination of, with or without biopsy (Anaes.) **Fee:** $124.80 **Benefit:** 75% = $93.60 85% = $106.10
53054	NASENDOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX one or more of these procedures (Anaes.) **Fee:** $124.80 **Benefit:** 75% = $93.60 85% = $106.10
53056	EXAMINATION OF NASAL CAVITY or POST-NASAL SPACE, or NASAL CAVITY AND POST-NASAL SPACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $73.10 **Benefit:** 75% = $54.85 85% = $62.15
53058	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) **Fee:** $124.80 **Benefit:** 75% = $93.60 85% = $106.10

O7. EAR, NOSE & THROAT	
53060	CAUTERISATION (other than by chemical means) OR CAUTERISATION by chemical means when performed under general anaesthesia OR DIATHERMY OF SEPTUM, TURBINATES FOR OBSTRUCTION OR HAEMORRHAGE SECONDARY TO SURGERY (OR TRAUMA) - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes.) **Fee:** $102.10 **Benefit:** 75% = $76.60 85% = $86.80
53062	POST SURGICAL NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) **Fee:** $91.45 **Benefit:** 75% = $68.60 85% = $77.75
53064	CRYOTHERAPY TO NOSE in the treatment of nasal haemorrhage (Anaes.) **Fee:** $165.55 **Benefit:** 75% = $124.20 85% = $140.75
53068	TURBINECTOMY or TURBINECTOMIES, partial or total, unilateral (Anaes.) **Fee:** $138.70 **Benefit:** 75% = $104.05 85% = $117.90
53070	TURBINATES, submucous resection of, unilateral (Anaes.) **Fee:** $180.90 **Benefit:** 75% = $135.70 85% = $153.80
O8. TEMPOROMANDIBULAR JOINT	
	Group O8. Temporomandibular Joint
53200	MANDIBLE, treatment of a dislocation of, not requiring open reduction (Anaes.) **Fee:** $71.80 **Benefit:** 75% = $53.85 85% = $61.05
53203	MANDIBLE, treatment of a dislocation of, requiring open reduction (Anaes.) **Fee:** $120.60 **Benefit:** 75% = $90.45 85% = $102.55
53206	TEMPOROMANDIBULAR JOINT, manipulation of, performed in the operating theatre of a hospital, not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.) **Fee:** $145.25 **Benefit:** 75% = $108.95
53209	GLENOID FOSSA, ZYGOMATIC ARCH and TEMPORAL BONE, reconstruction of (Obwegeser technique) (Anaes.) (Assist.) **Fee:** $1,675.50 **Benefit:** 75% = $1256.65 85% = $1590.80
53212	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.) **Fee:** $905.10 **Benefit:** 75% = $678.85 85% = $820.40
53215	TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes.) (Assist.) **Fee:** $415.25 **Benefit:** 75% = $311.45 85% = $353.00
53218	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedures (Anaes.) (Assist.) **Fee:** $664.25 **Benefit:** 75% = $498.20 85% = $579.55
53220	TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $334.85 **Benefit:** 75% = $251.15 85% = $284.65
53221	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.)

O8. TEMPOROMANDIBULAR JOINT	
	Fee: $886.25 **Benefit:** 75% = $664.70 85% = $801.55
53224	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $982.45 **Benefit:** 75% = $736.85 85% = $897.75
53225	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.) **Fee:** $295.15 **Benefit:** 75% = $221.40 85% = $250.90
53226	TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $317.30 **Benefit:** 75% = $238.00 85% = $269.75
53227	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without meniscus or capsular surgery, including meniscectomy when performed, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,207.20 **Benefit:** 75% = $905.40 85% = $1122.50
53230	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,359.85 **Benefit:** 75% = $1019.90 85% = $1275.15
53233	TEMPOROMANDIBULAR JOINT, surgery of, involving procedures to which items 53224, 53226, 53227 and 53230 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,528.10 **Benefit:** 75% = $1146.10 85% = $1443.40
53236	TEMPOROMANDIBULAR JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $478.25 **Benefit:** 75% = $358.70 85% = $406.55
53239	TEMPOROMANDIBULAR JOINT, arthrodesis of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $478.25 **Benefit:** 75% = $358.70 85% = $406.55
53242	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) **Fee:** $317.30 **Benefit:** 75% = $238.00 85% = $269.75

O9. TREATMENT OF FRACTURES	
	Group O9. Treatment Of Fractures
53400	MAXILLA, unilateral or bilateral, treatment of fracture of, not requiring splinting (See para ON.4.10 of explanatory notes to this Category) **Fee:** $131.25 **Benefit:** 75% = $98.45 85% = $111.60
53403	MANDIBLE, treatment of fracture of, not requiring splinting (See para ON.4.10 of explanatory notes to this Category) **Fee:** $160.40 **Benefit:** 75% = $120.30 85% = $136.35
53406	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $413.15 **Benefit:** 75% = $309.90 85% = $351.20

O9. TREATMENT OF FRACTURES	
53409	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $413.15 **Benefit:** 75% = $309.90 85% = $351.20
53410	ZYGOMATIC BONE, treatment of fracture of, not requiring surgical reduction (See para ON.4.10 of explanatory notes to this Category) **Fee:** $87.00 **Benefit:** 75% = $65.25 85% = $73.95
53411	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $242.60 **Benefit:** 75% = $181.95 85% = $206.25
53412	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $398.35 **Benefit:** 75% = $298.80 85% = $338.60
53413	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $488.05 **Benefit:** 75% = $366.05 85% = $414.85
53414	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $560.70 **Benefit:** 75% = $420.55 85% = $476.60
53415	MAXILLA, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $442.60 **Benefit:** 75% = $331.95 85% = $376.25
53416	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $442.60 **Benefit:** 75% = $331.95 85% = $376.25
53418	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $575.40 **Benefit:** 75% = $431.55 85% = $490.70
53419	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $575.40 **Benefit:** 75% = $431.55 85% = $490.70
53422	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $730.25 **Benefit:** 75% = $547.70 85% = $645.55
53423	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $730.25 **Benefit:** 75% = $547.70 85% = $645.55

O9. TREATMENT OF FRACTURES	
53424	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $626.50 **Benefit:** 75% = $469.90 85% = $541.80
53425	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $626.50 **Benefit:** 75% = $469.90 85% = $541.80
53427	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $855.75 **Benefit:** 75% = $641.85 85% = $771.05
53429	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $855.75 **Benefit:** 75% = $641.85 85% = $771.05
53439	MANDIBLE, treatment of a closed fracture of, involving a joint surface (Anaes.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $242.60 **Benefit:** 75% = $181.95 85% = $206.25
53453	ORBITAL CAVITY, reconstruction of a wall or floor with or without foreign implant (Anaes.) (Assist.) **Fee:** $491.00 **Benefit:** 75% = $368.25 85% = $417.35
53455	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.) **Fee:** $576.75 **Benefit:** 75% = $432.60 85% = $492.05
53458	NASAL BONES, treatment of fracture of, not being a service to which item 53459 or 53460 applies **Fee:** $43.75 **Benefit:** 75% = $32.85 85% = $37.20
53459	NASAL BONES, treatment of fracture of, by reduction (Anaes.) **Fee:** $239.25 **Benefit:** 75% = $179.45 85% = $203.40
53460	NASAL BONES, treatment of fractures of, by open reduction involving osteotomies (Anaes.) (Assist.) **Fee:** $488.05 **Benefit:** 75% = $366.05 85% = $414.85
O11. REGIONAL OR FIELD NERVE BLOCKS	
	Group O11. Regional Or Field Nerve Blocks
	(Note. Where an anaesthetic combines a regional nerve block with a general anaesthetic for an operative procedure, benefits will be paid only under the anaesthetic item relevant to the operation. The items in this Group are to be used in the practice of oral and maxillofacial surgery and are not to be used for dental procedures (eg. restorative dentistry or dental extraction.))
53700	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent **Fee:** $126.85 **Benefit:** 75% = $95.15 85% = $107.85
53702	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent **Fee:** $63.50 **Benefit:** 75% = $47.65 85% = $54.00

O11. REGIONAL OR FIELD NERVE BLOCKS	
53704	FACIAL NERVE, injection of an anaesthetic agent **Fee:** $38.25 **Benefit:** 75% = $28.70 85% = $32.55
53706	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies (See para ON.4.12 of explanatory notes to this Category) **Fee:** $126.85 **Benefit:** 75% = $95.15 85% = $107.85

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CATEGORY 5: DIAGNOSTIC IMAGING SERVICES

SUMMARY OF CHANGES FROM 01/11/2019

The 01/11/2019 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

New Items

57541 61524 61525 63531 63532 63533 63534

New item for mobile x-ray at residential aged care facilities

One new item providing a flagafall fee for the provision of skeletal x-ray (following a fall), chest x-ray (for suspected pneumonia or heart failure) and abdominal X-ray (for suspected acute abdomen or bowel obstruction) to patients within a residential aged care facility.

New items for Whole body 18F-FDG PET study for breast cancer

New items for: whole body 18F-FDG positron emission tomography (PET) study for: staging of locally advanced breast cancer; or evaluation of suspected metastatic or suspected locally or regionally recurrent breast carcinoma.

New MBS items for Breast MRI for specified populations

This change will introduce four new interim items for magnetic resonance imaging for breast cancer. These new items are for the diagnosis of breast cancer where other imaging is inconclusive, and for treatment planning for breast cancer.

IN.0.1 Requests For Diagnostic Imaging Services

Request requirements

Medicare benefits are not payable for diagnostic imaging services that are classified as R-type (requested) services unless prior to commencing the relevant service, the practitioner receives a signed and dated request from a requesting practitioner who determined the service was necessary.

There are exemptions to the request requirements in specified circumstances. These circumstances are detailed below under 'Exemptions from the written request requirements for R-type diagnostic imaging services'.

Form of a diagnostic imaging request

A request for a diagnostic imaging service does not have to be in a particular form, however, the legislation provides that a request must be in writing and contain sufficient information, in terms that are generally understood by the profession, to clearly identify the item/s of service requested.

A request to a medical imaging specialist for a diagnostic imaging service should include sufficient clinical information to assist the service provider to accurately provide the diagnostic imaging service requested and:

- ensure compliance with the MBS item descriptors, and
- where the requested service involves ionising radiation (x-ray, CT etc.), make a decision whether to expose the patient to radiation, consistent with the diagnostic imaging providers' obligations under the International Commission on Radiological Protection's (ICRP) doctrine of radiation protection.

Unless sufficient clinical information is provided, the requesting practitioner may be asked to provide additional information to the diagnostic imaging provider, which could result in delays for the patient.

The following should be provided on a request for a diagnostic imaging service:

(a) ***- A clear and legible request*** **-** a request must be in writing, dated and be legible so that all information contained is transferred between requestor and provider without loss of content or meaning, or risk of misinterpretation. The use of abbreviations should be avoided. Where permitted, verbal referrals should ensure clear communication between the requestor and provider.

- Under the Electronic Transactions Act 1999, this information can be provided in electronic form.

(b) **-** ***Identity of the patient*** – a request should include details which confirm the identity of the patient, including their contact details.

(c) **-** ***Identity of the requestor*** – a request should include the identity and contact details of the requesting practitioner, including their Medicare provider number, to ensure effective and timely communication.

(d) **-** ***Clinical detail*** **-** a request should include a clinical justification for each examination requested and performed to support the performance of the diagnostic imaging examination.

- Requests should contain information to enable the provider to confirm that the requested diagnostic imaging modality and examination are appropriate to that individual patient's presentation and circumstances, to answer the referrer's diagnostic question with the least number of diagnostic steps (with due regard for patient safety, radiation dose, local expertise and cost).
- Where the request is for diagnostic imaging involving ionising radiation (e.g. x-ray, CT) the request should include clinical information for the provider to determine whether the expected clinical benefit to the patient of being exposed to diagnostic radiation outweighs the risk of radiation exposure ('justification for medical radiation exposure').

The provider must have sufficient information to justify and approve a medical radiation procedure. Where known, this information should include pregnancy status for women of child-bearing age.

Before requesting a diagnostic imaging service, the requesting practitioner must turn their mind to the clinical relevance of the request and determine that the service is necessary. For example, an ultrasound to determine the sex of a foetus is generally not a clinically relevant service, unless there is an indication this service will determine further courses of treatment (e.g. where there is a genetic risk of a sex-related disease or condition).

The requestor should consider whether:

- they are duplicating recent tests,

- the results would change the diagnosis, affect patient management or do more harm than good.

  - The Royal Australian and New Zealand College of Radiologists' Education Modules for Appropriate Imaging Referrals contains decision support tools for select clinical scenarios

  - The Australian Radiation Protection and Nuclear Safety Agency's Radiation Protection of the Patient Module provides information about diagnostic imaging for medical practitioners, to ensure radiation use is justified, and may aid in communicating benefits and risks of diagnostic imaging modalities to patients.

- the benefits and risks to the patient or carer have been communicated, including any alternatives available, and

- there is information available to the patient about the tests requested. Consumer resources available include the:

  - *NPS MedicineWise Choosing Wisely* program
  - Consumers Health Forum's *Why do I even need this test? A Diagnostic Imaging and Informed Consent Consumer Resource*
  - The Royal Australian and New Zealand College of Radiologists' *Inside Radiology* website.

(e) - ***MBS requirements*** - a request should meet any specific MBS item requirements. Failure to provide this information may mean that a Medicare benefit is not paid for the service.

Who may request a diagnostic imaging service

The following practitioners may request a diagnostic imaging service:

- Specialists and consultant physicians can request any diagnostic imaging service.

- Other medical practitioners can request any service and specific Magnetic Resonance Imaging Services - see Note IN.0.18.

- A medical practitioner, on behalf of the treating practitioner, for example, by a resident medical officer at a hospital on behalf of the patient's treating practitioner.

- Dental Practitioners, Physiotherapists, Chiropractors, Osteopaths and Podiatrists registered or licensed under State or Territory laws

- Participating nurse practitioners and participating midwives.

All dental practitioners may request the following items:

57509, 57515, 57521, 57523, 57527, 57540, 57901, 57902, 57903, 57906, 57909, 57912, 57915, 57918, 57921, 57924, 57927, 57930, 57933, 57939, 57942, 57945, 57960, 57963, 57966, 57969, 58100, 58300, 58503, 58903, 59733, 59739, 59751, 60100, 60500, 60503.

Oral and maxillofacial surgeons, prosthodontists, dental specialists (periodontists, endodontists, pedeodontists, orthodontists) and specialists in oral medicine and oral pathology are also able to request the following items:

Oral and maxillofacial surgeons (without medical specialist registration)

55005, 55008, 55011, 55028, 55030, 55032, 56001 to 56220, 56224, 56227, 56230, 56259, 56301 to 56507, 56541, 56547, 56801 to 57007, 57041, 57047, 57341, 57345, 57703, 57705, 57709, 57711, 57712, 57714, 57715, 57717, 58103 to 58115, 58117, 58123, 58124, 58306, 58308, 58506, 58508, 58521 to 58527, 58529, 58909, 58911, 59103, 59104, 59703, 59704, 60000 to 60010, 60506, 60507, 60509, 60510, 61109, 61110, 61372, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 61672, 61690, 61691, 61693, 61694, 61695, 61696, 61702, 61703, 61704, 61705, 61706, 61707, 61710, 63007, 63016, 63334 and 63346.

Oral and maxillofacial surgeons (with medical specialist registration)

Oral and maxillofacial surgeons who also have a medical qualification and are registered as medical specialist can request any item in the Diagnostic Imaging Services Table, subject to their scope of practice and any clauses or requirements relevant to the individual item.

Prosthodontists

55005, 55028, 56013, 56016, 56022, 56028, 56053, 56056, 56062, 56068, 57362, 57363, 58306, 58308, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 61690, 61691, 61693, 61694, 61695, 61696, 61702, 61703, 61704, 61705, 61706, 61707, 61710, 63334 and 63346.

Dental specialists (periodontists, endodontists, pedeodontists, orthodontists).

56022, 56062, 57362, 57363, 58306, 58308, 61421, 61454, 61457, 61690, 61706, 61707, 63334, 63346.

Specialists in oral medicine and/or oral pathology

55005, 55008, 55011, 55028, 55030, 55032, 56001, 56007, 56010, 56013, 56016, 56022, 56028, 56041, 56047, 56050, 56053, 56056, 56062, 56068, 56101, 56107, 56141, 56147, 56301, 56307, 56341, 56347, 56401, 56407, 56441, 56447, 57341, 57345, 57362, 57363, 58306, 58308, 58506, 58508, 58909, 58911, 59103, 59104, 59703, 59704, 60000 to 60010, 60506, 60507 60509, 60510, 61109, 61110, 61372, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 61672, 61690, 61691, 61693, 61694, 61695, 61696, 61702, 61703, 61704, 61705, 61706, 61707, 61710, 63007, 63016, 63334, and 66346.

Chiropractors may request:

57712, 57714, 57715, 57717, 58100 to 58106 (inclusive), 58109, 58111, 58112, 58117 and 58123.

See para IN.0.17 of explanatory notes

Physiotherapists and Osteopaths may request:

57712, 57714, 57715, 57717, 58100 to 58106 (inclusive), 58109, 58111, 58112, 58117, 58120, 58121, 58123, 58126 and 58127.

See para IN.0.17 of explanatory notes

Podiatrists may request:

55836, 55837, 55840, 55841, 55844, 55845, 57521, 57523, 57527, 57536, 57540, 57539.

Participating Nurse Practitioners may request:

55014, 55036, 55059, 55061, 55070, 55076, 55600, 55601, 55768, 55769, 55800, 55801, 55804, 55805, 55808, 55809, 55812, 55813, 55816, 55817, 55820, 55821, 55824, 55825, 55828, 55829, 55832, 55833, 55836, 55837, 55840, 55841, 55844, 55845, 55848, 55849, 55850, 55851, 55852, 55853, 57509, 57515, 57521, 57523, 57527, 57530, 57533, 57536, 57540, 57703, 57705, 57709, 57711, 57712, 57714, 57715, 57717, 57721, 58503 to 58527 (inclusive) and 58529

Participating Midwives may request:

55700, 55701, 55704, 55706, 55707, 55710, 55713, 55714, 55718, 55722.

Form of a request

Responsibility for the adequacy of requesting details rests with the requesting practitioner. A request for a diagnostic imaging service does not have to be in a particular form. However, the legislation provides that a request must be in writing and contain sufficient information, in terms that are generally understood by the profession, to clearly identify the item/s of service requested. This includes, where relevant, noting on the request the clinical indication(s) for the requested service. The provision of additional relevant clinical information can often assist the service provider and enhance the overall service provided to the patient. As such, this practice is actively encouraged.

A written request must be signed and dated and contain the name and address or name and provider number in respect of the place of practice of the requesting practitioner.

Referral to specified provider not required

It is not necessary that a written request for a diagnostic imaging service be addressed to a particular provider or that, if the request is addressed to a particular provider, the service must be rendered by that provider. Request forms containing relevant information about a diagnostic imaging provider supplied, or made available to, a requesting practitioner by a diagnostic imaging provider on, or after, 1 August 2012 must include a statement that informs the patient that the request may be taken to a diagnostic imaging provider of the patient's choice.

Request for more than one service and limit on time to render services

The requesting practitioner may use a single request to order a number of diagnostic imaging services. However, all services provided under this request must be rendered within seven days after the rendering of the first service.

Contravention of request requirements

A practitioner who, without reasonable excuse makes a request for a diagnostic imaging service that does not include the required information in his or her request or in a request made on his or her behalf is guilty of an offence under the Health Insurance Act 1973 punishable, upon conviction, by a fine of $1000.

A practitioner who renders "R-type" diagnostic imaging services and who, without reasonable excuse, provides either directly or indirectly to a requesting practitioner a document to be used in the making of a request which would contravene the request information requirements is guilty of an offence under the Health Insurance Act 1973 punishable, upon conviction, by a fine of $1000.

Exemptions from the written request requirements for R-type diagnostic imaging services

There are exemptions from the general written request requirements (R-type) diagnostic imaging services and these are outlined as follows:

Consultant physician or specialist

A consultant physician or specialist is a medical practitioner recognised for the purposes of the Health Insurance Act 1973 as a specialist or consultant physician, in a particular specialty.

Except for R-type items which in their description state that a referral is required (such as most R-type items in General Ultrasound and items 59300, 59303), a written request is not required for the payment of Medicare benefits when the diagnostic imaging service is provided by or on behalf of a consultant physician or a specialist (other than a specialist in diagnostic radiology) in his or her specialty and after clinical assessment he/she determines that the service was necessary. For details required for accounts/receipts see Note IN.0.7.

However, if in the referral to the consultant physician or specialist, the referring practitioner specifically requests a diagnostic imaging service (eg to a cardiologist to perform an echocardiogram) the service provided is a requested, not self-determined service. If further services are subsequently provided, these further services are self-determined - see "Additional services".

Additional services

A written request is not required for a diagnostic imaging service if that service was provided after one which has been formally requested and the providing practitioner determines that, on the basis of the results obtained from the requested service, that an additional service was necessary. However, the following services cannot be self-determined as "additional services":

- R-type items which in their description (such as most R-type items in General Ultrasound and items 59300, 59303) state that a referral is required (practitioners should claim the NR item in these circumstances);

- MRI services; and

- services not otherwise able to be requested by the original requesting practitioner.

For details required for accounts/receipts see Note IN.0.7.

Substituted services

- A provider may substitute a service for the service originally requested when:

- the provider determines, from the clinical information provided on the request, that the substituted service would be more appropriate for the diagnosis of the patient's condition; and

- the provider has consulted with the requesting practitioner or taken all reasonable steps to do so before providing the substituted service; and

- the substituted service was one that would be accepted as a more appropriate service in the circumstances by the practitioner's speciality group.

However, the following services cannot be substituted:

- R-type items which in their description (such as most R-type items in General Ultrasound and items 59300, 59303) state that a referral is required;

- MRI services; and

- services not otherwise able to be requested by the original requesting practitioner.

For details required for accounts/receipts see Note IN.0.7.

Remote areas

A written request is not required for the payment of Medicare benefits for a R-type diagnostic imaging service rendered by a medical practitioner in a remote area provided:

- the R-type service is not one for which there is a corresponding NR-type service; and

- the medical practitioner rendering the service has been granted a remote area exemption for that service.

For details required for accounts/receipts see Note IN.0.7.

Definition of remote area

The definition of a remote area is one that is more than 30 kilometres by road from:

a) a hospital which provides a radiology service under the direction of a specialist in the specialty of diagnostic radiology; and

b) a free-standing radiology facility under the direction of a specialist in the specialty of diagnostic radiology.

Application for remote area exemption

A medical practitioner, other than a consultant physician or specialist, who believes that he or she qualifies for exemption under the remote area definition, should obtain an application form from the Department of Human Services' website www.humanservices.gov.au or by contacting the Department of Human Services' Provider Eligibility Section, by email at sa.prov.elig@humanservices.gov.au or via phone on 1800 032 259 Monday to Friday, between 8.30 am and 5.00 pm, Australian Eastern Standard Time.

Quality assurance requirement for remote area exemption

Application for, or continuation of, a remote area exemption will be contingent on practitioners being enrolled in an approved continuing medical education and quality assurance program. For further information, please visit the Australian College of Rural and Remote Medicine (ACRRM) website at www.acrrm.org.au, or call the ACRRM on 1800 223 226.

Emergencies

The written request requirement does not apply if the providing practitioner determines that, because the need for the service arose in an emergency, the service should be performed as quickly as possible.

For details required for accounts/receipts see Note IN.0.7.

Lost requests

The written request requirement does not apply where:

- the person who received the diagnostic imaging service, or someone acting on that person's behalf, claimed that a written request had been made for such a service but that the request had been lost; and

- the provider of the diagnostic imaging service or that provider's agent or employee obtained confirmation from the requesting practitioner that the request had been made.

The lost request exemption is applicable only to services that the practitioner could originally request.

For details required for accounts/receipts see Note IN.0.7.

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. The exemption applies to the services covered by the following Items: 57712, 57714, 57715, 57717, 57901, 57902, 57903, 57911, 57912, 57914, 57915, 57917, 57921, 57926, 57929, 57935, 58100 to 58115, 58117, 58123, 58124, 58521, 58523, 58524, 58526, 58527, 58529, 58700, 58702, 59103 and 59104.

To qualify for this "grandparent" exemption the providing practitioner must:

a) be treating his or her own patient;

b) have determined that the service was necessary;

c) have rendered between 17 October 1988 and 16 October 1990 at least 50 services (which resulted in the payment of Medicare benefits) of the kind which have been designated "R-type" services from 1 May 1991;

d) provide the exempted services at the practice location where the services which enabled the practitioner to qualify for the "grandparent" exemption were rendered; and

e) be enrolled in an approved continuing medical education and quality assurance program from 1 January 2001. For further information, please contact the Royal Australian College of General Practitioners (RACGP), at www.racgp.org.au, on 1800 472 247 or via email to racgp@racgp.org.au, or the Australian College of Rural and Remote Medicine (ACRRM), at www.acrrm.org.au or by calling 1800 223 226.

Benefits are only payable for services exempted under these provisions where the service was provided by the exempted medical practitioner at the exempted location. Exemptions are not transferable.

For details required for accounts/receipts see Note IN.0.7.

Retention of requests

A medical practitioner who has rendered an R-type diagnostic imaging service in response to a written request must retain that request for a period of two years commencing on the day on which the service was rendered.

A medical practitioner must, if requested by the Department of Human Services CEO, produce written requests retained by that practitioner for an R-type diagnostic imaging service as soon as practicable and in any case by the end of the day after the day on which the Department of Human Services CEO's request was made. An employee of the Department of Human Services is authorised to make and retain copies of or take and retain extracts from written requests or written confirmations of lost requests.

A medical practitioner who, without reasonable excuse, fails to comply with the above requirements is guilty of an offence under the Health Insurance Act 1973 punishable, upon conviction, by a fine of $1000.

The Department of Health has developed a Health Practitioner Guideline to substantiate that a valid request existed (pathology or diagnostic imaging), which is located online at www.health.gov.au.

IN.0.2 Who May Provide A Diagnostic Imaging Service

Unless otherwise stated, a diagnostic imaging service specified in the DIST may be provided by:

a) a medical practitioner; or

b) a person, other than a medical practitioner, who provides the service under the supervision of a medical practitioner in accordance with accepted medical practice.

For the purposes of Medicare, however, the rendering practitioner is the medical practitioner who provides the report.

Medicare benefits are not payable, for example, when a medical practitioner refers patients to self-employed paramedical personnel, such as radiographers or other persons, who either bill the patient or the practitioner requesting the service.

Reports provided by practitioners located outside Australia

Under the Act, Medicare benefits are only payable for services rendered in Australia. Where a service consists of a number of components, such as a diagnostic imaging service, all components need to be rendered in Australia in order to qualify for Medicare benefits. For diagnostic imaging services, this means that all elements of the service, including the preparation of report on the procedure, would need to be rendered in Australia.

As such, Medicare benefits are not payable for services which have been reported on by medical practitioners located outside Australia.

Who may perform a Diagnostic Radiology Procedure:

All items in Group I3 (excluding Sub-group 10) must be performed by:

a) a medical practitioner;

b) a medical radiation practitioner who provides the service under the supervision of a medical practitioner in accordance with accepted medical practice.

A medical radiation practitioner means a person registered or licenced as a medical radiation practitioner under a law of a State or Territory.

However, for a service mentioned in items 57901 to 57969, a diagnostic imaging procedure may also be performed by a dental practitioner who:

(a) may request the service because of the operation of subsection 16B (2) of the Health Insurance Act 1973; and

(b) provides the service under the supervision of a medical practitioner in accordance with accepted medical practice.

Exceptions to this requirement

Requirements on who must perform a diagnostic radiology procedure do not apply where the service is performed

in:

a) RA2, RA3 OR RA4; OR

b) both:

i) in RA1; and

ii) RRMA4 or RRMA5

RA1 means an inner regional area as classified by the ASGC.

RA2 means an outer regional area as classified by the ASGC.

RA3 means a remote area as classified by the ASGC.

RA4 means a very remote area as classified by the ASCG

RRMA4 means a small rural centre as classified by the Rural, Remote and Metropolitan Areas Classification.

RRMA5 means a rural centre with an urban centre population of less than 10,000 persons as classified by the Rural, Remote and Metropolitan Areas Classification.

However, diagnostic radiology procedures in these areas must also be performed by a medical practitioner; or a person, other than a medical practitioner, who provides the service under the supervision of a medical practitioner in accordance with accepted medical practice.

IN.0.3 Diagnostic Imaging Services - Overview

Section 4AA of the *Health Insurance Act 1973* (the Act) enables the *Health Insurance (Diagnostic Imaging Services Table) Regulations* to prescribe a table of diagnostic imaging services that sets out rules for interpretation of the table, items of diagnostic imaging services and the amount of fees applicable to each item.

For further information on diagnostic imaging, visit the Department of Health's website

IN.0.4 What Is A Diagnostic Imaging Service

A diagnostic imaging service is defined in the Act as meaning "an R-type diagnostic imaging service or an NR-type diagnostic imaging service to which an item in the DIST applies".

A diagnostic imaging procedure is defined in the Act as 'a procedure for the production of images (for example x-rays, computerised tomography scans, ultrasound scans, magnetic resonance imaging scans and nuclear scans) for use in the rendering of diagnostic imaging services'.

The Schedule fee for each diagnostic imaging service described in the DIST covers both the diagnostic imaging procedure and the reading and report on that procedure by the diagnostic imaging service provider. Exceptions to the reporting requirement are as follows:

(a) where the service is provided in conjunction with a surgical procedure, the findings may be noted on the operation record (items 55054, 55130, 55135, 55848, 55850, 57341, 57345, 59312, 59314, 60506, 60509 and 61109);

(b) where a service is provided in preparation of a radiological procedure (items 60918 and 60927).

As for all Medicare services, diagnostic imaging services have to be clinically relevant before they are eligible for Medicare benefits. A clinically relevant service is a service that is generally accepted in the profession as being necessary for the appropriate treatment of the patient.

For NR-type services (and R-type services provided without a request under the exemption provisions - see IN.0.1 - 'Exemptions from the written request requirements for R-type diagnostic imaging services'), the clinical relevance of the service is determined by the providing practitioner. For R-type services rendered at the request of another practitioner, responsibility for determining the clinical relevance of the service lies with the requesting practitioner.

IN.0.5 Maintaining Records of Diagnostic Imaging Services

Providers of diagnostic imaging services must keep records of diagnostic imaging services in a manner that facilitates retrieval on the basis of the patient's name and date of service. Records of R-type diagnostic imaging services must be retained for a period of 2 years commencing on the day on which the service was rendered.

The records must include the report by the providing practitioner on the diagnostic imaging service. For ultrasound services, where the service is performed on behalf of a medical practitioner the report must record the name of the sonographer.

- Where the provider *substitutes* a service for the service originally requested, the provider's records must include:

- words indicating that the providing practitioner has consulted with the requesting practitioner and the date of consultation; or

- if the providing practitioner has not consulted with the requesting practitioner, sufficient information to demonstrate that he or she has taken all reasonable steps to do so.

- For services rendered after a *lost request*, the records must include words to the effect that the request was lost but confirmed by the requesting practitioner and the manner of confirmation, eg. how and when.

j. For *emergency services*, the records must indicate the nature of the emergency.

If requested by the Managing Director, the Department of Human Services, records retained by a providing practitioner must be produced to an officer of the Department of Human Services as soon as practicable but in any event within seven days after the day the Managing Director requests the production of those records. the Department of Human Services officers may make and retain copies, or take and retain extracts, of such records.

A medical practitioner who, without reasonable excuse, contravenes any of the above provisions is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine of $1000.

IN.0.6 Registration of Site Undertaking Diagnostic Imaging Procedures

All sites (including hospitals) and bases for mobile equipment at or from which diagnostic imaging procedures are performed need to be registered with the Department of Human Services for the purposes of Medicare.

Registered sites and bases for mobile equipment are allocated a Location Specific Practice Number (LSPN). The LSPN is a unique identifier comprising a six digit numeric and is required on all accounts, receipts and Medicare assignment of benefits forms for diagnostic imaging services before patients can receive Medicare benefits. In addition, benefits are not payable unless there is equipment of appropriate type listed on the register for the practice.

Sites or bases for mobile equipment need only register once. To maintain registration, sites are required to advise the Department of Human Services of any changes to their primary information within 28 days of the change occurring. Primary information is:

- proprietor details;

- ACN (for companies);

- business name and ABN;

- address of practice site or base for mobile equipment;

- type of equipment located at the site;

- information about any health care provider not employed at, or contracted to provide services for the site or base, who has an interest in any of the equipment listed on the register.

Registration will be suspended if a proprietor fails to respond to notices from the Department of Human Services about registration details. The suspension will be lifted as soon as the notices are responded to and Medicare benefits will be backdated for the period of suspension.

Registration will be cancelled after a continuous period of three months suspension. Cancellation under these circumstances is taken to have commenced from the date of suspension.

The proprietor may, at any time, request cancellation of the registration of a practice site or base for mobile equipment. Otherwise, registration may be cancelled by the Department of Human Services if the registration was obtained improperly (false information supplied) or if the proprietor fails to notify the Department of Human Services of primary information. A decision to cancel a registration will only be made following due consideration of a submission by the site or base. The proprietor may apply to the Administrative Appeals Tribunal for a review of this decision. If registration is cancelled involuntarily, the proprietor may not apply to re-register the site or base for a period of 12 months unless permitted to do so.

Proprietors of unregistered practices (including where the registration is under suspension or has been cancelled) need to either advise patients in writing or display a notice that no Medicare benefits will be payable for the diagnostic imaging services.

For full details about Location Specific Practice Numbers, including how to register a practice site. A list of LSPN registrations is available on the Department of Human Services' website at www.medicaraustralia.gov.au/yourhealth/our_services/lspn_search.htm and this allows practitioners and the general public to verify the registration status of practice sites eligible for Medicare benefits.

From 1 July 2010 practices applying for an LSPN will also need to apply for and be accredited under the Stage II Diagnostic Imaging Accreditation Scheme in order to be eligible to provide diagnostic imaging services under Medicare.

ACCREDITATION OF SITES UNDERTAKING DIAGNOSTIC IMAGING SERVICES

Background

In June 2007, legislation was enacted to amend the Health Insurance Act 1973 to establish a diagnostic imaging accreditation scheme under which mandatory accreditation would be linked to the payment of Medicare benefits for radiology and non-radiology services.

The Scheme commenced on 1 July 2008 and covered only practices providing radiology services. From 1 July 2010, the Scheme continued the accreditation arrangements for practices providing radiology services, and broadened the scope of the scheme to include practices providing non-radiology services such as cardiac ultrasound and angiography, obstetric and gynaecological ultrasound and nuclear medicine imaging services.

ACCREDITATION OF PRACTICES UNDERTAKING DIAGNOSTIC IMAGING SERVICES

Background

In 2007, the Diagnostic Imaging Accreditation Scheme (the Scheme) was established by the Health Insurance Amendment (Diagnostic Imaging Accreditation) Act 2007 to ensure Medicare funding is directed to diagnostic imaging services that are safe, effective and responsive to the needs of health care consumers.

The Scheme was implemented in two stages.

Stage 1

In 2008 Stage 1 of the Scheme commenced requiring practices providing radiology and some ultrasound services to meet a minimum of 3 entry level standards.

Stage 2

In 2009 the Scheme was broadened to mandate accreditation for all practices providing Medicare rebateable diagnostic imaging services and increasing the number of standards from 3 entry level Practice Standards to 15 full suite Practice Accreditation Standards.

The deadline for Practices to attain the full suite of accreditation standards was phased in to allow practices time to meet the increased number of standards. Practices accredited under Stage 1 of the Scheme were required to meet the new standard by 1 July 2012, whereas Practices who gained entry into the Scheme in Stage 2 have until 2013 to become fully accredited.

First time accreditation

New practices entering the Scheme may choose to be accredited against either three entry-level Practice Standards or the full suite of Practice Accreditation Standards. Practices initially choosing to be accredited against the entry level Standards have a further period two years to become accredited against the full suite of Standards.

Re-accreditation of Practices

Practices previously accredited must seek re-accreditation against the full suite of Practice Standards and cannot apply for re-accreditation against the entry level Standards.

Medicare rebateable diagnostic imaging services

All Practices intending to render any diagnostic imaging services for the purpose of Medicare benefits must be accredited under the Scheme. This includes non-radiology services such as cardiac ultrasound and angiography, obstetrics and gynaecological ultrasound and nuclear medicine imaging services.

Non-Accredited Practices

Practices may choose not to be accredited and still provide diagnostic imaging services, but these services do not attract a Medicare rebate.

Practices providing non Medicare funded diagnostic imaging services are bound by the requirements of the Health Insurance Act 1973 (Div 5/Section 23DZZIAE) to inform patients prior to carrying out the service, that the Practice is not accredited and as such the service does not attract a Medicare rebate.

The Medical Imaging Accreditation Program (MIAP)

For a number of years the Royal Australian and New Zealand College of Radiologist (RANZCR) has delivered a voluntary accreditation program jointly with the National Association of Testing Authorities, Australia.

Practices participating in MIAP can seek recognition of their MIAP accreditation under the Scheme. This recognition will grant MIAP Practices accreditation against the full suite of Standards until the date of the expiration of the recognised MIAP accreditation. By this date Practices will need to either provide their Approved Accreditor with evidence of renewal of MIAP accreditation or have been granted accreditation against the full suite of Standard.

The Accreditation Standards

The current Practice Accreditation Standards are made up of three entry level Practice Accreditation Standards and the full suite of Practice Accreditation Standards. If a practice is applying for accreditation against the entry level Practice Accreditation Standards, an accreditation decision will be made within 15 business days of the lodgement of an application for accreditation. If a practice is applying for accreditation against the full suite of Practice Accreditation Standards, an accreditation decision will be made within 30 business days of the lodgement of an application for accreditation.

From the date of being granted accreditation, the practice site can provide diagnostic imaging services under Medicare.

<u>Entry Level Standards</u>

i. Registration and Licensing Standard
j. Radiation and Safety Standard
k. Equipment Inventory Standard

<u>Full Suite Accreditation Standards</u>

Part 1- Organisational Standards

Part 2 - Pre-procedure Standards

Part 3 - Procedure Standards

Part 4 - Post Procedure Standards

Applying for accreditation

Whether a practice is applying for accreditation against entry-level standards or the full suite of Practice Accreditation Standards, the application process is the same. A practice is required to submit to an approved accreditor either:

- an application for accreditation providing written documentary evidence of compliance with the entry level accreditation standards or the full suite Practice Accreditation Standards; or

- written evidence of accreditation under the Medical Imaging Accreditation Program (MIAP) jointly administered by the Royal Australian and New Zealand College of Radiologists (RANZCR) and the National Association of Testing Authorities Australia (NATA).

Renewal of Accreditation

Practices awarded accreditation against the full suite of Practice Accreditation Standards enter the maintenance program which requires them to be re-accredited every 4 years.

Approved Accreditors

There are three Accreditation agencies approved by the Minister for Health to provide Accreditation services:

Health and Disability Auditing Australia **Ph: 1800 601 696**

(HDAAu)

National Association of Testing Authorities **Ph: 1800 621 666**

(NATA)

Quality Innovation Performance **Ph: 1300 888 329**

(QIP)

Further information

Website: www.diagnosticimaging.health.gov.au

Email: diagnosticimagingandaccreditation@health.gov.au

Phone: (02) 6289 8859

IN.0.7 Details Required on Accounts, Receipts and Medicare Assignment of Benefit Forms

In addition to the normal particulars of the patient, date of service, the services performed and the fees charged, the details which must be entered on accounts or receipts, and Medicare assignment of benefits forms in respect of diagnostic imaging services are as follows:

- the Location Specific Practice Number (LSPN) of the diagnostic imaging premises or mobile facility where the diagnostic imaging procedure was undertaken;

- if the professional service is provided by a specialist in diagnostic radiology the name and either the address of the place of practice, or the provider number, of that specialist;

- if the medical practitioner is not a specialist in diagnostic radiology the name and either the practice address or provider number of the practitioner who is claiming or receiving fees;

- for "R-type" (requested) services and services rendered subsequent to lost requests, the account or receipt or the Medicare assignment form must indicate the date of the request and the name and provider number, or the name and address, of the requesting practitioner.

- services that are *self-determined* must be endorsed with the letters 'SD' to indicate that the service was self-determined. Services are classified as self determined when rendered:

- **by a *consultant physician or specialist,* in the course of that consultant physician or specialist practicing his or her specialty (other than a specialist in diagnostic radiology), or**

- **to provide *additional services* to those specified in the original request and the additional services are of the type that would have otherwise required a referral from a specialist or consultant physician; or**

- in a *remote area*, or

- **under a *pre-existing diagnostic imaging practice exemption.***

- *substituted services* the account etc. must be endorsed 'SS'.

- *emergencies*, the account etc. must be endorsed "emergency".

- *lost requests* the account etc. must be endorsed "lost request".

IN.0.8 Contravention of State and Territory Laws and Disqualified Practitioners

Medicare benefits are not payable where a diagnostic imaging service is provided by, or on behalf of, a medical practitioner, and the provision of that service by that practitioner or any other person contravenes a State or Territory law which, directly or indirectly, relates to the use of diagnostic imaging procedures or equipment. The Managing Director of the Department of Human Services may notify the relevant State or Territory authorities if he/she believes that a person may have contravened a law of a State or Territory relating directly or indirectly to the use of diagnostic imaging procedures or equipment.

IN.0.9 Prohibited Practices

Changes have been made to legislation relating to diagnostic imaging services provided under Medicare.

Amendments to the Health Insurance Act 1973 (the Act) relating to diagnostic services funded under Medicare came into effect on 1 March 2008. The changes were implemented following measures introduced in the *Health Insurance Amendment (Inappropriate and Prohibited Practices and other Measures) Act 2007*.

Who might be affected?

· Anyone who can provide or request a Medicare-funded diagnostic imaging service might be affected.

· Anyone who has a relevant connection to a provider or a requester, including relatives, bodies corporate, trusts, partnerships and employees may also be affected.

What is prohibited?

· It is unlawful to ask for, accept, offer or provide a benefit, or make a threat, that is reasonably likely to induce a requester to make diagnostic imaging requests, or is related to the business of providing diagnostic imaging services.

· It is a criminal offence to ask for, accept, offer, or provide a benefit, or make a threat, that is intended to induce requests to a particular provider.

· The prohibitions apply to the provision of benefits, or the making of threats, that are directed to a requester by a provider, whether directly or through another person.

A requester of diagnostic imaging services means:

· a medical practitioner;

· a dental practitioner, a chiropractor, a physiotherapist, a podiatrist or an osteopath (in relation to certain types of services prescribed in Regulations);

· a person who employs, or engages under a contract for services, one of the people mentioned above; or

· a person who exercises control or direction over one of the people mentioned above (in his or her professional capacity).

A provider of a diagnostic imaging service means:

· a person who renders that kind of service;

· a person who carries on a business of rendering that kind of service;

· a person who employs, or engages under a contract for services, one of the people detailed above; or

· a person who exercises control or direction over a person who renders that kind of service or a person who carries on a business of rendering that kind of service.

What is permitted?

Under the Act it is permitted to:

· share the profits of a diagnostic imaging business, provided the dividend is in proportion to the beneficiary's interest in the business;

· accept or pay remuneration, including salary, wages, commission, provided the remuneration is not substantially different from the usual remuneration paid to people engaged in similar employment;

· make or accept payments for property, goods or services, provided the amount paid is not substantially different from the market value of the property, goods or services;

· make or accept payments for shared property, goods or services, provided the amount paid is proportionate to the person's share of the cost of the property, goods or services and shared staff and/or equipment are not used to provide diagnostic imaging services;

· provide or accept property, goods or services, provided the benefit exchanged is not substantially different from the market value of the property, goods or services;

Are there any benefits, other than those described in the Act, that are permitted?

· The Minister has determined that certain types of benefit are permitted. These include items to support a requester to view diagnostic imaging reports, such as specially designed computer monitors. Modest gifts and hospitality may also be permitted, under certain circumstances.

Further information on the *Health Insurance (Permitted Benefits - diagnostic imaging services) Determination 2008* can be found on the Department of Health website at www.health.gov.au/legislativeamendments

What are the penalties for those not complying with the provisions?

· If you breach the provisions, you could potentially be subject to a range of penalties, depending on the kind of breach, including:

o civil penalties;

o criminal offences;

o referral to a Medicare Participation Review Committee (MPRC), possibly resulting in loss of access to Medicare.

For further information on Prohibited Practices visit the Department of Health website at www.health.gov.au/legislativeamendments

IN.0.10 Multiple Services Rules

Background

There are several rules that may apply when calculating Medicare benefits payable when multiple diagnostic imaging services are provided to a patient at the same attendance (same day). These rules were developed in association with the diagnostic imaging profession representative organisations and reflect that there are efficiencies to the provider when these services are performed on the same occasion. Unless there are clinical reasons for doing so, they should be provided to the patient at the one attendance and the efficiencies from doing this reflected in the overall fee charged.

General diagnostic imaging - multiples services

The diagnostic imaging multiple services rules apply to all diagnostic imaging services. There are three rules, and more than one rule may apply in a patient episode. The rules do not apply to diagnostic imaging services rendered in a remote area by a medical practitioner who has a remote area exemption for that area - see IN.0.1.

Rule A. When a medical practitioner renders two or more diagnostic imaging services to a patient on the same day, then:

- the diagnostic imaging service with the highest Schedule fee has an unchanged Schedule fee; and
- the Schedule fee for each additional diagnostic imaging service is reduced by $5.

Rule B. When a medical practitioner renders at least one R-type diagnostic imaging service and at least one consultation to a patient on the same day, there is a deduction to the Schedule fee for the diagnostic imaging service with the highest Schedule fee as follows:

- if the Schedule fee for the consultation is $40 or more - by $35; or
- if the Schedule fee for the consultation is less than $40 but more than $15 - by $15; or
- if the Schedule fee for the consultation is less than $15 - by the amount of that fee.

The deduction under Rule B is made once only. If there is more than one consultation, the consultation with the highest Schedule fee determines the deduction amount. There is no further deduction for additional consultations.

A 'consultation' is a service rendered under an item from Category 1 of the Medicare Benefits Schedule (MBS), that is, items 1 to 10816 inclusive.

Rule C. When a medical practitioner renders an R-type diagnostic imaging service and at least one non-consultation service to the same patient on the same day, the Schedule fee for the diagnostic imaging service with the highest Schedule fee is reduced by $5.

A deduction under Rule C is made once only. There is no further deduction for any additional medical services.

For Rule C, a 'non-consultation' is defined as any following item from the MBS:

- Category 2, items 11000 to 12533;
- Category 3, items 13020 to 51318;

- Category 4, items 51700 to 53460;

- Cleft Lip and Palate services, items 75001 to 75854 (as specified in the 'Medicare Benefits for the treatment of cleft lip and cleft palate conditions' book.)

Pathology services are not included in Rule C.

When both Rules B and C apply, the sum of the deductions in the Schedule fee for the diagnostic imaging service with the highest Schedule fee is not to exceed that Schedule fee.

Ultrasound - Vascular

This rule applies to all vascular ultrasound items claimed on the same day of service ie whether performed at the same attendance by the same practitioner or at different attendances.

Where more than one vascular ultrasound service is provided to the same patient by the same practitioner on the same date of service, the following formula applies to the Schedule fee for each service:

- 100% for the item with the greatest Schedule fee

- plus 60% for the item with the next greatest Schedule fee

- plus 50% for each other item.

When the Schedule fee for some of the items are the same, the reduction is calculated in the following order:

- 100% for the item with the greatest Schedule fee and the lowest item number

- plus 60% for the item with the greatest Schedule fee and the second lowest item number

- plus 50% for each other item

Note: If 2 or more Schedule fees are equally the highest, the one with the lowest item number is taken to have the higher fee eg. Item 55238 and 55280, item 55238 would be considered the highest.

When calculating the benefit, it should be noted that despite the reduction, the collective items are treated as one service for the application of Rule A of the General Diagnostic Imaging Multiple Services rules and the patient gap. Examples can be found at the Department of Human Services' website.

Magnetic Resonance Imaging (MRI) - Musculoskeletal

If a medical practitioner performs 2 or more scans from subgroup 12 and 13 for the same patient on the same day, the fees specified for items that apply to the service are affected as follows:

(a) the item with the highest schedule fee retains 100% of the schedule fee; and

(b) any other fee, except the highest is reduced by 50%.

Note: If 2 or more Schedule fees are equally the highest, the one with the lowest item number is taken to have the higher fee eg. Item 63322 and 63331, item 63322 would be considered the highest.

If the reduced fee is not a multiple of 5 cents, the reduced fee is taken to be the nearest amount that is a multiple of 5 cents.

In addition, the modifying item for contrast may only be claimed once for a group of services subject to this rule.

If a medical practitioner provides:

(a) 2 or more MRI services from subgroups 12 and 13 for the same patient on the same day; and

(b) 1 or more other diagnostic imaging services for that patient on that day

the amount of the fees payable for the MRI services is taken, for the purposes of this rule, to be an amount payable for 1 diagnostic imaging service in applying Rule A of the General Diagnostic Imaging Multiple Services rules.

IN.0.11 Capital Sensitivity Measure for Diagnostic Imaging Equipment

Almost all services listed in the Diagnostic Imaging Services Table of the Medicare Benefits Schedule (MBS), excluding Positron Emission Tomography (PET) services, have two different schedule fees - schedule '(K)' items (100 per cent of the MBS fee) and schedule '(NK)' items (approximately 50 per cent of the MBS fee) for diagnostic imaging services provided on aged equipment.

This is known as the 'capital sensitivity measure', and it is in place for almost all diagnostic imaging equipment providing services (excluding PET) under Medicare. The measure is intended to improve the quality of diagnostic imaging services by encouraging providers to upgrade and replace aged equipment as appropriate.

On 27 November 2013, the remote location exemptions provisions that apply to CT items 56001-57361 and angiography items 59903-59974 were amended so they are consistent with other diagnostic imaging modalities.

A regional exemption automatically applies if services are provided in a location in Remoteness Area (RA) outer regional, remote, or very remote. Exemptions may be granted by the Department of Health (subject to particular criteria) to practices located in RA inner regional areas, where the location was previously under the Rural, Remote and Metropolitan Area (RRMA) classification system, RRMA4 or RRMA5.

As there may be a number of diagnostic imaging providers which met the previous exemption criteria, but not the current criteria, a grandfathering provision will be implemented. A diagnostic imaging provider which was eligible to claim schedule '(K)' items for CT and angiography services because they met the previous exemption criteria prior to 27 November 2013, may claim schedule '(K)' items until 1 July 2016. This transition period will allow affected providers an opportunity to upgrade or replace their equipment.

As part of the 2014-15 Federal Budget the Government announced *the 'Medicare Benefits Schedule - revised capital sensitivity provisions for diagnostic imaging equipment'* measure, which will strenthen the quality and safety of MBS diagnostic imaging services through alignment and consistency of the capital sensitivity measure across all modalities (except PET).

This measure includes:

· the extension of the capital sensitivity measure to all angiography services, including the previously excluded MBS items 60000 to 60078;

iii. introduction of a 'maximum extended life age' of 15 years for CT and angiography services; and
iv. increasing the 'maximum extended life age' for MRI services to 20 years.

The changes will take effect on 1 January 2015.

After 1 January 2015, any CT and angiography machine that has not reached maximum extended life age (15 years) but has reached its new effective life age, and is upgraded before 1 January 2015 is eligible for K items from 1 January 2015, until the machine reached its maximum extended life age.

After 1 January 2015, any CT and angiography machine that has not reached its maximum extended life age (15 years) but has reached its new effective life age, and is upgraded between 1 January 2015 and 1 January 2016 , is eligible for K items on and from the day that it is upgraded until the machine reached its maximum extended life age.

Further detail

For full details about the rules for claiming the schedule '(K)' and schedule '(NK)' items, the exemptions, and the definition of upgrade, providers should access the Department of Health's website at: www.health.gov.au/capitalsensitivity

IN.0.12 Group I2 - Computed Tomography (CT)

Capital sensitivity items

A reduced Schedule fee applies to CT services provided on equipment that is 10 years old or older. This equipment must have been first installed in Australia ten or more years ago, or in the case of imported pre-used equipment, must have been first manufactured ten or more years ago. A range of items cover services provided on older equipment. These items are:

56041, 56047, 56050, 56053, 56056, 56062, 56068, 56070, 56076, 56141, 56147, 56259, 56341, 56347, 56441, 56447, 56449, 56452, 56541, 56547, 56659, 56665, 56841, 56847, 57041, 57047, 57247, 57345, 57355, 57361.

These items are identified by the addition of the letter '(NK)' at the end of the item. These items should be used where services are performed on equipment ten years old or older, except where equipment is located in a remote area when items with the letter "K", as described below, will apply.

Items 56001 to 57356 (which contain the symbol (K) at the end of the item should be used for services which are performed on a date which is less than ten years after the date on which the CT equipment used in performing the service was first installed in Australia. In the case of imported pre-used CT equipment, the services must have been performed on a date which is less than ten years from the first date of manufacture of the equipment.

Professional supervision

CT services (items 56001 to 57356) are not eligible for a Medicare rebate unless the service is performed:

(a) under the professional supervision of a specialist in the specialty of diagnostic radiology who is available:

(i) to monitor and influence the conduct and diagnostic quality of the examination; and

(ii) if necessary, to personally attend on the patient; or

(b) if paragraph (a) cannot be complied with

(i) in an emergency, or

(ii) because of medical necessity in a remote area - refer to DID.4.4 for definition of remote area.

Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

Items 57360 and 57361 apply only to a CT service that is:

(a) performed under the professional supervision of a specialist or consultant physician recognised by the Conjoint Committee for the Recognition of Training in CT Coronary Angiography who is available:

(i) to monitor and influence the conduct and diagnostic quality of the examination; and

(ii) if necessary, to attend on the patient personally; and

(b) reported by a specialist or consultant physician recognised by the Conjoint Committee for the Recognition of Training in CT Coronary Angiography; or

(c) if paragraph (a) and (b) cannot be complied with

(i) in an emergency, or

(ii) because of medical necessity in a remote area - refer to DID.4.4 for definition of remote area.

Use of a hybrid PET/CT or SPECT/CT machine

CT scans rendered on hybrid Positron Emission Tomography (PET)/CT or hybrid Single Photon Emission Computed Tomography (SPECT)/CT units are eligible for a Medicare benefit provided:

· the CT scan is not solely used for the purposes of attenuation correction and anatomical correlation of any associated PET or SPECT scan; and

· the CT scan is rendered under the same conditions as those applying to services rendered on stand-alone CT equipment. For example, the service would need to be properly requested and performed under the professional supervision of a specialist radiologist, including specialist radiologists with dual nuclear medicine qualifications.

Scan of more than one area

Items have been provided to cover the common combinations of regions - see Multiple Regions below. However, where regions are scanned on the one occasion which are not covered by a combination item, for example, item 56220 (scan of the spine) with item 56619 (scan of extremities), both examinations would attract separate benefit.

Multiple regions

Items have been provided to cover the common combinations of regions. The items relating to the individual contiguous regions should not be used when scans of multiple regions are performed.

More than one attendance of the patient to complete a scan

Items 56220 to 56240 and 56619 to 56665 apply once only for a service described in any of those items, regardless of the number of patient attendances required to complete the service. For example, where a request relates to two or more regions of the spine and one region only is scanned on one occasion with the balance of regions being scanned on a subsequent occasion, benefits are payable for one combination service only upon completion.

Pre contrast scans

Pre contrast scans are included in an item of service with contrast medium only when the pre-contrast scans are of the same region.

Head

Exclusion of acoustic neuroma

If an axial scan is performed for the exclusion of acoustic neuroma, Medicare benefits are payable under item 56001 or 56007.

Assessment of headache

If the service described in item 56007 or 56047 is used for the assessment of headache of a patient, the fee mentioned in the item applies only if:

(a) a scan without intravenous contrast medium has been undertaken on the patient; and

(b) the service is required because the result of the scan is abnormal.

This rule applies to a patient who:

(i) is under 50 years; and

(ii) is (apart from the headache) otherwise well; and

(iii) has no localising symptoms or signs; and

(iv) has no history of malignancy or immunosuppression.

Spine

CT items exist which separate the examination of the spine into the cervical, thoracic and lumbosacral regions. These items are 56220 to 56240 inclusive. They include items for CT scans of two regions of the spine (56233, 56234, 56235 and 56236) and for all three regions of the spine (56237, 56238, 56239 and 56240). Restrictions apply to the following items:

(a) item 56233 is used where two examinations of the kind referred to in items 56220, 56221 and 56223 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed.

(b) item 56234 is used where two examinations of the kind referred to in items 56224, 56225 and 56226 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed.

(c) item 56235 is used where two examinations of the kind referred to in items 56227, 56228 and 56229 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed

(d) item 56236 is used where two examinations of the kind referred to in items 56230, 56231 and 56232 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed

Example: for a CT examination of the spine where the cervical and thoracic regions are to be studied (item 56233), item numbers 56220 and 56221 must be specified.

With intrathecal contrast medium (Item 56219)

The item incorporates the cost of contrast medium for intrathecal injection and associated x-rays. Benefits are not payable for this item when rendered in association with myelograms (Item 59724). Where a myelogram is rendered under item 59724 and a CT is necessary, the relevant item would be scan of spine without intravenous contrast (Item 56220, 56221 or 56223).

Upper abdomen and pelvis

Items 56501, 56507, 56541 and 56547 are not eligible for Medicare Benefits if performed for the purpose of performing a virtual colonoscopy (otherwise known as CT colonography and CT colography). CT Colonography is covered by items 56553 and 56555.

Computed Tomography of the Colon (Items 56553 and 56555)

In items 56553 and 56555 the terms 'high risk' and 'incomplete colonoscopy' are defined as follows:

High Risk

Asymptomatic people fit into this category if they have:

- three or more first-degree or a combination of first-degree and second-degree relatives on the same side of the family diagnosed with bowel cancer (suspected hereditary non-polyposis colorectal cancer or NPCC), or

- two or more first-degree or second-degree relatives on the same side of the family diagnosed with bowel cancer, including any of the following high-risk features:

- multiple bowel cancers in the one person

- bowel cancer before the age of 50 years

- at least one relative with cancer of the endometrium, ovary, stomach, small bowel, ureter, biliary tract or brain

- at least one first-degree relative with a large number of adenomas throughout the large bowel (suspected familial adenomatis polyposis or FAP), or

- somebody in the family in whom the presence of a high-risk mutation in the adenomatis polyposis coli (APC) gene or one of the mismatch repair (MMR) genes has been identified.

Source: NHMRC 2005 Clinical Practice Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer - Category 3 - those at potentially high risk.

Incomplete Colonoscopy

For audit purposes, an incomplete colonoscopy is defined as one that is not completed for technical or medical reasons and must have been performed in the preceding 3 months.

Spiral angiography

Items 57350 and 57355 and items 57351 and 57356

CT spiral angiography items 57351 and 57356 apply under certain circumstances specified in the items including where a service to which items 57350 or 57355 have been performed on the same patient within the previous 12 months, whereas items 57350 and 57355 apply under the circumstances specified in the items and where the service has not been performed on the same patient within the previous 12 months.

Computed tomography of the coronary arteries (Items 57360 and 57361)

Payment of Medicare rebates for items 57360 and 57361 is limited to specialists or consultant physicians who have fulfilled the training and credentialing requirements developed by the Conjoint Committee for the Recognition of Training in CT Coronary Angiography (CTCA). The descriptors for CT spiral angiography items 57350, 57351, 57355 and 57356 and CT chest items 56301, 56307, 56341, 56347, 56801, 56807, 56841, 56847, 57001, 57007, 57041 and 57047 clarify that they are not to be used to image the coronary arteries.

IN.0.13 Group I4 - Nuclear Medicine Imaging

General

Benefits for a nuclear scanning service are only payable when the service is performed by a specialist or consultant physician, or by a person acting on behalf of the specialist and the final report of the service is compiled by the specialist or consultant physician who performed the preliminary examination of the patient and the estimation and administration of the dosage.

Additional benefits will only be attracted for specialist physician or consultant physician attendance under Category 1 of the Schedule where there is a request for a full medical examination accompanied by a referral letter or note of referral.

Credentialling for nuclear medicine imaging services

Payment of Medicare rebates for nuclear medicine imaging services is limited to specialists or consultant physicians who are credentialled by the Joint Nuclear Medicine Credentialling and Accreditation Committee of the Royal Australian College of Physicians (RACP) and the Royal Australian and New Zealand College of Radiologists (RANZCR). The scheme has been developed by the profession in consultation with Government to ensure that specialists in nuclear medicine are appropriately trained and licensed, provide appropriate personal supervision of procedures and are involved in ongoing continuing medical education.

For information regarding the Scheme and for application forms, please phone the RACP or RANZCR.

Radiopharmaceuticals

The Schedule fees for nuclear medicine imaging services incorporate the costs of radiopharmaceuticals.

Single Photon Emission Computed Tomography (SPECT)

Where SPECT has been performed in conjunction with another study and is not covered under the item descriptor or is not covered under Item 61462, no Medicare benefit is payable for the SPECT study.

Single myocardialperfusion studies (Items 61302 and 61303)

Items 61302 and 61303 apply to single myocardial perfusion studies which can only be used once and cannot be used in conjunction with any other myocardial perfusion study for an individual patient referral.

Myocardial perfusion (Items 61306 and 61307)

Items 61306 and 61307 refer to all myocardial perfusion studies involving two or more sets of imaging times related to an individual patient referral. This includes stress/rest, stress/re-injection, stress/rest and re-injection thallium studies, one or two-day technetium-based perfusion agent protocols, mixed technetium-based perfusion agent/thallium protocols and the use of gated SPECT when undertaken.

Hepatobiliary study (pre-treatment) (Item 61360)

Item 61360 - the standard hepatobiliary item - also includes allowance of the pre-procedural CCK administration for preparatory emptying of the gall bladder and also morphine augmentation.

Hepatobiliary study (infusion) (Item 61361)

Item 61361 applies specifically to a standard hepatobiliary study to which has been added an infusion of sinaclide (CCK-8) following which acquisition is continued and quantification of gallbladder ejection fraction and/or common bile duct activity time curves are performed.

Whole body studies (Items 61426-61438)

"Whole body" studies must include the trunk, head and upper and lower limbs down to the elbow and knee joints respectively, whether acquired as multiple overlapping camera views or whole body sweeps (runs) with additional camera views as required. Any study that does not fulfil these criteria is a localised study.

Repeat studies (Item 61462)

Item 61462 covers repeat planar (whole body or localised) and/or SPECT imaging performed on a separate occasion using the same administration of radiopharmaceutical. The repeat planar and SPECT imaging when performed on a separate occasion using the same administration of radiopharmaceutical should be itemised as item 61462 and the original item and date of service should be indicated for reference purposes.

This item does not apply to bone scans, adrenal studies or gastro-oesophageal reflux studies, myocardial perfusion studies, colonic transit or CFS transport studies, where allowance for performance of the delayed study is incorporated into the baseline benefit fee.

Thyroid study (Item 61473)

Item 61473 incorporates the measurement of thyroid uptake on a gamma camera using a proven technique, where clinically indicated.

Positron Emission Tomography (PET); (Items 61523 to 61647).

In patients with Hodgkin and non- Hodgkin lymphoma (excluding indolent non- Hodgkin lymphoma), whole body FDG PET studies should not to be used for surveillance nor for assessment of patients with suspected (as opposed to confirmed) disease recurrence.

Whole body FDG PET studies should be used as an alternative rather than additional to conventional CT scanning.

Payment of Medicare rebates for PET services is limited to credentialled specialists or consultant physicians who meet eligibility requirements in the *Diagnostic Imaging Services Table Regulations.* PET services must be:

iii. performed under the supervision of:

a) specialist or consultant physician credentialled under the Joint Nuclear Medicine Specialist Credentialling Program for the Recognition of the Credentials of Nuclear Medicine Specialists for Positron Emission Tomography overseen by the Joint Nuclear Medicine Credentialling and Accreditation Committee of the RACP and RANZCR; or

b) practitioner who is a Fellow of either RACP or RANZCR, and who, prior to 1 November 2011, reported 400 or more studies forming part of PET services for which a Medicare benefit was payable, and who holds a current license from the relevant State radiation licensing body to prescribe and administer the intended PET radiopharmaceuticals to humans;

h. provided in a comprehensive facility that can provide a full range of diagnostic imaging services (including PET, CT, X-Ray and diagnostic ultrasound) and cancer treatment services (including chemotherapy, radiation oncology and surgical oncology) at the one site;

i. provided using equipment that meets the Requirements for PET Accreditation (Instrumentation & Radiation Safety) 3nd Edition (2017) issued by the Australian and New Zealand Society of Nuclear Medicine Inc;

j. only provided following referral from a recognised specialist or consultant physician.

All PET providers must complete a specific PET provider Statutory Declaration prior to being eligible to claim Medicare rebates. Statutory declarations can be obtained directly from the Department of Human Services.

IN.0.14 Management of bulk-billed services

Additional bulk billing payment for diagnostic imaging services (item 64990 and 64991)

Item 64990 operates in the same way as item 10990 and item 64991 operates in the same way as item 10991, apart from the following differences:

· Item 64990 and 64991 can only be used in conjunction with items in the Diagnostic Imaging Services Table of the MBS;

· Item 64990 and 64991 applies to diagnostic imaging services self determined by general practitioners and specialists with dual qualifications acting in their capacity as general practitioners;

· Specialists and consultant physicians who provide diagnostic imaging services are not able to claim item 64990 or 64991 unless, for the purposes of the *Health Insurance Act 1973*, the medical practitioner is also a general practitioner and the service provided by the medical practitioner has not been referred to that practitioner by another medical practitioner or person with referring rights.

IN.0.15 Group I1 - Ultrasound

Professional supervision for ultrasound services - R-type eligible services

Ultrasound services (items 55028 to 55854) marked with the symbol *(R)* with the exception of items 55600 and 55603 are not eligible for a Medicare rebate unless the diagnostic imaging procedure is performed under the professional supervision of a:

(a) specialist or a consultant physician in the practice of his or her specialty who is available to monitor and influence the conduct and diagnostic quality of the examination, and if necessary to personally attend the patient; or

(b) practitioner who is not a specialist or consultant physician who meets the requirements of A or B hereunder, and who is available to monitor and influence the conduct and diagnostic quality of the examination and, if necessary, to personally attend the patient.

A. Between 1 September 1997 and 31 August 1999, at least 50 services were rendered by or on behalf of the practitioner at the location where the service was rendered and the rendering of those services entitled the payment of Medicare benefits.

B. Between 1 September 1997 and 31 August 1999, at least 50 services were rendered by or on behalf of the practitioner in nursing homes or patients' residences and the rendering of those services entitled payment of Medicare benefits.

If paragraph (a) or (b) cannot be complied with, ultrasound services are eligible for a Medicare rebate:

(i) in an emergency; or

(ii) in a location that is not less than 30 kilometres by the most direct road route from another practice where services that comply with paragraph (a) or (b) are available.

Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

Sonographer accreditation

Sonographers performing medical ultrasound examinations (either R or NR type items) on behalf of a medical practitioner must be suitably qualified, involved in a relevant and appropriate Continuing Professional Development program and be Registered on the Register of Accredited Sonographers held by the Department of Human Services.

Eligibility for registration

To be eligible for registration on the Register of Accredited Sonographers held by the Department of Human Services, the person must be accredited with the Australian Sonographer Accreditation Registry. For accreditation with the Australian Sonographer Accreditation Registry the person must:

- hold an accredited postgraduate qualification in medical ultrasound; or

- be studying ultrasound.

For further information, please contact the Department of Human Services, Provider Liaison Section, on 132150 for the cost of a local call or the Australian Sonographer Accreditation Registry through its website at www.asar.com.au.

Report requirements

The sonographer's initial and surname is to be written on the report. The name of the sonographer is not required to be included on the copy of the report given to the patient. For the purpose of this rule, the "name" means the sonographer's initial and surname.

Benefits payable

As a rule, benefit is payable once only for ultrasonic examination at the one attendance, irrespective of the areas involved.

Except as indicated in the succeeding paragraphs, *attendance* means that there is a clear separation between one service and the next. For example, where there is a short time between one ultrasound and the next, benefits will be payable for one service only. As a guide, the Department of Human Services will look to a separation of three hours between services and this must be stated on accounts issued for more than one service on the one day.

Where more than one ultrasound service is rendered on the one occasion and the service relates to a non-contiguous body area, and they are "clinically relevant", (ie. the service is generally accepted in the medical profession as being necessary for the appropriate treatment or management of the patient to whom it is rendered), benefits greater than the single rate may be payable. Accounts should be marked "non-contiguous body areas".

Benefits for two contiguous areas may be payable where it is generally accepted that there are different preparation requirements for the patient and a clear difference in set-up time and scanning. Accounts should be endorsed "contiguous body area with different set-up requirements".

Subgroup 1 - General Ultrasound

Abdominal Ultrasound Items 55014, 55016, 55036 and 55037

Medicare benefits are not payable for ultrasound items 55014, 55016, 55036 and 55037 unless a morphological assessment of the abdomen has been performed. For R-type services, the providing practitioner must provide a report of the service performed to the requesting practitioner. For NR-type services, the report must be included in the record of the consultation.

Post-void residual items 55084 and 55085

When a post-void residual is the only service clinically indicated and/or rendered, it is inappropriate to report a pelvic, urinary or abdominal ultrasound, instead of or in addition to this service (55084 or 55085). Similarly, if a complete pelvic, urinary or abdominal ultrasound is billed, it is inappropriate to bill separately for a post-void residual determination, since payment of this has already been included in the payment for the complete scans.

The report must contain an entry denoting the post-void residual amount and/or bladder capacity as calculated/estimated from the ultrasound device. In addition, the medical record must contain documentation of the indication for the service and the number of times performed.

Subgroup 2 - Cardiac ultrasound

Transoesophageal echocardiography - Item 55135 and consequential amendment to Item 55130

The Medical Services Advisory Committee (MSAC) has reviewed intra-operative transoesophageal echocardiography and recommended that public funding for this procedure be supported on an interim basis and be restricted to assessment of cardiac valve competence following valve replacement or repair. Item 55135 has been developed for these indications in consultation with the Australian Society of Anaesthetists, the Australian Medical Association and the Cardiac Society of Australia and New Zealand. Indications other than those recommended by MSAC will continue to be funded under item 55130. Further research will be undertaken to assist MSAC in its future evaluation of the use of intra-operative transoesophageal echocardiography.

Subgroup 3 - Vascular ultrasound

Benefits payable

Medicare benefits are only payable for:

a maximum of two vascular ultrasound studies in a seven-day period. A vascular ultrasound study may include one or more items. Additionally where a patient is referred for a bilateral study of both arms or both legs (eg both arms for item 55238), the account should indicate 'bilateral' or 'left' and 'right' to enable benefit to be paid.

clinically relevant services, that is, the service is generally accepted in the medical profession as being necessary for the appropriate treatment or management of the patient to whom it is rendered. Any decision to have a patient return on a different day to complete a multi-area diagnostic imaging service should only be made on the basis of clinical necessity.

Multiple Vascular Ultrasound Services - refer to DIJ

Separation of services on the one day/contiguous and non-contiguous body areas

These rules do not apply to the vascular ultrasound items and therefore will not impact on the MVUSSR.

Examination of peripheral vessels

Vascular ultrasound services can be claimed in conjunction with item 11612.

Subgroup 4: Urological ultrasound

Prostate ultrasound (Items 55600 to 55604)

Benefits for these items are payable where the service is rendered in the following circumstances:

- a digital rectal examination of the prostate was personally performed by the medical practitioner who also personally rendered the ultrasound service; and

- the transducer probe or probes used can obtain both axial and sagittal scans in 2 planes at right angles; and

- the patient was assessed prior to the service by a medical practitioner recognised in one or more of the specialties specified, not more than 60 days prior to the ultrasound service.

Items 55600 and 55601 cover the situation where the service was rendered by a medical practitioner who **did not** assess the patient, whereas items 55603 and 55604 cover the situation where the service was rendered by a medical practitioner who **did** assess the patient.

Subgroup 5: Obstetric and Gynaecological ultrasound

NR Services

Medicare benefits are not payable for more than three NR-type ultrasound services in Subgroup 5 of Group I1 (ultrasound) that are performed on the same patient in any one pregnancy.

Clinical indications

For items where clinical indications are listed (items 55700, 55704, 55707, 55718, 55759 and 55768), or where a clinical indication is required (items 55712, 55721, 55764 and 55772) for performance of subsequent scans the referral must identify the relevant clinical indication for the service.

It should be noted that a patient must have previously had either a 55706 or 55709 ultrasound in the same pregnancy to be eligible to claim for either a 55712 or 55715 obstetric service. To be eligible to claim for either a 55721 or 55725 obstetric service, a patient must have previously had either a 55718 or 55723 ultrasound in the same pregnancy.

If the service is self-determined (items 55703, 55705, 55708, 55715, 55723, 55725, 55762, 55766, 55770 and 55774), the clinical condition or indication must be recorded in the medical practitioner's clinical notes.

Dating of pregnancy

When dating a pregnancy for the purpose of items 55700 to 55774, a patient is:

a) "less than 12 weeks of gestation" means up to 11 weeks and 6 days of pregnancy;

b) "12 to 16 weeks of gestation" means from 12 weeks 0 days of pregnancy up to 16 weeks plus 6 days of pregnancy (inclusive);

c) "17 to 22 weeks of gestation" means from 17 weeks 0 days of pregnancy up to 22 weeks plus 6 days of pregnancy (inclusive); or

d) "after 22 weeks of gestation" means from 23 weeks 0 days of pregnancy onwards

e) "after 24 weeks of gestation" means from 25 weeks 0 days of pregnancy onwards.

Nuchal Translucency Testing

Where a nuchal translucency measurement is performed when the pregnancy is dated by a crown rump length of 45-84mm in conjunction with items 55700 (R) or 55703 (NR) or 55704 (R) or 55705 (NR), then items 55707 (R) or 55708 (NR) should be claimed. If nuchal translucency measurement for risk of foetal abnormality is performed in conjunction with any additional condition in items 55700, 55703, 55704 or 55705, only one fee is payable.

It should be noted that the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) provides a credentialling program for providers of nuchal translucency scans. It is anticipated that use of items 55707 and 55708 will be restricted to credentialed medical practitioners and sonographers in the future.

Multiple pregnancies

Obstetric ultrasound items 55759 to 55774 cover scanning of a patient who is experiencing a multiple pregnancy. The items incorporate a fee adjustment in recognition of the added complexity and costs associated with scanning multiple pregnancies. Based on the recommendations of the profession, the items apply only to patients where a multiple pregnancy has been confirmed by ultrasound. The items include identical restrictions and provisions as the second and third trimester items (55706-55725), and include items for referred and non-referred services.

Obstetric ultrasound and non-metropolitan providers (Items 55712, 55721, 55764 and 55772)

Where a practitioner has obstetric privileges at a non-metropolitan hospital and refers for items 55712, 55721 and 55764 and 55772, the practitioner must confirm his/her eligibility by stating 'non-metropolitan obstetric privileges' on the referral form.

In relation to items 55712, 55721, 55764 and 55772, non-metropolitan area includes any location outside of the Sydney, Melbourne, Brisbane, Adelaide, Perth, Greater Hobart, Darwin or Canberra major statistical divisions, as defined in the Australian Standard Geographical Classification 2010 published by the Australian Bureau of Statistics (publication number 1216.0 of 2010).

Subgroup 6: Musculoskeletal (MSK) ultrasound

Personal attendance

Medicare Benefits are only payable for a musculoskeletal ultrasound service (items 55800 to 55854) if the medical practitioner responsible for the conduct and report of the examination personally attends during the performance of the scan and personally examines the patient. Services that are performed because of medical necessity in a remote location are exempt from this requirement - see DID for definition of remote area. Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

Multiple Musculoskeletal Ultrasound Scans - items 55800 to 55846

Generally Medicare benefits are payable for more than one musculoskeletal ultrasound scan performed on the same day, however the scans are subject to Rule A of the general diagnostic imaging multiple services rules.

It is not permitted to split a bilateral scan. Where bilateral ultrasound scans are performed (or more than one area is scanned under items 55844 or 55646) the relevant item should be itemised once only on accounts and receipts or Medicare bulk billing forms. For example if both shoulders are scanned, Item 55808 (or 55810 as the case may be) should be claimed once only. This is because the item descriptor for these items covers one or both sides, or one or more areas. A patient should not be asked to make a second appointment in order to attract a benefit for multiple scans.

Shoulder and knee (Items 55808 and 55810 and 55828 and 55830)

Benefits for shoulder ultrasound items 55808 and 55810 are only payable when referral is based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific shoulder pain alone.

Benefits for knee ultrasound items 55828 and 55830 are only payable when referral is based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific knee pain alone or other knee conditions including:

- meniscal and cruciate ligament tears; and
- assessment of chondral surfaces.

IN.0.16 Restriction on item 55054

The Health Insurance (General Medical Services Table) Regulations now require that an item in Group T10 (Relative Value Guide) cannot be claimed in association with item 55054 (ultrasound when used in conjunction with procedures). This came into effect on 1 November 2012.

The use of ultrasound guidance provided in association with anaesthetic procedures is currently being assessed by the Medical Services Advisory Committee (MSAC) for safety, effectiveness and cost-effectiveness (MSAC Application 1183 - Ultrasound imaging in the practice of anaesthesia).

Medicare rebates will continue to be available for the procedures alone and whether individual anaesthetists choose to use ultrasound to assist with those procedures is a matter of clinical judgement for those providers.

IN.0.17 Group I3 - Diagnostic Radiology

Examination and report

As for all diagnostic imaging services, the benefits allocated to each item from 57506 to 60509 inclusive cover the total service, ie. the image, reading and report. Separate benefits are not payable for individual components of the service, eg preliminary reading. Benefits are not separately payable for associated plain films involved with these items.

Exposure of more than one film

Where the radiographic examination of a specific area involves the exposure of more than one film, benefits are payable once only, except where special provision is made in the description of the item for the inclusion of all films taken for the purpose of the examination. This means that if an x-ray of the foot is requested, regardless of the number of exposures from different angles, the completed service comprises x-ray of the foot by one or more exposures and the report. The exception to this would be the plain x-ray of the spine items (58100 to 58115) where the item number differs dependent upon the regions of the spine that are examined at the same occasion, ie. 58112 applies where two regions are examined.

Comparison X-rays

Where it is necessary for one or more films of the opposite limb to be taken for comparison purposes, benefits are payable for radiographic examination and reporting of one limb only. Comparison views are considered to be part of the examination requested.

Subgroup 4: Radiographic examination of the spine

Multiple regions

Multiple region items require that the regions of the spine to be studied must be specified on any account issued or patient assignment form completed.

Item 58112 - spine, two regions

Where item 58112 is rendered (spine, two regions), the item numbers for the regions of the spine being studied must be specified (ie. from items 58100, 58103, 58106 and 58109).

Example: for a radiographic examination of the spine where the cervical and thoracic regions are to be studied, item numbers 58100 and 58103 must be specified on any account issued or patient assignment forms completed.

Item 58115 - spine, three region

Where item 58115 is rendered (spine, three regions), the item numbers for the regions of the spine being studied must be specified (items 58100, 58103, 58106 and 58109).

Example: for a radiographic examination of the spine where the cervical, the thoracic and the lumbosacral regions are to be studied, item numbers 58100, 58103 and 58106 must be specified on any accounts issued or patient assignment forms completed.

Item 58115 & 58108 - spine, three and four region - medical practitioner

Three and four region radiographic examinations items 58115 and 58108 only apply when requested by a medical practitioner.

Items 58120, 58121, 58126 and 58127 - spine, three and four region - non-medical practitioner

Items 58120, 58121, 58126 and 58127 apply to physiotherapists and osteopaths who request a three or four region x-ray and only allow a benefit for one of the items, per patient, per calendar year.

Hand and wrist combination X-ray

An examination of the hand and the wrist on the same side should be claimed as item 57512 (NR) or 57515 (R). If items 57506 (NR) or 57509 (R) are claimed for multiple non-adjacent areas on the same side, or areas on different sides, the account should include annotation on this eg L and R hand, hand and humerus.

Images produced using Dual Energy X-ray Absorptiometry (DEXA) equipment

X-ray items of the spine 58100 to 58115 and hip 57712 and 57715 cannot be claimed when images are produced using Dual Energy X-ray Absorptiometry (DEXA) equipment.

Subgroup 8: Radiographic examination of alimentary tract and biliary system

Plain abdominal film (Items 58900/58903)

Benefits are not attracted for Items 58900/58903 in association with barium meal examinations or cholecystograms whether provided on the same day or previous day. Preliminary plain films are covered in each study.

Subgroup 10: Radiographic examination of the breasts

Request requirements (items 59300 and 59303)

Benefits under items 59300 and 59303 are attracted only where the patient has been referred in specific circumstances as indicated in the description of the items. To facilitate these provisions, the requesting medical practitioner is required to include in the request the clinical indication for the procedure. The requesting practitioner must personally sign the request.

The reference to "with or without thermography" has been removed from the item descriptor for items 59300 and 59303 with effect from 1 November 2003. The Radiology Management Committee (RMC) at its meeting of 12 August 2003, agreed that there is no current scientific evidence to support the use of thermography in the early detection of breast cancer and in the reduction of mortality.

Professional supervision

Mammography services (items 59300 to 59318) are not eligible for a Medicare rebate unless the diagnostic imaging procedure is performed under the professional supervision of a:

(a) specialist in the specialty of diagnostic radiology who is available to monitor and influence the conduct and diagnostic quality of the examination, and, if necessary, to personally attend on the patient; or

(b) if paragraph (a) cannot be complied with:

(i) in an emergency; or

(ii) because of medical necessity in a remote location.

Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

Subgroup 12: Radiographic examination with opaque or contrast media

Myelogram (Item 59724)

Benefits are not payable where a myelogram is rendered in association with a CT myelogram (Item 56219 - see DIL.9.1). Where it is necessary to render a CT and a myelogram, CT Items 56220, 56221 and 56223 would apply.

Subgroup 13: Angiography

Angiography services - meaning of (K) and (NK)

A reduced Schedule fees applies to cardiac angiography services provided on equipment that is 10 years old or older. This equipment must have been first installed in Australia ten or more years ago, or in the case of imported pre-used equipment, must have been first manufactured ten or more years ago.

A range of items cover services provided on older equipment. These items are 59971, 59972, 59973 and 59974, are identified by the addition of the letters '(NK)' at the end of the item and should be used where services are performed on equipment ten years old or older.

Items 59903, 59912, 59925 and 59970 have the letter '(K)' included at the end of the item. These items should be used where services are performed on equipment first installed in Australia less than ten years ago. In the case of imported pre-used equipment, the services must have been performed on a date which is less than ten years from the first date of manufacture of the equipment.

Digital subtraction angiography (DSA) (Items 60000-60078)

Benefits are payable only where these services are rendered in an angiography suite (a room that contains only equipment designed for angiography that is able to perform digital subtraction or rapid-sequence film angiography). Benefits are not payable when these services are rendered using mobile DSA imaging equipment as these services are covered by item 59970.

Each item includes all preparation and contrast injections other than for selective catheterisation. For Digital Subtraction Angiography (DSA), benefits are payable for a maximum of 1 DSA item (from Items 60000 to 60069). For selective DSA - 1 DSA item (from Items 60000 to 60069) and 1 item covering selective catheterisation (from 60072, 60075 or 60078).

If a DSA examination covers more than one of the specified regions/combinations, then the region/combination forming the major part of the examination should be selected, with itemisation to cover the total number of film runs obtained. A run is the injection of contrast, data acquisition, and the generation of a hard copy record.

Subgroup 16: Preparation for radiological procedure

Preparation items (Items 60918 and 60927)

Items 60918 and 60927 apply only to the preparation of a patient for a radiological procedure for a service to which any of items 59903 to 59974 apply. A report is not required for these services.

IN.0.18 Group I5 - Magnetic Resonance Imaging

Itemisation

MRI items in Group I5 are divided into subgroups defined according to the area of the body to be scanned, (ie head, spine, musculoskeletal system, cardiovascular system or body) and the number of occasions in a defined period in which Medicare benefits may be claimed by a patient. Subgroups are divided into individual items, with each item being for a specific clinical indication.

Eligible services

Items in Subgroups 1 to 21 of Group I5 (other than items 63541 to 63544) apply to a MRI or MRA service performed:

iii. on request by a recognised specialist or consultant physician, where the request made in writing identifies the clinical indication for the service;
iv. under the professional supervision of an eligible provider; and
v. with eligible equipment.

Items 63395 to 63398 and the items in Subgroups 19, 20 and 21 (other than items 63455 and 63461) of Group I5 apply to a MRI service performed:

iii. on request by a recognised specialist or consultant physician, where the request made in writing identifies the clinical indication for the service;
iv. under the professional supervision of an eligible provider; and
v. with partial eligible equipment.

Items in Subgroup 22 of Group I5 apply to a MRI or MRA service performed:

d. on request by a medical practitioner, where the request made in writing identifies the clinical indication for the service;
e. under the professional supervision of an eligible provider; and
f. with eligible equipment or partial eligible equipment.

Items in Subgroups 33 and 34 of Group I5 apply to a MRI service performed

k. on request by a medical practitioner other than a specialist or consultant physician, where the request made in writing identifies the clinical indication for the service;
l. under the professional supervision of an eligible provider; and
m. with eligible equipment or partial eligible equipment.

Prostate Multiparametric MRI items 63541 to 63544 apply to a service performed:

a. at the request of a specialist in the speciality of urology, radiation oncology, or medical oncology; and
b. in a permissible circumstance; and
c. using:
   (i) eligible equipment; or
   (ii) partial eligible equipment.

Requests

A request must be in writing and identify the clinical indications for the service.

MRI services can only be requested by a recognised specialist medical practitioner or consultant physician for the purpose of the Health Insurance Act 1973. However, there are exceptions to this provision for a limited number of MRI:

f. All dental specialists, prosthodontists, oral and maxillofacial surgeons, oral medicine specialists and oral pathology specialists may request item 63334 - scan of musculoskeletal system for derangement of the temporomandibular joint (s); and
g. Oral and maxillofacial surgeons and oral medicine and oral pathology specialists can also request item 63007 - scan of the head for skull base or orbital tumour; and
h. Items in subgroup 33 and 34 may only be requested by a medical practitioner other than a specialist or a consultant physician.

For cardiac MRI items 63395 to 63398 (scan for diagnosis of arrhythmogenic right ventricular cardiomyopathy (ARVC)), the request must specify that ARVC is suspected on the basis of diagnostic criteria endorsed by the Cardiac Society of Australia and New Zealand (CSANZ), in force at the time the service is requested.

Permissible circumstances for performance of service

Group I5 items must be performed as follows:

(a) both:

iv. 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; and
v. reported by an eligible provider; or

(b) if paragraph (a) is not complied with:

iv. in an emergency; or
v. because of medical necessity, in a remote location (refer to DID).

Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

Eligible providers

For items in Group I5 (excluding cardiac MRI items 63395 to 63398), an eligible provider is a specialist in diagnostic radiology who satisfies the Chief Executive Medicare (Department of Human Services) that he or she is a participant of the Royal Australian and New Zealand College of Radiologists' (RANZCR) Quality and Accreditation Program.

For cardiac MRI items 63395 to 63398, an eligible provider is a specialist in diagnostic radiology or a consultant physician, who is recognised by the Conjoint Committee for Certification in Cardiac MRI. The conjoint committee is comprised of specialists from the Royal Australian and New Zealand College of Radiologists (RANZCR) and the Cardiac Society of Australia and New Zealand (CSANZ).

Eligible Provider declaration

The specialist must give the Department of Human Services a statutory declaration:

iv. stating that he or she is enrolled in the RANZCR Quality and Accreditation Program (except for providers only providing cardiac MRI (items 63395 to 63398));
v. specifying the location of the MRI equipment;
vi. specifying the kinds of diagnostic imaging equipment offered at the location;
vii. stating the date of installation of the equipment (and the time of installation if this occurred on 12 May 1998); and
viii. if the equipment had not been installed before 7.30pm on 12 May 1998 (Eastern Standard Time), the specialist must also give the Department of Human Services a copy of the contract for the purchase or lease of the equipment.

In addition the Department of Human Services may request further supporting documentation or information. Specialists or consultant physicians are advised to contact the Provider Liaison Section, the Department of Human Services on 132 150 prior to lodging a declaration.

Eligible equipment is equipment which is:

h. is located at premises of a comprehensive practice; and
i. is made available to the practice by a person:
    a. who is subject to a deed with the Commonwealth that relates to the equipment; and
    b. for whom the deed has not been terminated; and
j. is not identified as partial eligible equipment in the deed

Partial eligible equipment is equipment which is:
Equipment that:

g. is located at premises of a comprehensive practice; and
h. is made available to the practice by a person:
    a. who is subject to a deed with the Commonwealth that relates to the equipment; and
    b. for whom the deed has not been terminated; and
i. is identified as partial eligible equipment in the deed

The location of Medicare-eligible MRI machines is available at the Department of Health's website at http://www.health.gov.au

Number of eligible services

Services in subgroups 1, 4, 6, 8, 11 and 18 have no frequency restriction.

For other MRI subgroups frequency restrictions on services are as follows:

MRI or MRA items	Limitation period	Maximum number of services
63040 to 63085	12 months	3
63101 and 63104	12 months	3
63125 to 63136	12 months	3
63161 to 63194	12 months	3
63219 to 63265	12 months	3
63271 to 63285	12 months	3
63322 to 63348	12 months	3
63361 and 63364	12 months	2
63385 to 63394	12 months	2

63395 and 63396	12 months	1
63397 and 63398	36 months	1
63401 to 63408	12 months	3
63416 and 63419	12 months	1
63425 to 63433	12 months	2
63455 to 63458 and 63461 to 63467	12 months	1
63545 to 63546	12 months	1
63547 and 63548	patient's lifetime	1
63482 and 63486	12 months	3
63507 to 63523 and 63551 to 63561	12 months	3

Items 63470 or 63473 in subgroup 20 may be claimed only once in a patient's lifetime.

Items in subgroup 22 (modifying items) may only be ordered in conjunction with an eligible MRI/MRA service.

Items 63501 and 63502 in subgroup 32 may only be claimed once in any 12-month period, and items 63504 and 63505 have no restrictions.

Example: Item 63271 in subgroup 10 can be claimed by a patient on three occasions in any 12 month period. If the patient had claimed Medicare benefits for the following:

Item	Date of Service
63271	10/12/04
63271	18/4/05
63271	16/10/05
63271	11/12/05

The following table provides examples of further dates of service would, and would not, be eligible:

Date of service	Claimable?	Why?
12/3/05	No	Between 10/12/04 and 9/12/05, the patient would have had 4 x 63271 in 12 months - 10/12/04, 12/3/05, 18/4/05 and 16/10/05
4/3/06	No	Between 5/3/05 and 4/3/06, the patient would have had 4 x 63271 in 12 months - 18/4/05, 16/10/05, 11/12/05 and 4/3/06
20/4/06	Yes	Between 21/4/05 and 20/4/06, the patient would have had 3x 63271 in 12 months - 16/10/05, 11/12/05 and 20/4/06

The frequency restrictions are therefore considered to be rolling restrictions and not based on calendar or financial years.

In addition, restrictions on the number of services of the kind described in subgroup 12 apply to specific anatomical sites. Where an item description applies to more than one anatomical site the restriction on the number of services applies to each site.

Item 63328, MRI scan for derangement of the knee or its supporting structures, applies to two specific anatomical sites, ie, right knee and left knee. Each anatomical site may be scanned up to 3 times in any 12-month period.

Prostate Multiparametric MRI items 63541 and 63542 are applicable not more than once in a 12 month period.

Prostate Multiparametric MRI items 63543 and 63544 may be claimed:

j. at the time of diagnosis of prostate cancer; and
k. 12 months following diagnosis; and
l. every third year thereafter; or
m. at any time if there is clinical concern from the specialist requesting the service.

Clinical concern means a clinical decision that the prostate cancer has progressed, and includes prostate specific antigen progression.

Items 63543 and 63544 are not applicable for the purposes of treatment planning or for monitoring after treatment of prostate cancer.

IN.0.19 Bulk Billing Incentive

To provide an incentive to bulk-bill, for out of hospital services that are bulk billed the schedule fee is reduced by 5% and rebates paid at 100% of this revised fee (except for item 61369, and all items in Group I5 - Magnetic Resonance Imaging). For items in Group I5 - Magnetic Resonance Imaging, the bulk billing incentive for out of hospital services is 100% of the Schedule Fee listed in the table.

IN.1.1 New Explanatory Note for DVT

Medical practitioners referring patients for duplex ultrasound for suspected lower limb DVT (items 55221, 55222, 55244 and 55246) should read and consider the Royal Australian and New Zealand College of Radiologists' RANZCR 2015 Choosing Wisely recommendations, or such RANZCR Choosing Wisely recommendations that succeed it.

IN.1.2 Duplex Ultrasound for Pulmonary Embolism

Medical practitioners referring patients for imaging for suspected PE (items 57351, 57356, 61328, 61340, 61348) should read and consider The Royal Australian and New Zealand College of Radiologists RANZCR 2015 Choosing Wisely recommendations, or such clinical RANZCR Choosing Wisely recommendations as succeed it.

I1. ULTRASOUND	1. GENERAL
	Group I1. Ultrasound
	Subgroup 1. General
55005	HEAD, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55007	HEAD, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55008	ORBITAL CONTENTS, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55010	ORBITAL CONTENTS, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55011	NECK, 1 or more structures of, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner

	is a member (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55013	NECK, 1 or more structures of, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55014	Abdomen, ultrasound scan of (including scan of urinary tract when performed), if: (a) the patient is referred by a medical practitioner or participating nurse practitioner; and (b) if the patient is referred by a medical practitioner-the medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) if the patient is referred by a participating nurse practitioner-the nurse practitioner does not have a business or financial arrangement with the providing practitioner; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (e) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and (f) within 24 hours of the service, a service mentioned in item 55017, 55038, 55067 or 55065 is not performed on the same patient by the providing practitioner (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.65 **Benefit:** 75% = $41.75 85% = $47.35
55016	ABDOMEN, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service to which an item in Subgroup 4,applies where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55017	Urinary tract, ultrasound scan of, if: (a) the patient is referred by a medical practitioner; and (b) the medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and (e) within 24 hours of the service, a service mentioned in item 55014, 55038, 55067 or 55065 is not performed on the same patient by the providing practitioner (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40

55019	URINARY TRACT, ultrasound scan of, but not being a service associated with the service to which an item in Subgroup 4,applies, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55023	SCROTUM, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.75 **Benefit:** 75% = $41.10 85% = $46.55
55025	SCROTUM, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (NK) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55026	ULTRASONIC CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this Group applies (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55028	HEAD, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55029	HEAD, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55030	ORBITAL CONTENTS, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a

	service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55031	ORBITAL CONTENTS, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55032	NECK, 1 or more structures of, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55033	NECK, 1 or more structures of, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55036	Abdomen, ultrasound scan of (including scan of urinary tract when performed), if: (a) the patient is referred by a medical practitioner or participating nurse practitioner for ultrasonic examination; and (b) if the patient is referred by a medical practitioner-the medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) if the patient is referred by a participating nurse practitioner-the nurse practitioner does not have a business or financial arrangement with the providing practitioner; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (e) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and (f) within 24 hours of the service, a service mentioned in item 55017, 55038, 55067 or 55065 is not

	performed on the same patient by the providing practitioner (R) (K) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $111.30 **Benefit:** 75% = $83.50 85% = $94.65
55037	ABDOMEN, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service described in item 55600 or item 55603, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55038	Urinary tract, ultrasound scan of, if: (a) the patient is referred by a medical practitioner for ultrasonic examination; and (b) the medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and (e) within 24 hours of the service, a service mentioned in item 55017, 55036, 55067 or 55065 is not performed on the same patient by the providing practitioner (R) (K) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55039	URINARY TRACT, ultrasound scan of, but not being a service associated with the service described in item 55600 or item 55603, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55048	SCROTUM, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.50 **Benefit:** 75% = $82.15 85% = $93.10
55049	SCROTUM, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55054	ULTRASONIC CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using

	interventional techniques, not being a service associated with a service to which any other item in this Group applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75 **Extended Medicare Safety Net Cap:** $87.30
55059	BREAST, one, ultrasound scan of, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $49.15 **Benefit:** 75% = $36.90 85% = $41.80
55060	BREAST, one, ultrasound scan of, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $17.05 **Benefit:** 75% = $12.80 85% = $14.50
55061	BREASTS, both, ultrasound scan of, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55062	BREASTS, both, ultrasound scan of, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55063	Urinary bladder, ultrasound scan of, by any or all approaches, if: (a) the patient is referred by a medical practitioner for ultrasonic examination; and (b) the medical practitioner is not a member of a group of practitioners of which the providing

	practitioner is a member; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) within 24 hours of the service, a service mentioned in item 11917, 55014, 55017, 55036, 55038, 55600, 55601, 55603, 55604, 55067 or 55065 is not performed on the same patient by the providing practitioner (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $49.15 **Benefit:** 75% = $36.90 85% = $41.80
55064	Urinary bladder, ultrasound scan of, by any or all approaches, if: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (c) within 24 hours of the service, a service mentioned in item 11917, 55016, 55019, 55037, 55039, 55600, 55601, 55603, 55604, 55068 or 55069 is not performed on the same patient by the providing practitioner (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $17.05 **Benefit:** 75% = $12.80 85% = $14.50
55065	PELVIS, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2, or 3, applies; and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and (e) the service is not performed with item 55014, 55017, 55036 or 55038 on the same patient within 24 hours (R)(K) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $98.25 **Benefit:** 75% = $73.70 85% = $83.55
55067	PELVIS, ultrasound scan of, by any or all approaches, where: a) the patient is referred by a medical practitioner; and b) the medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and d) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and e) within 24 hours of the service, a service mentioned in item 55014, 55017, 55036 or 55038 is not performed on the same patient by the providing practitioner (R) (NK) (See para IN.0.19 of explanatory notes to this Category)

	Fee: $50.25 **Benefit:** 75% = $37.70 85% = $42.75
55068	PELVIS, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this Group applies; and (c) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs (NR)(K) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75
55069	PELVIS, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this Group applies; and (c) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $17.85 **Benefit:** 75% = $13.40 85% = $15.20
55070	BREAST, one, ultrasound scan of, where: (a) the patient is referred by a referring practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $98.25 **Benefit:** 75% = $73.70 85% = $83.55
55073	BREAST, one, ultrasound scan of, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $34.05 **Benefit:** 75% = $25.55 85% = $28.95
55076	BREASTS, both, ultrasound scan of, where: (a) the patient is referred by a referring practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and

	(c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55079	BREASTS, both, ultrasound scan of, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55084	Urinary bladder, ultrasound scan of, by any or all approaches, if: (a) the patient is referred by a medical practitioner; and (b) the medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) within 24 hours of the service, a service mentioned in item 11917, 55014, 55017, 55036, 55038, 55600, 55601, 55603, 55604, 55067 or 55065 is not performed on the same patient by the providing practitioner (R) (K) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $98.25 **Benefit:** 75% = $73.70 85% = $83.55
55085	Urinary bladder, ultrasound scan of, by any or all approaches, if: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (c) within 24 hours of the service, a service mentioned in item 11917, 55016, 55019, 55037, 55039, 55600, 55601, 55603, 55604, 55068 or 55069 is not performed on the same patient by the providing practitioner (NR) (K) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $34.05 **Benefit:** 75% = $25.55 85% = $28.95

	Group I1. Ultrasound
	Subgroup 2. Cardiac
55113	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup (with the exception of items 55118 and 55130), applies, for the

	investigation of symptoms or signs of cardiac failure, or suspected or known ventricular hypertrophy or dysfunction, or chest pain (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $230.65 **Benefit:** 75% = $173.00 85% = $196.10
55114	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup (with the exception of items 55118 and 55130), applies, for the investigation of suspected or known acquired valvular, aortic, pericardial, thrombotic, or embolic disease, or heart tumour (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $230.65 **Benefit:** 75% = $173.00 85% = $196.10
55115	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup (with the exception of items 55118 and 55130), applies, for the investigation of symptoms or signs of congenital heart disease (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $230.65 **Benefit:** 75% = $173.00 85% = $196.10
55116	EXERCISE STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before exercise (baseline) from at least three acoustic windows and matching recordings from the same windows at, or immediately after, peak exercise, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup applies (with the exception of items 55118 and 55130). Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $261.65 **Benefit:** 75% = $196.25 85% = $222.45
55117	PHARMACOLOGICAL STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before drug infusion (baseline) from at least three acoustic windows and matching recordings from the same windows at least twice during drug infusion, including a recording at the peak drug dose not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup, applies (with the exception of items 55118 and 55130). Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $261.65 **Benefit:** 75% = $196.25 85% = $222.45
55118	HEART, 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL EXAMINATION of, from at least two levels, and in more than one plane at each level: (a) with: (i) real time colour flow mapping and, if indicated, pulsed wave Doppler examination; and

	(ii) recordings on video tape or digital medium; and (b) not being an intra-operative service or a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, applies (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $275.50 **Benefit:** 75% = $206.65 85% = $234.20
55119	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this Subgroup (with the exception of items 55118, 55125, 55130 and 55131), applies, for the investigation of symptoms or signs of cardiac failure, or suspected or known ventricular hypertrophy or dysfunction, or chest pain (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $115.35 **Benefit:** 75% = $86.55 85% = $98.05
55120	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this Subgroup (with the exception of items 55118, 55125, 55130 and 55131), applies, for the investigation of suspected or known acquired valvular, aortic, pericardial, thrombotic, or embolic disease, or heart tumour (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $115.35 **Benefit:** 75% = $86.55 85% = $98.05
55121	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this Subgroup (with the exception of items 55118, 55125, 55130 and 55131), applies, for the investigation of symptoms or signs of congenital heart disease (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $115.35 **Benefit:** 75% = $86.55 85% = $98.05
55122	EXERCISE STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before exercise (baseline) from at least three acoustic windows and matching recordings from the same windows at, or immediately after, peak exercise, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this Subgroup applies (with the exception of items 55118, 55125, 55130 and 55131). Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $130.85 **Benefit:** 75% = $98.15 85% = $111.25
55123	PHARMACOLOGICAL STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before drug infusion (baseline) from at least three acoustic windows and matching recordings from the same windows at least twice during drug infusion, including

	a recording at the peak drug dose not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this Subgroup, applies (with the exception of items 55118, 55125, 55130 and 55131). Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $130.85 **Benefit:** 75% = $98.15 85% = $111.25
55125	HEART, 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL EXAMINATION of, from at least two levels, and in more than one plane at each level: (a) with: (i) real time colour flow mapping and, if indicated, pulsed wave Doppler examination; and (ii) recordings on video tape or digital medium; and (b) not being an intra-operative service or a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 3, applies (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $137.75 **Benefit:** 75% = $103.35 85% = $117.10
55130	INTRA-OPERATIVE 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac surgery incorporating sequential assessment of cardiac function before and after the surgical procedure - not associated with item 55135 (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $170.00 **Benefit:** 75% = $127.50 85% = $144.50
55131	INTRA-OPERATIVE 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac surgery incorporating sequential assessment of cardiac function before and after the surgical procedure - not associated with items 55135 and 55136 (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $85.00 **Benefit:** 75% = $63.75 85% = $72.25
55135	INTRA-OPERATIVE 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac valve surgery (repair or replacement) incorporating sequential assessment of cardiac function and valve competence before and after the surgical procedure - not associated with item 55130 (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $353.60 **Benefit:** 75% = $265.20 85% = $300.60
55136	INTRA-OPERATIVE 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac valve surgery (repair or replacement) incorporating sequential assessment of cardiac function and valve competence before and after the surgical procedure - not associated with items 55130 and 55131 (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)

I1. ULTRASOUND	2. CARDIAC
	Fee: $176.80 **Benefit:** 75% = $132.60 85% = $150.30

I1. ULTRASOUND	3. VASCULAR
	Group I1. Ultrasound
	Subgroup 3. Vascular
55220	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb OR of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55221	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for acute venous thrombosis, not being a service associated with a service to which item 55222 or 55246 or an item in Subgroup 1 (with the exception of items 55026 and 55054) or 4 applies (R) (NK) (See para IN.0.19, IN.1.1 of explanatory notes to this Category) **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55222	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, not being a service associated with a service to which item 55221 or 55244 or an item in Subgroup 1 (with the exception of items 55026 and 55054) or 4 applies (R) (NK) (See para IN.0.19, IN.1.1 of explanatory notes to this Category) **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55223	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the upper limb OR of arteries and bypass grafts in the upper limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55224	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the upper limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55226	DUPLEX SCANNING, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of extra-cranial bilateral carotid and vertebral vessels, with or without subclavian and innominate vessels, with or without oculoplethysmography or peri-orbital Doppler examination, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Groups applies (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05

55227	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-abdominal, aorta and iliac arteries or inferior vena cava and iliac veins OR of intra-abdominal, aorta and iliac arteries and inferior vena cava and iliac veins, excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55228	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of renal or visceral vessels OR of renal and visceral vessels, including aorta, inferior vena cava and iliac vessels as required excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55229	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-cranial vessels, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55230	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of cavernosal artery of the penis following intracavernosal administration of a vasoactive agent, performed during the period of pharmacological activity of the injected agent, to confirm a diagnosis of vascular aetiology for impotence, where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55232	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of cavernosal tissue of the penis to confirm a diagnosis and, where indicated, assess the progress and management of: (a) priapism; or (b) fibrosis of any type; or (c) fracture of the tunica; or (d) arteriovenous malformations; where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items

	55026 and 55054) or 4 of this Groups applies (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55233	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of surgically created arteriovenous fistula or surgically created arteriovenous access graft in the upper or lower limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55235	DUPLEX SCANNING, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or veins OR arteries and veins, for mapping of bypass conduit prior to vascular surgery, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054), 3 or 4 of this Group applies - including any associated skin marking (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55236	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow spectral analysis and marking of veins in the lower limb below the inguinal ligament prior to varicose vein surgery, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054), 3 or 4 of this Group applies - including any associated skin marking (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.55 **Benefit:** 75% = $41.70 85% = $47.25
55238	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb OR of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55244	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for acute venous thrombosis, not being a service associated with a service to which item 55222, 55246 or an item in Subgroup 1 (with the exception of items 55026 and 55054) or 4 applies (R) (K) (See para IN.0.19, IN.1.1 of explanatory notes to this Category) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55246	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, not being a service associated with a service to which item 55221 or 55244 or an item in Subgroup 1 (with the exception of items 55026 and 55054) or 4 applies (R) (K) (See para IN.0.19, IN.1.1 of explanatory notes to this Category) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55248	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the upper limb OR of arteries and bypass grafts in the upper limb, not being a service associated with a service to which an item in

	Subgroup 1 (with the exception of items 55026 and 55054) or 4 of this Group applies - (R) (K) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55252	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the upper limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55274	DUPLEX SCANNING, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of extra-cranial bilateral carotid and vertebral vessels, with or without subclavian and innominate vessels, with or without oculoplethysmography or peri-orbital Doppler examination, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Groups applies - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55276	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-abdominal, aorta and iliac arteries or inferior vena cava and iliac veins OR of intra-abdominal, aorta and iliac arteries and inferior vena cava and iliac veins, excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55278	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of renal or visceral vessels OR of renal and visceral vessels, including aorta, inferior vena cava and iliac vessels as required excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55280	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-cranial vessels, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55282	DUPLEX SCANNING involving B mode ultrasound imaging and integrated doppler flow measurements: (a) by spectral analysis of cavernosal artery of the penis following intracavernosal administration of a vasoactive agent; and (b) performed during the period of pharmacological activity of the injected agent, to confirm a diagnosis of vascular aetiology for impotence; and (c) 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 thepractice location where the service is performed, immediately before or for a period during the performance of the service; and (d) where 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 Subgroup 1 (with the exception of items 55026 and 55054) or 4 applies (R)

I1. ULTRASOUND	3. VASCULAR
	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55284	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of cavernosal tissue of the penis to confirm a diagnosis and, where indicated, assess the progress and management of: (a) priapism; or (b) fibrosis of any type; or (c) fracture of the tunica; or (d) arteriovenous malformations; where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Groups applies - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55292	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of surgically created arteriovenous fistula or surgically created arteriovenous access graft in the upper or lower limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55294	DUPLEX SCANNING, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or veins OR arteries and veins, for mapping of bypass conduit prior to vascular surgery, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054), 3 or 4 of this Group applies - including any associated skin marking (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55296	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow spectral analysis and marking of veins in the lower limb below the inguinal ligament prior to varicose vein surgery, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054), 3 or 4 of this Group applies - including any associated skin marking (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $111.05 **Benefit:** 75% = $83.30 85% = $94.40

I1. ULTRASOUND	4. UROLOGICAL
	Group I1. Ultrasound
	Subgroup 4. Urological
55600	Prostate, bladder base and urethra, ultrasound scan of, if performed: (a) personally by a medical practitioner (not being the medical practitioner who assessed the patient as specified in paragraph (c)) using one or more transducer probes that can obtain both axial and sagittal scans in 2 planes at right angles; and (b) after a digital rectal examination of the prostate by that medical practitioner; and

	(c) on a patient who has been assessed by: (i) a specialist in urology, radiation oncology or medical oncology; or (ii) a consultant physician in medical oncology; who has: (iii) examined the patient in the 60 days before the scan; and (iv) recommended the scan for the management of the patient's current prostatic disease (R) (K) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55601	Prostate, bladder base and urethra, ultrasound scan of, if performed: (a) personally by a medical practitioner (not being the medical practitioner who assessed the patient as specified in paragraph (c)) using one or more transducer probes that can obtain both axial and sagittal scans in 2 planes at right angles; and (b) after a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by: (i) a specialist in urology, radiation oncology or medical oncology; or (ii) a consultant physician in medical oncology; who has: (iii) examined the patient in the 60 days before the scan; and (iv) recommended the scan for the management of the patient's current prostatic disease (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55603	Prostate, bladder base and urethra, ultrasound scan of, if performed: (a) personally by a medical practitioner who made the assessment mentioned in paragraph (c) using one or more transducer probes that can obtain both axial and sagittal scans in 2 planes at right angles; and (b) after a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by: (i) a specialist in urology, radiation oncology or medical oncology; or (ii) a consultant physician in medical oncology; who has:

	(iii) examined the patient in the 60 days before the scan; and (iv) recommended the scan for the management of the patient's current prostatic disease (R) (K) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55604	Prostate, bladder base and urethra, ultrasound scan of, if performed: (a) personally by a medical practitioner who made the assessment mentioned in paragraph (c) using one or more transducer probes that can obtain both axial and sagittal scans in 2 planes at right angles; and (b) after a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by: (i) a specialist in urology, radiation oncology or medical oncology; or (ii) a consultant physician in medical oncology; who has: (iii) examined the patient in the 60 days before the scan; and (iv) recommended the scan for the management of the patient's current prostatic disease (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40

	Group I1. Ultrasound
	Subgroup 5. Obstetric And Gynaecological
55700	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, if: (a) the patient is referred by a medical practitioner or participating midwife; and (b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) if the patient is referred by a medical practitioner -- the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) if the patient is referred by a participating midwife - the referring midwife does not have a business or financial arrangement with the providing practitioner; and

(f) 1 or more of the following conditions are present:

(i) hyperemesis gravidarum;

(ii) diabetes mellitus;

(iii) hypertension;

(iv) toxaemia of pregnancy;

(v) liver or renal disease;

(vi) autoimmune disease;

(vii) cardiac disease;

(viii) alloimmunisation;

(ix) maternal infection;

(x) inflammatory bowel disease;

(xi) bowel stoma;

(xii) abdominal wall scarring;

(xiii) previous spinal or pelvic trauma or disease;

(xiv) drug dependency;

(xv) thrombophilia;

(xvi) significant maternal obesity;

(xvii) advanced maternal age;

(xviii) abdominal pain or mass;

(xix) uncertain dates;

(xx) high risk pregnancy;

(xxi) previous post dates delivery;

(xxii) previous caesarean section;

(xxiii) poor obstetric history;

(xxiv) suspicion of ectopic pregnancy;

(xxv) risk of miscarriage;

(xxvi) diminished symptoms of pregnancy;

(xxvii) suspected or known cervical incompetence;

	(xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (R) Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55707 (R). Fee is payable only for item 55700 or item 55707, not both items. (See para IN.0.19 of explanatory notes to this Category) **Fee:** $60.00 **Benefit:** 75% = $45.00 85% = $51.00 **Extended Medicare Safety Net Cap:** $32.95
55701	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease;

	(xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (R) Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55707 or 55714 (R) (NK). Fee is payable only for item 55700 or 55701, or, or item 55707 or 55714, not both items (See para IN.0.19 of explanatory notes to this Category) **Fee:** $30.00 **Benefit:** 75% = $22.50 85% = $25.50 **Extended Medicare Safety Net Cap:** $16.50
55702	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) one or more of the following conditions are present:

(i) hyperemesis gravidarum;

(ii) diabetes mellitus;

(iii) hypertension;

(iv) toxaemia of pregnancy;

(v) liver or renal disease;

(vi) autoimmune disease;

(vii) cardiac disease;

(viii) alloimmunisation;

(ix) maternal infection;

(x) inflammatory bowel disease;

(xi) bowel stoma;

(xii) abdominal wall scarring;

(xiii) previous spinal or pelvic trauma or disease;

(xiv) drug dependency;

(xv) thrombophilia;

(xvi) significant maternal obesity;

(xvii) advanced maternal age;

(xviii) abdominal pain or mass;

(xix) uncertain dates;

(xx) high risk pregnancy;

(xxi) previous post dates delivery;

(xxii) previous caesarean section;

(xxiii) poor obstetric history;

(xxiv) suspicion of ectopic pregnancy;

(xxv) risk of miscarriage;

(xxvi) diminished symptoms of pregnancy;

(xxvii) suspected or known cervical incompetence;

(xxviii) suspected or known uterine abnormality;

	(xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (NR) Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55708 or 55716 (R) (NK). Fee is payable only for item 55702 or 55703, or, item 55707 or 55714, not both items (See para IN.0.19 of explanatory notes to this Category) **Fee:** $17.50 **Benefit:** 75% = $13.15 85% = $14.90 **Extended Medicare Safety Net Cap:** $8.30
55703	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia;

	(xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (NR) Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55708 (R). Fee is payable only for item 55703 or item 55707, not both items. (See para IN.0.19 of explanatory notes to this Category) **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75 **Extended Medicare Safety Net Cap:** $16.55
55704	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a)the patient is referred by a medical practitioner or participating midwife; and (b)the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and (c)the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) if the patient is referred by a medical practitioner -- the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) if the patient is referred by a participating midwife -- the referring midwife does not have a business or financial arrangement with the providing practitioner; and (f) one or more of the following conditions are present: (i)hyperemesis gravidarum; (ii)diabetes mellitus; (iii)hypertension; (iv)toxaemia of pregnancy; (v)liver or renal disease; (vi)autoimmune disease; (vii)cardiac disease; (viii)alloimmunisation; (ix)maternal infection; (x)inflammatory bowel disease; (xi)bowel stoma; (xii)abdominal wall scarring; (xiii)previous spinal or pelvic trauma or disease; (xiv)drug dependency; (xv)thrombophilia; (xvi)significant maternal obesity; (xvii)advanced maternal age; (xviii)abdominal pain or mass; (xix)uncertain dates; (xx)high risk pregnancy; (xxi)previous post dates delivery; (xxii)previous caesarean section; (xxiii)poor obstetric history; (xxiv)suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or

	known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality Footnote: for nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55707 (r). fee is payable only for item 55704 or item 55707, not both items. (See para IN.0.19 of explanatory notes to this Category) **Fee:** $70.00 **Benefit:** 75% = $52.50 85% = $59.50 **Extended Medicare Safety Net Cap:** $38.50
55705	PELVIS OR ABDOMEN, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner;and (b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) one or more of the following conditions are present: (i) hyperemesis gravidarum;(ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75 **Extended Medicare Safety Net Cap:** $16.55
55706	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the patient is referred by a medical practitioner or participating midwife; and (b) the dating for the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) if the patient is referred by a medical practitioner - the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) if the patient is referred by a participating midwife - the referring midwife does not have a business or financial arrangement with the providing practitioner; and (f) the service is not performed in the same pregnancy as item 55709 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00 **Extended Medicare Safety Net Cap:** $54.90
55707	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, if;

	(a) the patient is referred by a medical practitioner or participating midwife; and (b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) if the patient is referred by a medical practitioner - the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) if the patient is referred by a participating midwife - the referring midwife does not have a business or financial arrangement with the providing practitioner; and (f) at least 1 condition mentioned in paragraph (f) of item 55704 is present; and (g) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (h) the service is not performed with item 55700, 55703, 55704 or 55705 on the same patient within 24 hours (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $70.00 **Benefit:** 75% = $52.50 85% = $59.50 **Extended Medicare Safety Net Cap:** $38.50
55708	PELVIS OR ABDOMEN, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84 mm; and (c) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (d) at least 1 condition mentioned in paragraph (e) of item 55704 is present; and (e) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (f) the service is not performed with item 55700, 55703, 55704 or 55705 on the same patient within 24 hours (nr) (item is subject to subrule 11 (2)) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75 **Extended Medicare Safety Net Cap:** $16.55
55709	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a)the patient is not referred by a medical practitioner; and (b)the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c)the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d)the service is not performed in the same pregnancy as item 55706 or 55713 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.00 **Benefit:** 75% = $28.50 85% = $32.30 **Extended Medicare Safety Net Cap:** $22.00
55710	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where:(a) the patient is referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(e) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal

	infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (r) Footnote: for nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item 55704 or 55707 (r) (nk). Fee is payable only for item 55704 or 55710, or, item 55707 or 55714, not both items (See para IN.0.19 of explanatory notes to this Category) **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75 **Extended Medicare Safety Net Cap:** $19.30
55711	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where:(a) the patient is not referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) one or more of the following conditions are present: (i) hyperemesis gravidarum (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (nr) Footnote: for nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item 55708 or 55716 (r) (nk). Fee is payable only for item 55705 or 55711, or, item 55708 or 55716, not both items (See para IN.0.19 of explanatory notes to this Category) **Fee:** $17.50 **Benefit:** 75% = $13.15 85% = $14.90 **Extended Medicare Safety Net Cap:** $8.30
55712	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group

	applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55706 or 55709 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $115.00 **Benefit:** 75% = $86.25 85% = $97.75 **Extended Medicare Safety Net Cap:** $65.90
55713	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner; and (b) the dating for the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) the service is not performed in the same pregnancy as item 55709 or 55717 (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $50.00 **Benefit:** 75% = $37.50 85% = $42.50 **Extended Medicare Safety Net Cap:** $27.50
55714	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where; (a) the patient is referred by a medical practitioner; and (b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) one or more of the conditions mentioned in subparagraphs (e) (i) to (xxx) of item 55704 or 55710 are present; and (f) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (g) the service is not performed with item 55700, 55701, 55702, 55703, 55704, 55705, 55710 or 55711 on the same patient within 24 hours (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75

	Extended Medicare Safety Net Cap: $19.30
55715	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) further examination is clinically indicated in the same pregnancy to which item 55706 or 55709 applies (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $40.00 **Benefit:** 75% = $30.00 85% = $34.00 **Extended Medicare Safety Net Cap:** $22.00
55716	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where; (a) the patient is not referred by a medical practitioner; and (b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) one or more of the conditions in subparagraphs (e) (i) to (xxx) of item 55704 or 55710 are present; and (e) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (f) the service is not performed in conjunction with item 55700, 55701, 55702, 55703, 55704, 55705, 55710 or 55711 on the same patient within 24 hours (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $17.50 **Benefit:** 75% = $13.15 85% = $14.90 **Extended Medicare Safety Net Cap:** $8.30
55717	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the service is not performed in the same pregnancy as item 55706 or 55713 (NR) (NK) (See para IN.0.19 of explanatory notes to this Category)

	Fee: $19.00 **Benefit:** 75% = $14.25 85% = $16.15 **Extended Medicare Safety Net Cap:** $11.05
55718	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, if:(a) the patient is referred by a medical practitioner or participating midwife; and(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) if the patient is referred by a medical practitioner -- the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) if the patient is referred by a participating midwife -- the referring midwife does not have a business or financial arrangement with the providing practitioner; and (f) the service is not performed in the same pregnancy as item 55723; and (g) 1 or more of the following conditions are present: (i) known or suspected fetal abnormality or fetal cardiac arrhythmia; (ii) fetal anatomy (late booking or incomplete mid-trimester scan); (iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery; (viii) uterine scar assessment; (ix) uterine fibroid; (x) previous fetal death in utero or neonatal death; (xi) antepartum haemorrhage; (xii) clinical suspicion of intrauterine growth retardation; (xiii) clinical suspicion of macrosomia; (xiv) reduced fetal movements; (xv) suspected fetal death; (xvi) abnormal cardiotocography; (xvii) prolonged pregnancy; (xviii) premature labour; (xix) fetal infection; (xx) pregnancy after assisted reproduction; (xxi) trauma; (xxii) diabetes mellitus; (xxiii) hypertension; (xxiv) toxaemia of pregnancy; (xxv) liver or renal disease; (xxvi) autoimmune disease; (xxvii) cardiac disease; (xxviii) alloimmunisation; (xxix) maternal infection; (xxx) inflammatory bowel disease; (xxxi) bowel stoma; (xxxii) abdominal wall scarring; (xxxiii) previous spinal or pelvic trauma or disease; (xxxiv) drug dependency; (xxxv) thrombophilia; (xxxvi) significant maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (r) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00 **Extended Medicare Safety Net Cap:** $54.90
55719	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55706, 55709, 55713 or 55717 applies (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $57.50 **Benefit:** 75% = $43.15 85% = $48.90 **Extended Medicare Safety Net Cap:** $32.95

55720	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) further examination is clinically indicated in the same pregnancy to which item 55706, 55709, 55713 or 55717 applies (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $20.00 **Benefit:** 75% = $15.00 85% = $17.00 **Extended Medicare Safety Net Cap:** $11.05
55721	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of by any or all approaches, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has qualifications recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $115.00 **Benefit:** 75% = $86.25 85% = $97.75 **Extended Medicare Safety Net Cap:** $65.90
55722	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where:(a) the patient is referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member;and(e) the service is not performed in the same pregnancy as item 55723 or 55726; and(f) one or more of the following conditions are present: (i) known or suspected fetal abnormality or fetal cardiac arrhythmia; (ii) fetal anatomy (late booking or incomplete mid-trimester scan); (iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery; (viii) uterine scar assessment; (ix) uterine fibroid; (x) previous fetal death in utero or neonatal death; (xi) antepartum haemorrhage; (xii) clinical suspicion of intrauterine growth retardation; (xiii) clinical suspicion of macrosomia; (xiv) reduced fetal movements; (xv) suspected fetal death; (xvi) abnormal cardiotocography; (xvii) prolonged pregnancy; (xviii)

	premature labour; (xix) fetal infection; (xx) pregnancy after assisted reproduction; (xxi) trauma; (xxii) diabetes mellitus; (xxiii) hypertension; (xxiv) toxaemia of pregnancy; (xxv) liver or renal disease; (xxvi) autoimmune disease; (xxvii) cardiac disease; (xxviii) alloimmunisation; (xxix) maternal infection; (xxx) inflammatory bowel disease; (xxxi) bowel stoma; (xxxii) abdominal wall scarring; (xxxiii) previous spinal or pelvic trauma or disease; (xxxiv) drug dependency; (xxxv) thrombophilia; (xxxvi) significant maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (r) (nk) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $50.00 **Benefit:** 75% = $37.50 85% = $42.50 **Extended Medicare Safety Net Cap:** $27.50
55723	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 after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (d) the service is not 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 fetalcardiac 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) gross maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (nr)(item is subject to subrule 11 (2)) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.00 **Benefit:** 75% = $28.50 85% = $32.30 **Extended Medicare Safety Net Cap:** $22.00
55724	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of by any or all approaches, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has qualifications recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55718, 55722,

	55723 or 55726 applies (R) NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $57.50 **Benefit:** 75% = $43.15 85% = $48.90 **Extended Medicare Safety Net Cap:** $32.95
55725	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $40.00 **Benefit:** 75% = $30.00 85% = $34.00 **Extended Medicare Safety Net Cap:** $22.00
55726	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where:(a) the patient is not referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) the service is not performed in the same pregnancy as item 55718 or 55722; and(e) one or more of the following conditions are present: (i) known or suspected fetal abnormality or fetal cardiac arrhythmia; (ii) fetal anatomy (late booking or incomplete mid-trimester scan); (iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery; (viii) uterine scar assessment; (ix) uterine fibroid; (x) previous fetal death in utero or neonatal death; (xi) antepartum haemorrhage; (xii) clinical suspicion of intrauterine growth retardation; (xiii) clinical suspicion of macrosomia; (xiv) reduced fetal movements; (xv) suspected fetal death; (xvi) abnormal cardiotocography; (xvii) prolonged pregnancy; (xviii) premature labour; (xix) fetal infection; (xx) pregnancy after assisted reproduction; (xxi) trauma; (xxii) diabetes mellitus; (xxiii) hypertension; (xxiv) toxaemia of pregnancy; (xxv) liver or renal disease; (xxvi) autoimmune disease; (xxvii) cardiac disease; (xxviii) alloimmunisation; (xxix) maternal infection; (xxx) inflammatory bowel disease; (xxxi) bowel stoma; (xxxii) abdominal wall scarring; (xxxiii) previous spinal or pelvic trauma or disease; (xxxiv) drug dependency; (xxxv) thrombophilia; (xxxvi) significant maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (nr) (nk) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $19.00 **Benefit:** 75% = $14.25 85% = $16.15 **Extended Medicare Safety Net Cap:** $11.05
55727	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and

	(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) further examination is clinically indicated in the same pregnancy to which item 55718, 55722, 55723 or 55726 applies (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $20.00 **Benefit:** 75% = $15.00 85% = $17.00 **Extended Medicare Safety Net Cap:** $11.05
55729	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of the umbilical artery, and measured assessment of amniotic fluid volume after the 24th week of gestation where the patient is referred by a medical practitioner for this procedure and where there is reason to suspect intrauterine growth retardation or a significant risk of foetal death, not being a service associated with a service to which an item in this Group applies - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $27.25 **Benefit:** 75% = $20.45 85% = $23.20 **Extended Medicare Safety Net Cap:** $16.55
55730	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of the umbilical artery, and measured assessment of amniotic fluid volume after the 24th week of gestation where the patient is referred by a medical practitioner for this procedure and where there is reason to suspect intrauterine growth retardation or a significant risk of foetal death, not being a service associated with a service to which an item in this Group applies (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $13.65 **Benefit:** 75% = $10.25 85% = $11.65 **Extended Medicare Safety Net Cap:** $8.30
55735	PELVIS, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of medical practitioners of which the providing practitioner is a member; and (d) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $63.50 **Benefit:** 75% = $47.65 85% = $54.00
55736	PELVIS, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group

	applies; and (c) the referring medical practitioner is not a member of a group of medical practitioners of which the providing practitioner is a member; and (d) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $127.00 **Benefit:** 75% = $95.25 85% = $107.95
55737	PELVIS, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $28.50 **Benefit:** 75% = $21.40 85% = $24.25
55739	PELVIS, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $57.00 **Benefit:** 75% = $42.75 85% = $48.45
55759	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and (f) the service is not performed in conjunction with item 55706, 55709, 55712, 55715 or 55762 during

	the same pregnancy (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50
55760	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and (f) the service is not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717, 55719, 57721, 55762 or 55763 during the same pregnancy (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $75.00 **Benefit:** 75% = $56.25 85% = $63.75
55762	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not performed in conjunction with item 55706, 55709, 55712, 55715 or 55759during the same pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $60.00 **Benefit:** 75% = $45.00 85% = $51.00 **Extended Medicare Safety Net Cap:** $32.95
55763	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717,

	55719, 55720, 55759 or 55760 during the same pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $30.00 **Benefit:** 75% = $22.50 85% = $25.50 **Extended Medicare Safety Net Cap:** $16.50
55764	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and (f) further examination is clinically indicated in the same pregnancy to which item 55759 or 55762 has been performed; and (g) not performed in conjunction with item 55706, 55709, 55712 or 55715 during the same pregnancy (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $160.00 **Benefit:** 75% = $120.00 85% = $136.00 **Extended Medicare Safety Net Cap:** $87.85
55765	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing

	practitioner is a member; and (f) further examination is clinically indicated in the same pregnancy to which item 55759, 55760, 55762 or 55763 has been performed; and (g) not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717, 55719 during the same pregnancy (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $80.00 **Benefit:** 75% = $60.00 85% = $68.00 **Extended Medicare Safety Net Cap:** $44.00
55766	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; (e) further examination is clinically indicated in the same pregnancy to which item 55759, or 55762 has been performed; and (f) not performed in conjunction with item 55706, 55709, 55712 or 55715 during the same pregnancy (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $65.00 **Benefit:** 75% = $48.75 85% = $55.25 **Extended Medicare Safety Net Cap:** $32.95
55767	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; (e) further examination is clinically indicated in the same pregnancy to which item 55759, 55760, 55762 or 55763 has been performed; and (f) not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717, 55719 or 55720 during the same pregnancy (NR) (NK) (See para IN.0.19 of explanatory notes to this Category)

	Fee: $32.50 **Benefit:** 75% = $24.40 85% = $27.65 **Extended Medicare Safety Net Cap:** $16.50
55768	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where: (a)dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (b)the ultrasound confirms a multiple pregnancy; and (c)the patient is referred by a medical practitioner; and (d)the service is not performed in the same pregnancy as item 55770 or 55771; and (e)the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f)the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g)the service is not performed in conjunction with item 55718, 55721, 55722, 55723, 55724, or 55725, 55726 or 55727 during the same pregnancy (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50 **Extended Medicare Safety Net Cap:** $82.40
55769	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where: (a) dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (b) the ultrasound confirms a multiple pregnancy; and (c) the patient is referred by a medical practitioner; and (d) the service is not performed in the same pregnancy as item 55770 or 55771; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55722, 55723, 55724, 55725, 55726 or 55727 during the same pregnancy (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $75.00 **Benefit:** 75% = $56.25 85% = $63.75 **Extended Medicare Safety Net Cap:** $41.25
55770	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy), by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) the service is not performed in the same pregnancy as item 55768; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and

	(f) the service is not performed in conjunction with item 55718, 55721, 55723 or 55725 during the same pregnancy (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $60.00 **Benefit:** 75% = $45.00 85% = $51.00 **Extended Medicare Safety Net Cap:** $32.95
55771	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy), by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) the service is not performed in the same pregnancy as item 55768 or 55759; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the service is not performed in conjunction with item 55718, 55721, 55723, 55724,,55725, 55726 or 55727 during the same pregnancy (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $30.00 **Benefit:** 75% = $22.50 85% = $25.50 **Extended Medicare Safety Net Cap:** $16.50
55772	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55723 or 55725 during the same pregnancy (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $160.00 **Benefit:** 75% = $120.00 85% = $136.00

	Extended Medicare Safety Net Cap: $87.85
55773	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (c) further examination is clinically indicated in the same pregnancy to which item 55768, 55769, 55770 or 55771 has been performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55722, 55723, 55724, 55725, 55726 or 55727 during the same pregnancy (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $80.00 **Benefit:** 75% = $60.00 85% = $68.00 **Extended Medicare Safety Net Cap:** $44.00
55774	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed ;and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the service is not performed in conjunction with item 55718, 55721 55723 or 55725 during the same pregnancy (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $65.00 **Benefit:** 75% = $48.75 85% = $55.25

	Extended Medicare Safety Net Cap: $38.50
55775	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) further examination is clinically indicated in the same pregnancy to which item 55768, 55769, 55770 or 5571 has been performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the service is not performed in conjunction with item 55718, 55721, 55722, 55723, 55724, 55725, 55726 or 55727 during the same pregnancy (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $32.50 **Benefit:** 75% = $24.40 85% = $27.65 **Extended Medicare Safety Net Cap:** $19.30

	Group I1. Ultrasound
	Subgroup 6. Musculoskeletal
55800	HAND OR WRIST, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55801	HAND OR WRIST, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55802	HAND OR WRIST, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and

	(b) the patient is not referred by a medical practitioner (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55803	HAND OR WRIST, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55804	FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55805	FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55806	FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55807	FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55808	

	SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions: - evaluation of injury to tendon, muscle or muscle/tendon junction; or - rotator cuff tear/calcification/tendinosis (biceps, subscapular, suspraspinatus, infraspinatus); or - biceps subluxation; or - capsulitis and bursitis; or - evaluation of mass including ganglion; or - occult fracture; or - acromioclavicular joint pathology.(R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55809	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific shoulder pain alone*. SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions: - evaluation of injury to tendon, muscle or muscle/tendon junction; or - rotator cuff tear/calcification/tendinosis (biceps, subscapular, suspraspinatus, infraspinatus); or - biceps subluxation; or - capsulitis and bursitis; or

	- evaluation of mass including ganglion; or - occult fracture; or - acromioclavicular joint pathology (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55810	SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions: - evaluation of injury to tendon, muscle or muscle/tendon junction; or - rotator cuff tear/calcification/tendinosis (biceps, subscapular, suspraspinatus, infraspinatus); or - biceps subluxation; or - capsulitis and bursitis; or - evaluation of mass including ganglion; or - occult fracture; or - acromioclavicular joint pathology.(NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55811	Note: Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific shoulder pain alone. SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions: - evaluation of injury to tendon, muscle or muscle/tendon junction; or

	- rotator cuff tear/calcification/tendinosis (biceps, subscapular, suspraspinatus, infraspinatus); or - biceps subluxation; or - capsulitis and bursitis; or - evaluation of mass including ganglion; or - occult fracture; or - acromioclavicular joint pathology (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55812	CHEST OR ABDOMINAL WALL, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55813	CHEST OR ABDOMINAL WALL, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55814	CHEST OR ABDOMINAL WALL, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55815	CHEST OR ABDOMINAL WALL, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55816	HIP OR GROIN, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group

	applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55817	HIP OR GROIN, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55818	HIP OR GROIN, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies: and (b) the patient is not referred by a medical practitioner (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55819	HIP OR GROIN, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies: and (b) the patient is not referred by a medical practitioner (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55820	PAEDIATRIC HIP EXAMINATION FOR DYSPLASIA, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55821	PAEDIATRIC HIP EXAMINATION FOR DYSPLASIA, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40

55822	PAEDIATRIC HIP EXAMINATION FOR DYSPLASIA, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55823	PAEDIATRIC HIP EXAMINATION FOR DYSPLASIA, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55824	BUTTOCK OR THIGH, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55825	BUTTOCK OR THIGH, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55826	BUTTOCK OR THIGH, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55827	BUTTOCK OR THIGH, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15

55828	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific knee pain alone or other knee condition including:* - meniscal and cruciate ligament tears - assessment of chondral surfaces KNEE, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided for the assessment of one or more of the following conditions or suspected conditions: - abnormality of tendons or bursae about the knee; or - meniscal cyst, popliteal fossa cyst, mass or pseudomass; or - nerve entrapment, nerve or nerve sheath tumour; or - injury of collateral ligaments.(R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55829	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific knee pain alone or other knee condition including:* - meniscal and cruciate ligament tears - assessment of chondral surfaces KNEE, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided for the assessment of one or more of the following conditions or suspected conditions:

	- abnormality of tendons or bursae about the knee; or - meniscal cyst, popliteal fossa cyst, mass or pseudomass; or - nerve entrapment, nerve or nerve sheath tumour; or - injury of collateral ligaments (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55830	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific knee pain alone or other knee condition including:* - meniscal and cruciate ligament tears - assessment of chondral surfaces KNEE, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner and where the service is provided for the assessment of one or more of the following conditions or suspected conditions: - abnormality of tendons or bursae about the knee; or - meniscal cyst, popliteal fossa cyst, mass or pseudomass; or - nerve entrapment, nerve or nerve sheath tumour; or - injury of collateral ligaments.(NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55831	Note: Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific knee pain alone or other knee condition including: - meniscal and cruciate ligament tears - assessment of chondral surfaces KNEE, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner and where the service is provided for the

	assessment of one or more of the following conditions or suspected conditions: - abnormality of tendons or bursae about the knee; or - meniscal cyst, popliteal fossa cyst, mass or pseudomass; or - nerve entrapment, nerve or nerve sheath tumour; or - injury of collateral ligaments (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55832	LOWER LEG, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55833	LOWER LEG, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55834	LOWER LEG, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55835	LOWER LEG, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55836	ANKLE OR HIND FOOT, 1 or both sides, ultrasound scan of, where:

	(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55837	ANKLE OR HIND FOOT, 1 or both sides, ultrasound scan of, where: (a) the services is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55838	ANKLE OR HIND FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55839	ANKLE OR HIND FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55840	MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55841	MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK)

	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55842	MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55843	MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55844	ASSESSMENT OF A MASS ASSOCIATED WITH THE SKIN OR SUBCUTANEOUS STRUCTURES, NOT BEING A PART OF THE MUSCULOSKELETAL SYSTEM, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $87.35 **Benefit:** 75% = $65.55 85% = $74.25
55845	ASSESSMENT OF A MASS ASSOCIATED WITH THE SKIN OR SUBCUTANEOUS STRUCTURES, NOT BEING A PART OF THE MUSCULOSKELETAL SYSTEM, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $43.70 **Benefit:** 75% = $32.80 85% = $37.15
55846	ASSESSMENT OF A MASS ASSOCIATED WITH THE SKIN OR SUBCUTANEOUS STRUCTURES, NOT BEING A PART OF THE MUSCULOSKELETAL SYSTEM, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (See para IN.0.19 of explanatory notes to this Category)

	Fee: $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55847	ASSESSMENT OF A MASS ASSOCIATED WITH THE SKIN OR SUBCUTANEOUS STRUCTURES, NOT BEING A PART OF THE MUSCULOSKELETAL SYSTEM, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55848	MUSCULOSKELETAL CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies, and not performed in conjunction with item 55054 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55849	MUSCULOSKELETAL CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies, and not performed in conjunction with item 55054 or 55026 (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55850	MUSCULOSKELETAL CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, where: (a) the referring practitioner has indicated on a referral for a musculoskeletal ultrasound that a ultrasound guided intervention be performed if clinically indicated; (b) the service is not performed in conjunction with items 55054, or 55800 to 55848, and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $152.85 **Benefit:** 75% = $114.65 85% = $129.95
55851	MUSCULOSKELETAL CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, where: (a) the referring practitioner has indicated on a referral for a musculoskeletal ultrasound that a ultrasound guided intervention be performed if clinically indicated; (b) the service is not performed in conjunction with items 55026, 55054, or 55800 to 55849, and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK)

	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $76.45 **Benefit:** 75% = $57.35 85% = $65.00
55852	PAEDIATRIC SPINE, SPINAL CORD AND OVERLYING SUBCUTANEOUS TISSUES, Ultrasound scan of, where: a) the patient is referred by a referring practitioner b) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55853	PAEDIATRIC SPINE, SPINAL CORD AND OVERLYING SUBCUTANEOUS TISSUES, Ultrasound scan of, where: a) the patient is referred by a medical practitioner b) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55854	PAEDIATRIC SPINE, SPINAL CORD AND OVERLYING SUBCUTANEOUS TISSUES, Ultrasound scan of, where: a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and b) the patient is not referred by a medical practitioner (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55855	PAEDIATRIC SPINE, SPINAL CORD AND OVERLYING SUBCUTANEOUS TISSUES, Ultrasound scan of, where: a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and b) the patient is not referred by a medical practitioner (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15

I2. COMPUTED TOMOGRAPHY 1. HEAD

	Group I2. Computed Tomography
	Subgroup 1. Head

I2. COMPUTED TOMOGRAPHY	1. HEAD
56001	COMPUTED TOMOGRAPHY - scan of brain without intravenous contrast medium, not being a service to which item 57001 applies (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $195.05 **Benefit:** 75% = $146.30 85% = $165.80
56007	COMPUTED TOMOGRAPHY - scan of brain with intravenous contrast medium and with any scans of the brain prior to intravenous contrast injection, when undertaken, not being a service to which item 57007 applies (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50
56010	COMPUTED TOMOGRAPHY - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $252.10 **Benefit:** 75% = $189.10 85% = $214.30
56013	COMPUTED TOMOGRAPHY - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50
56016	COMPUTED TOMOGRAPHY - scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $290.00 **Benefit:** 75% = $217.50 85% = $246.50
56022	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $225.00 **Benefit:** 75% = $168.75 85% = $191.25
56028	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both prior to intravenous contrast injection, when undertaken (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $336.80 **Benefit:** 75% = $252.60 85% = $286.30
56030	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $225.00 **Benefit:** 75% = $168.75 85% = $191.25
56036	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, with intravenous contrast medium, where: (a) a scan without intravenous contrast medium has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $336.80 **Benefit:** 75% = $252.60 85% = $286.30
56041	COMPUTED TOMOGRAPHY - scan of brain without intravenous contrast medium, not being a service

	to which item 57041 applies (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $98.75 **Benefit:** 75% = $74.10 85% = $83.95
56047	COMPUTED TOMOGRAPHY - scan of brain with intravenous contrast medium and with any scans of the brain prior to intravenous contrast injection, when undertaken, not being a service to which item 57047 applies (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $126.10 **Benefit:** 75% = $94.60 85% = $107.20
56050	COMPUTED TOMOGRAPHY - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.20 **Benefit:** 75% = $96.15 85% = $109.00
56053	COMPUTED TOMOGRAPHY - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.20 **Benefit:** 75% = $96.15 85% = $109.00
56056	COMPUTED TOMOGRAPHY - scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $155.45 **Benefit:** 75% = $116.60 85% = $132.15
56062	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $113.15 **Benefit:** 75% = $84.90 85% = $96.20
56068	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both prior to intravenous contrast injection, when undertaken (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $168.40 **Benefit:** 75% = $126.30 85% = $143.15
56070	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $113.15 **Benefit:** 75% = $84.90 85% = $96.20
56076	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, with intravenous contrast medium, where: (a) a scan without intravenous contrast medium has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $168.40 **Benefit:** 75% = $126.30 85% = $143.15

I2. COMPUTED TOMOGRAPHY	2. NECK
	Group I2. Computed Tomography
	Subgroup 2. Neck
56101	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56801 applies (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $230.00 **Benefit:** 75% = $172.50 85% = $195.50
56107	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) - with intravenous contrast medium and with any scans of soft tissues of neck including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) prior to intravenous contrast injection, when undertaken, not being a service associated with a service to which item 56807 applies (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $340.00 **Benefit:** 75% = $255.00 85% = $289.00
56141	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56841 applies (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $116.45 **Benefit:** 75% = $87.35 85% = $99.00
56147	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) - with intravenous contrast medium and with any scans of soft tissues of neck including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) prior to intravenous contrast injection, when undertaken, not being a service associated with a service to which item 56847 applies (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $171.60 **Benefit:** 75% = $128.70 85% = $145.90

I2. COMPUTED TOMOGRAPHY	3. SPINE
	Group I2. Computed Tomography
	Subgroup 3. Spine
56219	COMPUTED TOMOGRAPHY - scan of spine, 1 or more regions with intrathecal contrast medium, including the preparation for intrathecal injection of contrast medium and any associated plain X-rays, not being a service to which item 59724 applies (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $326.20 **Benefit:** 75% = $244.65 85% = $277.30
56220	COMPUTED TOMOGRAPHY - scan of spine, cervical region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $240.00 **Benefit:** 75% = $180.00 85% = $204.00
56221	COMPUTED TOMOGRAPHY - scan of spine, thoracic region, without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)

	Fee: $240.00 **Benefit:** 75% = $180.00 85% = $204.00
56223	COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $240.00 **Benefit:** 75% = $180.00 85% = $204.00
56224	COMPUTED TOMOGRAPHY - scan of spine, cervical region, with intravenous contrast medium and with any scans of the cervical region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70
56225	COMPUTED TOMOGRAPHY - scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine prior to intravenous contrast injection when undertaken, only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70
56226	COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70
56227	COMPUTED TOMOGRAPHY - scan of spine, cervical region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
56228	COMPUTED TOMOGRAPHY - scan of spine, thoracic region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
56229	COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
56230	COMPUTED TOMOGRAPHY - scan of spine, cervical region, with intravenous contrast medium, and with any scans to the cerival region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $177.45 **Benefit:** 75% = $133.10 85% = $150.85

56231	COMPUTED TOMOGRAPHY - scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $177.45 **Benefit:** 75% = $133.10 85% = $150.85
56232	COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $177.45 **Benefit:** 75% = $133.10 85% = $150.85
56233	*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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $240.00 **Benefit:** 75% = $180.00 85% = $204.00
56234	*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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70
56235	*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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $122.45 **Benefit:** 75% = $91.85 85% = $104.10
56236	*NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item*

I2. COMPUTED TOMOGRAPHY	3. SPINE
	COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56230, 56231 and 56232 with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $177.45 **Benefit:** 75% = $133.10 85% = $150.85
56237	COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $240.00 **Benefit:** 75% = $180.00 85% = $204.00
56238	COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit, payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70
56239	COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $122.45 **Benefit:** 75% = $91.85 85% = $104.10
56240	COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit, payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $177.45 **Benefit:** 75% = $133.10 85% = $150.85
56259	COMPUTED TOMOGRAPHY - scan of spine, 1 or more regions with intrathecal contrast medium, including the preparation for intrathecal injection of contrast medium and any associated plain X-rays, not being a service to which item 59724 applies (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $164.80 **Benefit:** 75% = $123.60 85% = $140.10

I2. COMPUTED TOMOGRAPHY	4. CHEST AND UPPER ABDOMEN
	Group I2. Computed Tomography
	Subgroup 4. Chest and upper abdomen
56301	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56801 or 57001 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $295.00 **Benefit:** 75% = $221.25 85% = $250.75

I2. COMPUTED TOMOGRAPHY	4. CHEST AND UPPER ABDOMEN
56307	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest including lungs, mediastinum, chest wall or pleura and upper abdomen prior to intravenous contrast injection, when undertaken, not being a service to which item 56807 or 57007 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00
56341	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56841 or 57041 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05
56347	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest including lungs, mediastinum, chest wall or pleura and upper abdomen prior to intravenous contrast injection, when undertaken, not being a service to which item 56847 or 57047 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $202.00 **Benefit:** 75% = $151.50 85% = $171.70

I2. COMPUTED TOMOGRAPHY	5. UPPER ABDOMEN ONLY
	Group I2. Computed Tomography
	Subgroup 5. Upper abdomen only
56401	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest) without intravenous contrast medium, not being a service to which item 56301, 56501, 56801 or 57001 applies (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50
56407	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest) with intravenous contrast medium and with any scans of upper abdomen (diaphragm to iliac crest) prior to intravenous contrast injection, when undertaken, not being a service to which item 56307, 56507, 56807 or 57007 applies (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $360.00 **Benefit:** 75% = $270.00 85% = $306.00
56409	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) without intravenous contrast medium not being a service associated with a service to which item 56401 applies (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50
56412	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) with intravenous contrast medium and with any scans of pelvis (iliac crest to pubic symphysis) prior to intravenous

I2. COMPUTED TOMOGRAPHY	5. UPPER ABDOMEN ONLY
	contrast injection, when undertaken, not being a service to which item 56407 applies (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $360.00 **Benefit:** 75% = $270.00 85% = $306.00
56441	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest), without intravenous contrast medium, not being a service to which item 56341, 56541, 56841 or 57041 applies (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $126.80 **Benefit:** 75% = $95.10 85% = $107.80
56447	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest) with intravenous contrast medium, and with any scans of upper abdomen (diaphragm to iliac crest) prior to intravenous contrast injection, when undertaken, not being a service to which item 56347, 56547, 56847 or 57047 applies (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $181.50 **Benefit:** 75% = $136.15 85% = $154.30
56449	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) without intravenous contrast medium, not being a service to which item 56441 applies (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $126.80 **Benefit:** 75% = $95.10 85% = $107.80
56452	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) with intravenous contrast medium, and with any scans of pelvis (iliac crest to pubic symphysis) prior to intravenous contrast injection, when undertaken, not being a service to which item 56447 applies (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $181.50 **Benefit:** 75% = $136.15 85% = $154.30

I2. COMPUTED TOMOGRAPHY	6. UPPER ABDOMEN AND PELVIS
	Group I2. Computed Tomography
	Subgroup 6. Upper abdomen and pelvis
56501	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis without intravenous contrast medium, not for the purposes of virtual colonoscopy, not being a service to which item 56801 or 57001 applies (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $385.00 **Benefit:** 75% = $288.75 85% = $327.25
56507	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis with intravenous contrast medium and with any scans of upper abdomen and pelvis prior to intravenous contrast injection, when undertaken, not for the purposes of virtual colonoscopy, not being a service to which item 56807 or 57007 applies (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $480.05 **Benefit:** 75% = $360.05 85% = $408.05
56541	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis without intravenous contrast medium, not for the purposes of virtual colonoscopy, not being a service to which item 56841 or 57041 applies (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $193.15 **Benefit:** 75% = $144.90 85% = $164.20

I2. COMPUTED TOMOGRAPHY	6. UPPER ABDOMEN AND PELVIS
56547	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis with intravenous contrast medium, and with any scans of upper abdomen and pelvis prior to intravenous contrast injection, when undertaken, not for the purposes of virtual colonoscopy, not being a service to which item 56847 or 57047 applies (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $243.75 **Benefit:** 75% = $182.85 85% = $207.20
56553	Computed tomography-scan of colon for exclusion or diagnosis of colorectal neoplasia in a symptomatic or high risk patient if: (a) one [or more] of the following applies: (i) the patient has had an incomplete colonoscopy in the 3 months before the scan; (ii) there is a high-grade colonic obstruction; (iii) the patient is referred by a specialist or consultant physician who performs colonoscopies [in the practice of his or her speciality]; and (b) the service is not a service to which item 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies; and (c) the service has not been performed on the patient in the 36 months before the scan (R) (K) (Anaes.) (See para IN.0.12 of explanatory notes to this Category) **Fee:** $520.00 **Benefit:** 75% = $390.00 85% = $442.00
56555	Computed tomography-scan of colon for exclusion or diagnosis of colorectal neoplasia in a symptomatic or high risk patient if: (a) one [or more] of the following applies: (i) the patient has had an incomplete colonoscopy in the 3 months before the scan; (ii) there is a high-grade colonic obstruction; (iii) the patient is referred by a specialist or consultant physician who performs colonoscopies [in the practice of his or her speciality]; and (b) the service is not a service to which item 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies; and (c) the service has not been performed on the patient in the 36 months before the scan (R) (NK) (Anaes.) (See para IN.0.12 of explanatory notes to this Category) **Fee:** $260.00 **Benefit:** 75% = $195.00 85% = $221.00

I2. COMPUTED TOMOGRAPHY	7. EXTREMITIES
	Group I2. Computed Tomography

	Subgroup 7. Extremities
56619	COMPUTED TOMOGRAPHY - scan of extremities, one region (other than knee), or more than one region (which may include knee), without intravenous contrast medium. Payable once only whether one or more attendances are required to complete the service, not being a service to which any of items 56620, 56626, 56660 or 56666 apply (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $220.00 **Benefit:** 75% = $165.00 85% = $187.00
56620	COMPUTED TOMOGRAPHY - scan of knee, without intravenous contrast medium. Payable once only whether one or more attendances are required to complete the service, not being a service to which any of items 56619, 56625, 56659 or 56665 apply (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $220.00 **Benefit:** 75% = $165.00 85% = $187.00
56625	COMPUTED TOMOGRAPHY - scan of extremities, one region (other than knee), or more than one region (which may include knee), with intravenous contrast medium and with any scans of extremities before intravenous contrast injection, when performed. Payable once only whether one or more attendances are required to complete the service, not being a service to which any of items 56620, 56626, 56660 or 56666 apply. (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $334.65 **Benefit:** 75% = $251.00 85% = $284.50
56626	COMPUTED TOMOGRAPHY - scan of the knee, with intravenous contrast medium and with any scans of the knee prior to intravenous contrast injection, when undertaken. Payable once only whether one or more attendances are required to complete the service, not being a service to which any of items 56619, 56625, 56659 or 56665 apply (R) (K) (Anaes.). (See para IN.0.19 of explanatory notes to this Category) **Fee:** $334.65 **Benefit:** 75% = $251.00 85% = $284.50
56659	COMPUTED TOMOGRAPHY - scan of extremities, one region (other than knee), or more than one region (which may include knee), without intravenous contrast medium. Payable once only whether one or more attendances are required to complete the service, not being a service to which any of items 56620, 56626, 56660 or 56666 apply (R) (NK) (Anaes.). (See para IN.0.19 of explanatory notes to this Category) **Fee:** $112.10 **Benefit:** 75% = $84.10 85% = $95.30
56660	COMPUTED TOMOGRAPHY - scan of the knee, without intravenous contrast medium. Payable once only whether one or more attendances are required to complete the service, not being a service to which any of items 56619, 56625, 56659 or 56665 apply (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $112.10 **Benefit:** 75% = $84.10 85% = $95.30
56665	COMPUTED TOMOGRAPHY - scan of extremities, one region (other than knee), or more than one region (which may include knee), with intravenous contrast medium and with any scans of extremities before intravenous contrast injection, when performed. Payable once only whether one or more attendances are required to complete the service, not being a service to which any of items 56620, 56626, 56660 or 56666 apply (R) (NK) (Anaes.). (See para IN.0.19 of explanatory notes to this Category) **Fee:** $167.40 **Benefit:** 75% = $125.55 85% = $142.30
56666	COMPUTED TOMOGRAPHY - scan of knee, with intravenous contrast medium, and with any scans of the knee prior to intravenous contrast injection, when performed. Payable once only whether one or

I2. COMPUTED TOMOGRAPHY	7. EXTREMITIES
	more attendances are required to complete the service, not being a service to which any of items 56619, 56625, 56659 or 56665 apply (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $167.40 **Benefit:** 75% = $125.55 85% = $142.30

I2. COMPUTED TOMOGRAPHY	8. CHEST, ABDOMEN, PELVIS AND NECK
	Group I2. Computed Tomography
	Subgroup 8. Chest, abdomen, pelvis and neck
56801	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $466.55 **Benefit:** 75% = $349.95 85% = $396.60
56807	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $560.00 **Benefit:** 75% = $420.00 85% = $476.00
56841	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $233.35 **Benefit:** 75% = $175.05 85% = $198.35
56847	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $283.85 **Benefit:** 75% = $212.90 85% = $241.30

I2. COMPUTED TOMOGRAPHY	9. BRAIN, CHEST AND UPPER ABDOMEN
	Group I2. Computed Tomography
	Subgroup 9. Brain, chest and upper abdomen
57001	COMPUTED TOMOGRAPHY - scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $466.65 **Benefit:** 75% = $350.00 85% = $396.70
57007	COMPUTED TOMOGRAPHY- scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen prior to

I2. COMPUTED TOMOGRAPHY	9. BRAIN, CHEST AND UPPER ABDOMEN
	intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $567.75 **Benefit:** 75% = $425.85 85% = $483.05
57041	COMPUTED TOMOGRAPHY- scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $233.40 **Benefit:** 75% = $175.05 85% = $198.40
57047	COMPUTED TOMOGRAPHY- scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $283.90 **Benefit:** 75% = $212.95 85% = $241.35

I2. COMPUTED TOMOGRAPHY	10. PELVIMETRY
	Group I2. Computed Tomography
	Subgroup 10. Pelvimetry
57201	COMPUTED TOMOGRAPHY - PELVIMETRY (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $155.20 **Benefit:** 75% = $116.40 85% = $131.95
57247	COMPUTED TOMOGRAPHY - PELVIMETRY (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $77.55 **Benefit:** 75% = $58.20 85% = $65.95

I2. COMPUTED TOMOGRAPHY	11. INTERVENTIONAL TECHNIQUES
	Group I2. Computed Tomography
	Subgroup 11. Interventional techniques
57341	COMPUTED TOMOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $470.00 **Benefit:** 75% = $352.50 85% = $399.50
57345	COMPUTED TOMOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $241.60 **Benefit:** 75% = $181.20 85% = $205.40

I2. COMPUTED TOMOGRAPHY	12. SPIRAL ANGIOGRAPHY

	Group I2. Computed Tomography
	Subgroup 12. Spiral angiography
57350	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (c) the service has not been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $510.00 **Benefit:** 75% = $382.50 85% = $433.50
57351	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of acute or recurrent pulmonary embolism; acute symptomatic arterial occlusion; post operative complication of arterial surgery; acute ruptured aneurysm; or acute dissection of the aorta, carotid or vertebral artery; and (c) the services to which 57350 or 57355 apply have been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (K) (Anaes.) (See para IN.0.19, IN.1.2 of explanatory notes to this Category) **Fee:** $510.00 **Benefit:** 75% = $382.50 85% = $433.50
57355	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (c) the service has not been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)

I2. COMPUTED TOMOGRAPHY	12. SPIRAL ANGIOGRAPHY
	Fee: $264.15 **Benefit:** 75% = $198.15 85% = $224.55
57356	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: a) the service is not a service to which another item in this group applies; and b) the service is performed for the exclusion of acute or recurrent pulmonary embolism; acute symptomatic arterial occlusion; post operative complication of arterial surgery; or acute ruptured aneurysm; acute dissection of the aorta, carotid or vertebral artery; and (c) the services to which 57350 or 57355 apply have been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (NK) (Anaes.) (See para IN.0.19, IN.1.2 of explanatory notes to this Category) **Fee:** $264.15 **Benefit:** 75% = $198.15 85% = $224.55
57360	COMPUTED TOMOGRAPHY OF THE CORONARY ARTERIES performed on a minimum of a 64 slice (or equivalent) scanner, where the request is made by a specialist or consultant physician, and: a) the patient has stable symptoms consistent with coronary ischaemia, is at low to intermediate risk of coronary artery disease and would have been considered for coronary angiography; or b) the patient requires exclusion of coronary artery anomaly or fistula; or c) the patient will be undergoing non-coronary cardiac surgery (R) (K) (Anaes.) (See para IN.0.12, IN.0.19 of explanatory notes to this Category) **Fee:** $700.00 **Benefit:** 75% = $525.00 85% = $615.30
57361	COMPUTED TOMOGRAPHY OF THE CORONARY ARTERIES performed on a minimum of a 64 slice (or equivalent) scanner, where the request is made by a specialist or consultant physician, and: a) the patient has stable symptoms consistent with coronary ischaemia, is at low to intermediate risk of coronary artery disease and would have been considered for coronary angiography; or b) the patient requires exclusion of coronary artery anomaly or fistula; or c) the patient will be undergoing non-coronary cardiac surgery (R) (NK) (Anaes.) (See para IN.0.12, IN.0.19 of explanatory notes to this Category) **Fee:** $350.00 **Benefit:** 75% = $262.50 85% = $297.50

I2. COMPUTED TOMOGRAPHY	13. CONE BEAM COMPUTED TOMOGRAPHY
	Group I2. Computed Tomography
	Subgroup 13. Cone beam computed tomography
57362	Dental & temporo-mandibular joint imaging for diagnosis and management of mandibular and dento-alveolar fractures, dental implant planning, orthodontics, endodontic, periodontal and temporo-

	mandibular joint conditions: without contrast medium. Restricted to requesting by dental specialists and medical practitioners and must be performed on equipment located in practices accredited under the Diagnostic Imaging Accreditation Scheme using dedicated (rather than hybrid) CBCT units. Claims for more than one CBCT per patient per day are excluded. Claiming with two-dimensional imaging in the same episode (items 57959-57969) and with CT in the same episode (items 56001-57361) are also excluded. (K) **Fee:** $113.15 **Benefit:** 75% = $84.90 85% = $96.20
57363	Dental & temporo-mandibular joint imaging for diagnosis and management of mandibular and dento-alveolar fractures, dental implant planning, orthodontics, endodontic, periodontal and temporo-mandibular joint conditions: without contrast medium. Restricted to requesting by dental specialists and medical practitioners and must be performed on equipment located in practices accredited under the Diagnostic Imaging Accreditation Scheme using dedicated (rather than hybrid) CBCT units. Claims for more than one CBCT per patient per day are excluded. Claiming with two-dimensional imaging in the same episode (items 57959-57969) and with CT in the same episode (items 56001-57361) are also excluded. (NK) **Fee:** $56.60 **Benefit:** 75% = $42.45 85% = $48.15

I3. DIAGNOSTIC RADIOLOGY — 1. RADIOGRAPHIC EXAMINATION OF EXTREMITIES

	Group I3. Diagnostic Radiology
	Subgroup 1. Radiographic Examination Of Extremities
57506	HAND, WRIST, FOREARM, ELBOW OR HUMERUS (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $29.75 **Benefit:** 75% = $22.35 85% = $25.30
57509	HAND, WRIST, FOREARM, ELBOW OR HUMERUS (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $39.75 **Benefit:** 75% = $29.85 85% = $33.80
57512	HAND AND WRIST OR HAND, WRIST AND FOREARM OR FOREARM AND ELBOW OR ELBOW AND HUMERUS (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $40.50 **Benefit:** 75% = $30.40 85% = $34.45
57515	HAND AND WRIST OR HAND, WRIST AND FOREARM OR FOREARM AND ELBOW OR ELBOW AND HUMERUS (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.00 **Benefit:** 75% = $40.50 85% = $45.90

57518	FOOT, ANKLE, LEG, OR FEMUR (NR)(K) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $32.50 **Benefit:** 75% = $24.40 85% = $27.65
57521	FOOT, ANKLE, LEG, OR FEMUR (R)(K) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $43.40 **Benefit:** 75% = $32.55 85% = $36.90
57522	Knee (NR)(K) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $32.50 **Benefit:** 75% = $24.40 85% = $27.65
57523	Knee (R)(K) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $43.40 **Benefit:** 75% = $32.55 85% = $36.90
57524	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $49.40 **Benefit:** 75% = $37.05 85% = $42.00
57527	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $65.75 **Benefit:** 75% = $49.35 85% = $55.90
57529	HAND, WRIST, FOREARM, ELBOW OR HUMERUS (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $14.90 **Benefit:** 75% = $11.20 85% = $12.70
57530	HAND, WRIST, FOREARM, ELBOW OR HUMERUS (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $19.90 **Benefit:** 75% = $14.95 85% = $16.95
57532	HAND AND WRIST OR HAND, WRIST AND FOREARM OR FOREARM AND ELBOW OR ELBOW AND HUMERUS (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $20.25 **Benefit:** 75% = $15.20 85% = $17.25
57533	HAND AND WRIST OR HAND, WRIST AND FOREARM OR FOREARM AND ELBOW OR ELBOW AND HUMERUS (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $27.00 **Benefit:** 75% = $20.25 85% = $22.95
57535	FOOT, ANKLE, LEG, OR FEMUR (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $16.25 **Benefit:** 75% = $12.20 85% = $13.85
57536	FOOT, ANKLE, LEG, OR FEMUR (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $21.70 **Benefit:** 75% = $16.30 85% = $18.45

I3. DIAGNOSTIC RADIOLOGY	1. RADIOGRAPHIC EXAMINATION OF EXTREMITIES
57537	Knee (NR)(NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $16.25 **Benefit:** 75% = $12.20 85% = $13.85
57538	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $24.70 **Benefit:** 75% = $18.55 85% = $21.00
57539	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $32.90 **Benefit:** 75% = $24.70 85% = $28.00
57540	Knee (R)(NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $21.70 **Benefit:** 75% = $16.30 85% = $18.45

I3. DIAGNOSTIC RADIOLOGY	2. RADIOGRAPHIC EXAMINATION OF SHOULDER OR PELVIS
	Group I3. Diagnostic Radiology
	Subgroup 2. Radiographic Examination Of Shoulder Or Pelvis
57700	SHOULDER OR SCAPULA (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $40.50 **Benefit:** 75% = $30.40 85% = $34.45
57702	SHOULDER OR SCAPULA (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $20.25 **Benefit:** 75% = $15.20 85% = $17.25
57703	SHOULDER OR SCAPULA (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.00 **Benefit:** 75% = $40.50 85% = $45.90
57705	SHOULDER OR SCAPULA (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $27.00 **Benefit:** 75% = $20.25 85% = $22.95
57706	CLAVICLE (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $32.50 **Benefit:** 75% = $24.40 85% = $27.65
57708	CLAVICLE (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $16.25 **Benefit:** 75% = $12.20 85% = $13.85
57709	CLAVICLE (R) (See para IN.0.19 of explanatory notes to this Category)

I3. DIAGNOSTIC RADIOLOGY	2. RADIOGRAPHIC EXAMINATION OF SHOULDER OR PELVIS
	Fee: $43.40 **Benefit:** 75% = $32.55 85% = $36.90
57711	CLAVICLE (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $21.70 **Benefit:** 75% = $16.30 85% = $18.45
57712	HIP JOINT (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10
57714	HIP JOINT (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $23.60 **Benefit:** 75% = $17.70 85% = $20.10
57715	PELVIC GIRDLE (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $60.90 **Benefit:** 75% = $45.70 85% = $51.80
57717	PELVIC GIRDLE (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $30.45 **Benefit:** 75% = $22.85 85% = $25.90
57721	FEMUR, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $99.25 **Benefit:** 75% = $74.45 85% = $84.40
57723	FEMUR, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $49.65 **Benefit:** 75% = $37.25 85% = $42.25

I3. DIAGNOSTIC RADIOLOGY	3. RADIOGRAPHIC EXAMINATION OF HEAD
	Group I3. Diagnostic Radiology
	Subgroup 3. Radiographic Examination Of Head
57901	SKULL, not in association with item 57902 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $64.50 **Benefit:** 75% = $48.40 85% = $54.85
57902	CEPHALOMETRY, not in association with item 57901 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $64.50 **Benefit:** 75% = $48.40 85% = $54.85
57903	SINUSES (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.30 **Benefit:** 75% = $35.50 85% = $40.25
57906	MASTOIDS (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $64.50 **Benefit:** 75% = $48.40 85% = $54.85

57909	PETROUS TEMPORAL BONES (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $64.50 **Benefit:** 75% = $48.40 85% = $54.85
57911	SKULL, not in association with item 57902 or 57914 (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $32.25 **Benefit:** 75% = $24.20 85% = $27.45
57912	FACIAL BONES orbit, maxilla or malar, any or all (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10
57914	CEPHALOMETRY, not in association with item 57901 or 57911 (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $32.25 **Benefit:** 75% = $24.20 85% = $27.45
57915	MANDIBLE, not by orthopantomography technique (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10
57917	SINUSES (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $23.65 **Benefit:** 75% = $17.75 85% = $20.15
57918	SALIVARY CALCULUS (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10
57920	MASTOIDS (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $32.25 **Benefit:** 75% = $24.20 85% = $27.45
57921	NOSE (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10
57923	PETROUS TEMPORAL BONES (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $32.25 **Benefit:** 75% = $24.20 85% = $27.45
57924	EYE (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10
57926	FACIAL BONES orbit, maxilla or malar, any or all (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $23.60 **Benefit:** 75% = $17.70 85% = $20.10
57927	TEMPOROMANDIBULAR JOINTS (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $49.65 **Benefit:** 75% = $37.25 85% = $42.25

57929	MANDIBLE, not by orthopantomography technique (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $23.60 **Benefit:** 75% = $17.70 85% = $20.10
57930	TEETH SINGLE AREA (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $32.90 **Benefit:** 75% = $24.70 85% = $28.00
57932	SALIVARY CALCULUS (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $23.60 **Benefit:** 75% = $17.70 85% = $20.10
57933	TEETH FULL MOUTH (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $78.25 **Benefit:** 75% = $58.70 85% = $66.55
57935	NOSE (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $23.60 **Benefit:** 75% = $17.70 85% = $20.10
57938	EYE (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $23.60 **Benefit:** 75% = $17.70 85% = $20.10
57939	PALATOPHARYNGEAL STUDIES with fluoroscopic screening (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $64.50 **Benefit:** 75% = $48.40 85% = $54.85
57941	TEMPOROMANDIBULAR JOINTS (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $24.85 **Benefit:** 75% = $18.65 85% = $21.15
57942	PALATOPHARYNGEAL STUDIES without fluoroscopic screening (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $49.65 **Benefit:** 75% = $37.25 85% = $42.25
57944	TEETH SINGLE AREA (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $16.45 **Benefit:** 75% = $12.35 85% = $14.00
57945	LARYNX, LATERAL AIRWAYS AND SOFT TISSUES OF THE NECK, not being a service associated with a service to which item 57939 or 57942 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $43.40 **Benefit:** 75% = $32.55 85% = $36.90
57947	TEETH FULL MOUTH (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $39.15 **Benefit:** 75% = $29.40 85% = $33.30
57950	PALATOPHARYNGEAL STUDIES with fluoroscopic screening (R) (NK) (See para IN.0.19 of explanatory notes to this Category)

	Fee: $32.25 **Benefit:** 75% = $24.20 85% = $27.45
57953	PALATOPHARYNGEAL STUDIES without fluoroscopic screening (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $24.85 **Benefit:** 75% = $18.65 85% = $21.15
57956	LARYNX, LATERAL AIRWAYS AND SOFT TISSUES OF THE NECK, not being a service associated with a service to which item 57939, 57942, 57950 or 57953 applies (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $21.70 **Benefit:** 75% = $16.30 85% = $18.45
57959	Orthopantomography, for diagnosis and/or management of trauma, infection, tumours, congenital conditions or surgical conditions of the teeth or maxillofacial region (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $23.70 **Benefit:** 75% = $17.80 85% = $20.15
57960	Orthopantomography, for diagnosis and/or management of trauma, infection, tumours, congenital conditions or surgical conditions of the teeth or maxillofacial region (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.40 **Benefit:** 75% = $35.55 85% = $40.30
57962	Orthopantomography, for diagnosis and/or management of impacted teeth, caries, periodontal or peripical pathology where signs or symptoms of those conditions are evident (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $23.70 **Benefit:** 75% = $17.80 85% = $20.15
57963	Orthopantomography, for diagnosis and/or management of impacted teeth, caries, periodontal or peripical pathology where signs or symptoms of those conditions are evident (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.40 **Benefit:** 75% = $35.55 85% = $40.30
57965	Orthopantomography, for diagnosis and/or management of missing or crowded teeth, or developmental anomalies of the teeth or jaws (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $23.70 **Benefit:** 75% = $17.80 85% = $20.15
57966	Orthopantomography, for diagnosis and/or management of missing or crowded teeth, or developmental anomalies of the teeth or jaws (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.40 **Benefit:** 75% = $35.55 85% = $40.30
57968	Orthopantomography, for diagnosis and/or management of temporomandibular joint arthroses or dysfunction (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $23.70 **Benefit:** 75% = $17.80 85% = $20.15
57969	Orthopantomography, for diagnosis and/or management of temporomandibular joint arthroses or dysfunction (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.40 **Benefit:** 75% = $35.55 85% = $40.30

	Group I3. Diagnostic Radiology
	Subgroup 4. Radiographic Examination Of Spine
58100	SPINE CERVICAL (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $67.15 **Benefit:** 75% = $50.40 85% = $57.10
58102	SPINE CERVICAL (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $33.60 **Benefit:** 75% = $25.20 85% = $28.60
58103	SPINE THORACIC (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.10 **Benefit:** 75% = $41.35 85% = $46.85
58105	SPINE THORACIC (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $27.55 **Benefit:** 75% = $20.70 85% = $23.45
58106	SPINE LUMBOSACRAL (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $77.00 **Benefit:** 75% = $57.75 85% = $65.45
58108	Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.00 **Benefit:** 75% = $82.50 85% = $93.50
58109	SPINE SACROCOCCYGEAL (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.00 **Benefit:** 75% = $35.25 85% = $39.95
58111	SPINE LUMBOSACRAL (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.50 **Benefit:** 75% = $28.90 85% = $32.75
58112	*NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item* Spine, two examinations of the kind referred to in items 58100, 58103, 58106 and 58109 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
58114	Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.00 **Benefit:** 75% = $41.25 85% = $46.75
58115	*NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item*

	Spine, three examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.00 **Benefit:** 75% = $82.50 85% = $93.50
58117	SPINE SACROCOCCYGEAL (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $23.50 **Benefit:** 75% = $17.65 85% = $20.00
58120	Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal (R), if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year **Fee:** $110.00 **Benefit:** 75% = $82.50 85% = $93.50
58121	*NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item* Spine, three examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R), if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year **Fee:** $110.00 **Benefit:** 75% = $82.50 85% = $93.50
58123	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item Spine, two examinations of the kind referred to in items 58100, 58102, 58103, 58105, 58106, 58109, 58111 and 58117 (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $48.65 **Benefit:** 75% = $36.50 85% = $41.40
58124	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item Spine, three examinations of the kind mentioned in items 58100, 58102, 58103, 58105, 58106, 58109, 58111 and 58117 (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.00 **Benefit:** 75% = $41.25 85% = $46.75
58126	Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal, if the service to which item 58120, 58121, 58126 or 58127 applies has not been performed on the same patient within the same calendar year (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.00 **Benefit:** 75% = $41.25 85% = $46.75
58127	*NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item*

I3. DIAGNOSTIC RADIOLOGY	4. RADIOGRAPHIC EXAMINATION OF SPINE
	Spine, three examinations of the kind mentioned in items 58100, 58102, 58103, 58105, 58106 and 58109, 58111 and 58117 if the service to which item 58120, 58121, 58126 or 58127 applies has not been performed on the same patient within the same calendar year (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.00 **Benefit:** 75% = $41.25 85% = $46.75

I3. DIAGNOSTIC RADIOLOGY	5. BONE AGE STUDY AND SKELETAL SURVEYS
	Group I3. Diagnostic Radiology
	Subgroup 5. Bone Age Study And Skeletal Surveys
58300	BONE AGE STUDY (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $40.10 **Benefit:** 75% = $30.10 85% = $34.10
58302	BONE AGE STUDY (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $20.05 **Benefit:** 75% = $15.05 85% = $17.05
58306	SKELETAL SURVEY (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $89.40 **Benefit:** 75% = $67.05 85% = $76.00
58308	SKELETAL SURVEY (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.70 **Benefit:** 75% = $33.55 85% = $38.00

I3. DIAGNOSTIC RADIOLOGY	6. RADIOGRAPHIC EXAMINATION OF THORACIC REGION
	Group I3. Diagnostic Radiology
	Subgroup 6. Radiographic Examination Of Thoracic Region
58500	CHEST (lung fields) by direct radiography (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $35.35 **Benefit:** 75% = $26.55 85% = $30.05
58502	CHEST (lung fields) by direct radiography (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $17.70 **Benefit:** 75% = $13.30 85% = $15.05
58503	CHEST (lung fields) by direct radiography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10
58505	CHEST (lung fields) by direct radiography (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $23.60 **Benefit:** 75% = $17.70 85% = $20.10

I3. DIAGNOSTIC RADIOLOGY	6. RADIOGRAPHIC EXAMINATION OF THORACIC REGION
58506	CHEST (lung fields) by direct radiography with fluoroscopic screening (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $60.75 **Benefit:** 75% = $45.60 85% = $51.65
58508	CHEST (lung fields) by direct radiography with fluoroscopic screening (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $30.40 **Benefit:** 75% = $22.80 85% = $25.85
58509	THORACIC INLET OR TRACHEA (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $39.75 **Benefit:** 75% = $29.85 85% = $33.80
58511	THORACIC INLET OR TRACHEA (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $19.90 **Benefit:** 75% = $14.95 85% = $16.95
58521	LEFT RIBS, RIGHT RIBS OR STERNUM (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $43.40 **Benefit:** 75% = $32.55 85% = $36.90
58523	LEFT RIBS, RIGHT RIBS OR STERNUM (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $21.70 **Benefit:** 75% = $16.30 85% = $18.45
58524	LEFT AND RIGHT RIBS, LEFT RIBS AND STERNUM, OR RIGHT RIBS AND STERNUM (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $56.50 **Benefit:** 75% = $42.40 85% = $48.05
58526	LEFT AND RIGHT RIBS, LEFT RIBS AND STERNUM, OR RIGHT RIBS AND STERNUM (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $28.25 **Benefit:** 75% = $21.20 85% = $24.05
58527	LEFT RIBS, RIGHT RIBS AND STERNUM (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $69.40 **Benefit:** 75% = $52.05 85% = $59.00
58529	LEFT RIBS, RIGHT RIBS AND STERNUM (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $34.70 **Benefit:** 75% = $26.05 85% = $29.50

I3. DIAGNOSTIC RADIOLOGY	7. RADIOGRAPHIC EXAMINATION OF URINARY TRACT
	Group I3. Diagnostic Radiology
	Subgroup 7. Radiographic Examination Of Urinary Tract
58700	PLAIN RENAL ONLY (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $46.05 **Benefit:** 75% = $34.55 85% = $39.15

I3. DIAGNOSTIC RADIOLOGY	7. RADIOGRAPHIC EXAMINATION OF URINARY TRACT
58702	PLAIN RENAL ONLY (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $23.05 **Benefit:** 75% = $17.30 85% = $19.60
58706	INTRAVENOUS PYELOGRAPHY, with or without preliminary plain films and with or without tomography - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $157.90 **Benefit:** 75% = $118.45 85% = $134.25
58708	INTRAVENOUS PYELOGRAPHY, with or without preliminary plain films and with or without tomography - (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $78.95 **Benefit:** 75% = $59.25 85% = $67.15
58715	ANTEGRADE OR RETROGRADE PYELOGRAPHY, with or without preliminary plain films and with preparation and contrast injection - 1 side - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $151.55 **Benefit:** 75% = $113.70 85% = $128.85
58717	ANTEGRADE OR RETROGRADE PYELOGRAPHY, with or without preliminary plain films and with preparation and contrast injection - 1 side - (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $75.80 **Benefit:** 75% = $56.85 85% = $64.45
58718	RETROGRADE CYSTOGRAPHY OR RETROGRADE URETHROGRAPHY with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $126.10 **Benefit:** 75% = $94.60 85% = $107.20
58720	RETROGRADE CYSTOGRAPHY OR RETROGRADE URETHROGRAPHY with or without preliminary plain films and with preparation and contrast injection - (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $63.05 **Benefit:** 75% = $47.30 85% = $53.60
58721	RETROGRADE MICTURATING CYSTOURETHROGRAPHY, with preparation and contrast injection - (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $138.25 **Benefit:** 75% = $103.70 85% = $117.55
58723	RETROGRADE MICTURATING CYSTOURETHROGRAPHY, with preparation and contrast injection - (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $69.15 **Benefit:** 75% = $51.90 85% = $58.80

I3. DIAGNOSTIC RADIOLOGY	8. RADIOGRAPHIC EXAMINATION OF ALIMENTARY TRACT AND BILIARY SYSTEM
	Group I3. Diagnostic Radiology
	Subgroup 8. Radiographic Examination Of Alimentary Tract And Biliary System

58900	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58912 or 58915 applies (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $35.70 **Benefit:** 75% = $26.80 85% = $30.35
58902	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58911, 58912, 58914, 58915 or 58917 applies (NR) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $17.85 **Benefit:** 75% = $13.40 85% = $15.20
58903	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58912 or 58915 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.60 **Benefit:** 75% = $35.70 85% = $40.50
58905	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58911, 58912, 58914, 58915 or 58917 applies (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $23.80 **Benefit:** 75% = $17.85 85% = $20.25
58909	BARIUM or other opaque meal of 1 or more of PHARYNX, OESOPHAGUS, STOMACH OR DUODENUM, with or without preliminary plain films of pharynx, chest or duodenum, not being a service associated with a service to which item 57939 or 57942 or 57945 applies - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $89.95 **Benefit:** 75% = $67.50 85% = $76.50
58911	BARIUM or other opaque meal of 1 or more of PHARYNX, OESOPHAGUS, STOMACH OR DUODENUM, with or without preliminary plain films of pharynx, chest or duodenum, not being a service associated with a service to which item 57939, 57942, 57945, 57950, 57953 or 57956 applies - (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $45.00 **Benefit:** 75% = $33.75 85% = $38.25
58912	BARIUM or other opaque meal OF OESOPHAGUS, STOMACH, DUODENUM AND FOLLOW THROUGH TO COLON, with or without screening of chest, with or without preliminary plain film (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $110.25 **Benefit:** 75% = $82.70 85% = $93.75
58914	BARIUM or other opaque meal OF OESOPHAGUS, STOMACH, DUODENUM AND FOLLOW THROUGH TO COLON, with or without screening of chest, with or without preliminary plain film (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.15 **Benefit:** 75% = $41.40 85% = $46.90
58915	BARIUM or other opaque meal, SMALL BOWEL SERIES ONLY, with or without preliminary plain film (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $78.95 **Benefit:** 75% = $59.25 85% = $67.15
58916	SMALL BOWEL ENEMA, barium or other opaque study of the small bowel, including DUODENAL INTUBATION, with or without preliminary plain films, not being a service associated with a service to

	which item 30488 applies - (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $138.50 **Benefit:** 75% = $103.90 85% = $117.75
58917	BARIUM or other opaque meal, SMALL BOWEL SERIES ONLY, with or without preliminary plain film (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $39.50 **Benefit:** 75% = $29.65 85% = $33.60
58920	SMALL BOWEL ENEMA, barium or other opaque study of the small bowel, including DUODENAL INTUBATION, with or without preliminary plain films, not being a service associated with a service to which item 30488 applies - (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $69.25 **Benefit:** 75% = $51.95 85% = $58.90
58921	OPAQUE ENEMA, with or without air contrast study and with or without preliminary plain films - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $135.25 **Benefit:** 75% = $101.45 85% = $115.00
58923	OPAQUE ENEMA, with or without air contrast study and with or without preliminary plain films - (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $67.65 **Benefit:** 75% = $50.75 85% = $57.55
58927	CHOLEGRAPHY DIRECT, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 30439 applies - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $76.45 **Benefit:** 75% = $57.35 85% = $65.00
58929	CHOLEGRAPHY DIRECT, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 30439 applies - (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.25 **Benefit:** 75% = $28.70 85% = $32.55
58933	CHOLEGRAPHY, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $205.60 **Benefit:** 75% = $154.20 85% = $174.80
58935	CHOLEGRAPHY, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection - (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $102.80 **Benefit:** 75% = $77.10 85% = $87.40
58936	CHOLEGRAPHY, drip infusion, with or without preliminary plain films, with preparation and contrast injection and with or without tomography - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $195.95 **Benefit:** 75% = $147.00 85% = $166.60
58938	CHOLEGRAPHY, drip infusion, with or without preliminary plain films, with preparation and contrast

I3. DIAGNOSTIC RADIOLOGY	8. RADIOGRAPHIC EXAMINATION OF ALIMENTARY TRACT AND BILIARY SYSTEM
	injection and with or without tomography - (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $98.00 **Benefit:** 75% = $73.50 85% = $83.30
58939	DEFAECOGRAM (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $139.30 **Benefit:** 75% = $104.50 85% = $118.45
58941	DEFAECOGRAM (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $69.65 **Benefit:** 75% = $52.25 85% = $59.25

I3. DIAGNOSTIC RADIOLOGY	9. RADIOGRAPHIC EXAMINATION FOR LOCALISATION OF FOREIGN BODIES
	Group I3. Diagnostic Radiology
	Subgroup 9. Radiographic Examination For Localisation Of Foreign Bodies
59103	Localisation of foreign body, if provided in conjunction with a service described in Subgroups 1 to 12 of Group I3 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $21.30 **Benefit:** 75% = $16.00 85% = $18.15
59104	Localisation of foreign body, if provided in conjunction with a service described in Subgroups 1 to 12 of Group I3 (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $10.65 **Benefit:** 75% = $8.00 85% = $9.10

I3. DIAGNOSTIC RADIOLOGY	10. RADIOGRAPHIC EXAMINATION OF BREASTS
	Group I3. Diagnostic Radiology
	Subgroup 10. Radiographic Examination Of Breasts
59300	*(Note: These items are intended for use in the investigation of a clinical abnormality of the breast/s and NOT for individual, group or opportunistic screening of asymptomatic patients)* MAMMOGRAPHY OF BOTH BREASTS, if there is a reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner. Unless otherwise indicated, mammography includes both breasts (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $89.50 **Benefit:** 75% = $67.15 85% = $76.10

	(Note: These items are intended for use in the investigation of a clinical abnormality of the breast/s and NOT for individual, group or opportunistic screening of asymptomatic patients) MAMMOGRAPHY OF BOTH BREASTS, if there is a reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner. Unless otherwise indicated, mammography includes both breasts (R) (NK) (See para IN.0.19 of explanatory notes to this Category)
59301	**Fee:** $44.75 **Benefit:** 75% = $33.60 85% = $38.05
	Three dimensional tomosynthesis of both breasts, not being a service associated with item 59300 or 59301, if there is reason to suspect the presence of malignancy because of: d. the past occurrence of breast malignancy in the patient or members of the patient's family; or e. symptoms or indications of malignancy found on examination of the patient by a medical practitioner (R) (K) (See para IN.0.19 of explanatory notes to this Category)
59302	**Fee:** $202.00 **Benefit:** 75% = $151.50 85% = $171.70
	MAMMOGRAPHY OF ONE BREAST, if: (a) the patient is referred with a specific request for a unilateral mammogram; and (b) there is reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner (R) (See para IN.0.19 of explanatory notes to this Category)
59303	**Fee:** $53.95 **Benefit:** 75% = $40.50 85% = $45.90
	MAMMOGRAPHY OF ONE BREAST, if: (a) the patient is referred with a specific request for a unilateral mammogram; and (b) there is reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner (R) (NK) (See para IN.0.19 of explanatory notes to this Category)
59304	**Fee:** $27.00 **Benefit:** 75% = $20.25 85% = $22.95
59305	Three dimensional tomosynthesis of one breast, not being a service associated with item 59303 or 59304, if there is reason to suspect the presence of malignancy because of:

	d. the past occurrence of breast malignancy in the patient or members of the patient's family; or e. symptoms or indications of malignancy found on examination of the patient by a medical practitioner (R) (K) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $114.00 **Benefit:** 75% = $85.50 85% = $96.90
59306	MAMMARY DUCTOGRAM (galactography) - 1 breast (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $100.30 **Benefit:** 75% = $75.25 85% = $85.30
59307	MAMMARY DUCTOGRAM (galactography) - 1 breast (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $50.15 **Benefit:** 75% = $37.65 85% = $42.65
59309	MAMMARY DUCTOGRAM (galactography) - 2 breasts (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $200.60 **Benefit:** 75% = $150.45 85% = $170.55
59310	MAMMARY DUCTOGRAM (galactography) - 2 breasts (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $100.30 **Benefit:** 75% = $75.25 85% = $85.30
59312	RADIOGRAPHIC EXAMINATION OF BOTH BREASTS, in conjunction with a surgical procedure on each breast, using interventional techniques - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $87.00 **Benefit:** 75% = $65.25 85% = $73.95
59313	RADIOGRAPHIC EXAMINATION OF BOTH BREASTS, in conjunction with a surgical procedure on each breast, using interventional techniques - (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $43.50 **Benefit:** 75% = $32.65 85% = $37.00
59314	RADIOGRAPHIC EXAMINATION OF 1 BREAST, in conjunction with a surgical procedure using interventional techniques - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $52.50 **Benefit:** 75% = $39.40 85% = $44.65
59315	RADIOGRAPHIC EXAMINATION OF 1 BREAST, in conjunction with a surgical procedure using interventional techniques - (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $26.25 **Benefit:** 75% = $19.70 85% = $22.35
59318	RADIOGRAPHIC EXAMINATION OF EXCISED BREAST TISSUE to confirm satisfactory excision of 1 or more lesions in 1 breast or both following pre-operative localisation in conjunction with a service under item 31536 - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.05 **Benefit:** 75% = $35.30 85% = $40.00
59319	RADIOGRAPHIC EXAMINATION OF EXCISED BREAST TISSUE to confirm satisfactory excision of 1 or more lesions in 1 breast or both following pre-operative localisation in conjunction with a service

I3. DIAGNOSTIC RADIOLOGY	10. RADIOGRAPHIC EXAMINATION OF BREASTS
	under item 31536 - (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $23.55 **Benefit:** 75% = $17.70 85% = $20.05

I3. DIAGNOSTIC RADIOLOGY	12. RADIOGRAPHIC EXAMINATION WITH OPAQUE OR CONTRAST MEDIA
	Group I3. Diagnostic Radiology
	Subgroup 12. Radiographic Examination With Opaque Or Contrast Media
59700	DISCOGRAPHY, each disc, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $96.55 **Benefit:** 75% = $72.45 85% = $82.10
59701	DISCOGRAPHY, each disc, with or without preliminary plain films and with preparation and contrast injection - (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $48.30 **Benefit:** 75% = $36.25 85% = $41.10
59703	DACRYOCYSTOGRAPHY, 1 side, with or without preliminary plain film and with preparation and contrast injection - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $75.90 **Benefit:** 75% = $56.95 85% = $64.55
59704	DACRYOCYSTOGRAPHY, 1 side, with or without preliminary plain film and with preparation and contrast injection - (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $37.95 **Benefit:** 75% = $28.50 85% = $32.30
59712	HYSTEROSALPINGOGRAPHY, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $113.70 **Benefit:** 75% = $85.30 85% = $96.65
59713	HYSTEROSALPINGOGRAPHY, with or without preliminary plain films and with preparation and contrast injection - (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $56.85 **Benefit:** 75% = $42.65 85% = $48.35
59715	BRONCHOGRAPHY, one side, with or without preliminary plain films and with preparation and contrast injection, on a person under 16 years of age - (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $143.55 **Benefit:** 75% = $107.70 85% = $122.05
59716	BRONCHOGRAPHY, one side, with or without preliminary plain films and with preparation and contrast injection, on a person under 16 years of age - (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $71.80 **Benefit:** 75% = $53.85 85% = $61.05

59718	PHLEBOGRAPHY, 1 side, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $134.65 **Benefit:** 75% = $101.00 85% = $114.50
59719	PHLEBOGRAPHY, 1 side, with or without preliminary plain films and with preparation and contrast injection - (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $67.35 **Benefit:** 75% = $50.55 85% = $57.25
59724	MYELOGRAPHY, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 56219 applies - (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $226.45 **Benefit:** 75% = $169.85 85% = $192.50
59725	MYELOGRAPHY, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 56219 or 56259 applies - (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $113.25 **Benefit:** 75% = $84.95 85% = $96.30
59733	SIALOGRAPHY, 1 side, with preparation and contrast injection, not being a service associated with a service to which item 57918 applies - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $107.70 **Benefit:** 75% = $80.80 85% = $91.55
59734	SIALOGRAPHY, 1 side, with preparation and contrast injection, not being a service associated with a service to which item 57918 or 57932 applies - (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $53.85 **Benefit:** 75% = $40.40 85% = $45.80
59739	SINOGRAM OR FISTULOGRAM, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $73.75 **Benefit:** 75% = $55.35 85% = $62.70
59740	SINOGRAM OR FISTULOGRAM, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection - (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $36.90 **Benefit:** 75% = $27.70 85% = $31.40
59751	ARTHROGRAPHY, each joint, excluding the facet (zygapophyseal) joints of the spine, single or double contrast study, with or without preliminary plain films and with preparation and contrast injection - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $139.15 **Benefit:** 75% = $104.40 85% = $118.30
59752	ARTHROGRAPHY, each joint, excluding the facet (zygapophyseal) joints of the spine, single or double contrast study, with or without preliminary plain films and with preparation and contrast injection - (R) (NK) (See para IN.0.19 of explanatory notes to this Category)

	Fee: $69.60 **Benefit:** 75% = $52.20 85% = $59.20
59754	LYMPHANGIOGRAPHY, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection - (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $219.35 **Benefit:** 75% = $164.55 85% = $186.45
59755	LYMPHANGIOGRAPHY, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection - (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $109.70 **Benefit:** 75% = $82.30 85% = $93.25
59763	AIR INSUFFLATION during video - fluoroscopic imaging including associated consultation (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $133.90 **Benefit:** 75% = $100.45 85% = $113.85
59764	AIR INSUFFLATION during video - fluoroscopic imaging including associated consultation (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $66.95 **Benefit:** 75% = $50.25 85% = $56.95

	Group I3. Diagnostic Radiology
	Subgroup 13. Angiography
59903	Angiocardiography, including the service mentioned in item 59970, 59974, 61109 or 61110, not being a service to which item 59912 or 59925 applies (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $114.55 **Benefit:** 75% = $85.95 85% = $97.40
59912	Selective coronary arteriography, including the service mentioned in item 59970, 59974, 61109 or 61110, not being a service to which item 59903 or 59925 applies (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $305.20 **Benefit:** 75% = $228.90 85% = $259.45
59925	Selective coronary arteriography and angiocardiography, including a service mentioned in item 59903, 59912, 59970, 59974, 61109 or 61110 (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $362.45 **Benefit:** 75% = $271.85 85% = $308.10
59970	ANGIOGRAPHY AND/OR DIGITAL SUBTRACTION ANGIOGRAPHY with fluoroscopy and image acquisition using a mobile image intensifier, 1 or more regions including any preliminary plain films, preparation and contrast injection (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $168.30 **Benefit:** 75% = $126.25 85% = $143.10
59971	Angiocardiography, including the service mentioned in item 59970, 59974, 61109 or 61110, not being a service to which item 59972 or 59973 applies (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)

	Fee: $57.30 **Benefit:** 75% = $43.00 85% = $48.75
59972	Selective coronary arteriography, including the service mentioned in item 59970, 59974, 61109 or 61110, not being a service to which item 59971 or 59973 applies (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $152.60 **Benefit:** 75% = $114.45 85% = $129.75
59973	Selective coronary arteriography and angiocardiography, including a service mentioned in item 59970, 59971, 59972, 59974, 61109 or 61110 (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $181.25 **Benefit:** 75% = $135.95 85% = $154.10
59974	ANGIOGRAPHY AND/OR DIGITAL SUBTRACTION ANGIOGRAPHY with fluoroscopy and image acquisition using a mobile image intensifier, 1 or more regions including any preliminary plain films, preparation and contrast injection (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $84.20 **Benefit:** 75% = $63.15 85% = $71.60
60000	BY DIGITAL SUBTRACTION TECHNIQUE DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 1 to 3 data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $564.00 **Benefit:** 75% = $423.00 85% = $479.40
60001	Digital subtraction angiography, examination of head and neck with or without arch aortography - 1 to 3 data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $282.00 **Benefit:** 75% = $211.50 85% = $239.70
60003	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 4 to 6 data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $827.10 **Benefit:** 75% = $620.35 85% = $742.40
60004	Digital subtraction angiography, examination of head and neck with or without arch aortography - 4 to 6 data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $413.55 **Benefit:** 75% = $310.20 85% = $351.55
60006	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 7 to 9 data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,176.10 **Benefit:** 75% = $882.10 85% = $1091.40
60007	Digital subtraction angiography, examination of head and neck with or without arch aortography - 7 to 9 data acquisition runs (R) (NK) (Anaes.)

	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $588.05 **Benefit:** 75% = $441.05 85% = $503.35
60009	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 10 or more data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,376.30 **Benefit:** 75% = $1032.25 85% = $1291.60
60010	Digital subtraction angiography, examination of head and neck with or without arch aortography - 10 or more data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $688.15 **Benefit:** 75% = $516.15 85% = $603.45
60012	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 1 to 3 data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $564.00 **Benefit:** 75% = $423.00 85% = $479.40
60013	Digital subtraction angiography, examination of thorax - 1 to 3 data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $282.00 **Benefit:** 75% = $211.50 85% = $239.70
60015	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 4 to 6 data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $827.10 **Benefit:** 75% = $620.35 85% = $742.40
60016	Digital subtraction angiography, examination of thorax - 4 to 6 data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $413.55 **Benefit:** 75% = $310.20 85% = $351.55
60018	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 7 to 9 data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,176.10 **Benefit:** 75% = $882.10 85% = $1091.40
60019	Digital subtraction angiography, examination of thorax - 7 to 9 data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $588.05 **Benefit:** 75% = $441.05 85% = $503.35
60021	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 10 or more data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,376.30 **Benefit:** 75% = $1032.25 85% = $1291.60
60022	Digital subtraction angiography, examination of thorax - 10 or more data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $688.15 **Benefit:** 75% = $516.15 85% = $603.45
60024	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 1 to 3 data acquisition runs (R) (K) (Anaes.)

	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $564.00 **Benefit:** 75% = $423.00 85% = $479.40
60025	Digital subtraction angiography, examination of abdomen - 1 to 3 data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $282.00 **Benefit:** 75% = $211.50 85% = $239.70
60027	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 4 to 6 data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $827.10 **Benefit:** 75% = $620.35 85% = $742.40
60028	Digital subtraction angiography, examination of abdomen - 4 to 6 data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $413.55 **Benefit:** 75% = $310.20 85% = $351.55
60030	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 7 to 9 data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,176.10 **Benefit:** 75% = $882.10 85% = $1091.40
60031	Digital subtraction angiography, examination of abdomen - 7 to 9 data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $588.05 **Benefit:** 75% = $441.05 85% = $503.35
60033	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 10 or more data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,376.30 **Benefit:** 75% = $1032.25 85% = $1291.60
60034	Digital subtraction angiography, examination of abdomen - 10 or more data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $688.15 **Benefit:** 75% = $516.15 85% = $603.45
60036	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 1 to 3 data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $564.00 **Benefit:** 75% = $423.00 85% = $479.40
60037	Digital subtraction angiography, examination of upper limb or limbs - 1 to 3 data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $282.00 **Benefit:** 75% = $211.50 85% = $239.70
60039	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 4 to 6 data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $827.10 **Benefit:** 75% = $620.35 85% = $742.40

60040	Digital subtraction angiography, examination of upper limb or limbs - 4 to 6 data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $413.55 **Benefit:** 75% = $310.20 85% = $351.55
60042	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 7 to 9 data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,176.10 **Benefit:** 75% = $882.10 85% = $1091.40
60043	Digital subtraction angiography, examination of upper limb or limbs - 7 to 9 data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $588.05 **Benefit:** 75% = $441.05 85% = $503.35
60045	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 10 or more data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,376.30 **Benefit:** 75% = $1032.25 85% = $1291.60
60046	Digital subtraction angiography, examination of upper limb or limbs - 10 or more data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $688.15 **Benefit:** 75% = $516.15 85% = $603.45
60048	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 1 to 3 data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $564.00 **Benefit:** 75% = $423.00 85% = $479.40
60049	Digital subtraction angiography, examination of lower limb or limbs - 1 to 3 data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $282.00 **Benefit:** 75% = $211.50 85% = $239.70
60051	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 4 to 6 data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $827.10 **Benefit:** 75% = $620.35 85% = $742.40
60052	Digital subtraction angiography, examination of lower limb or limbs - 4 to 6 data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $413.55 **Benefit:** 75% = $310.20 85% = $351.55
60054	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 7 to 9 data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,176.10 **Benefit:** 75% = $882.10 85% = $1091.40
60055	Digital subtraction angiography, examination of lower limb or limbs - 7 to 9 data acquisition runs (R)

	(NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $588.05 **Benefit:** 75% = $441.05 85% = $503.35
60057	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 10 or more data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,376.30 **Benefit:** 75% = $1032.25 85% = $1291.60
60058	Digital subtraction angiography, examination of lower limb or limbs - 10 or more data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $688.15 **Benefit:** 75% = $516.15 85% = $603.45
60060	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 1 to 3 data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $564.00 **Benefit:** 75% = $423.00 85% = $479.40
60061	Digital subtraction angiography, examination of aorta and lower limb or limbs - 1 to 3 data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $282.00 **Benefit:** 75% = $211.50 85% = $239.70
60063	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 4 to 6 data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $827.10 **Benefit:** 75% = $620.35 85% = $742.40
60064	Digital subtraction angiography, examination of aorta and lower limb or limbs - 4 to 6 data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $413.55 **Benefit:** 75% = $310.20 85% = $351.55
60066	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 7 to 9 data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,176.10 **Benefit:** 75% = $882.10 85% = $1091.40
60067	Digital subtraction angiography, examination of aorta and lower limb or limbs - 7 to 9 data acquisition runs (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $588.05 **Benefit:** 75% = $441.05 85% = $503.35
60069	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 10 or more data acquisition runs (R) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,376.30 **Benefit:** 75% = $1032.25 85% = $1291.60
60070	Digital subtraction angiography, examination of aorta and lower limb or limbs - 10 or more data acquisition runs (R) (NK) (Anaes.)

	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $688.15 **Benefit:** 75% = $516.15 85% = $603.45
60072	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique - 1 vessel (NR) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $48.10 **Benefit:** 75% = $36.10 85% = $40.90
60073	Selective arteriography or selective venography by digital subtraction angiography technique - one vessel (NR) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $24.05 **Benefit:** 75% = $18.05 85% = $20.45
60075	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique - 2 vessels (NR) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $96.10 **Benefit:** 75% = $72.10 85% = $81.70
60076	Selective arteriography or selective venography by digital subtraction angiography technique - 2 vessels (NR) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $48.05 **Benefit:** 75% = $36.05 85% = $40.85
60078	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique - 3 or more vessels (NR) (K) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $144.25 **Benefit:** 75% = $108.20 85% = $122.65
60079	Selective arteriography or selective venography by digital subtraction angiography technique - 3 or more vessels (NR) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $72.15 **Benefit:** 75% = $54.15 85% = $61.35

	Group I3. Diagnostic Radiology
	Subgroup 15. Fluoroscopic Examination
60500	FLUOROSCOPY, with general anaesthesia (not being a service associated with a radiographic examination) (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $43.40 **Benefit:** 75% = $32.55 85% = $36.90
60501	FLUOROSCOPY, with general anaesthesia (not being a service associated with a radiographic examination) (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $21.70 **Benefit:** 75% = $16.30 85% = $18.45
60503	FLUOROSCOPY, without general anaesthesia (not being a service associated with a radiographic examination) (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $29.75 **Benefit:** 75% = $22.35 85% = $25.30

I3. DIAGNOSTIC RADIOLOGY	15. FLUOROSCOPIC EXAMINATION
60504	FLUOROSCOPY, without general anaesthesia (not being a service associated with a radiographic examination) (R) (NK) **Fee:** $14.90 **Benefit:** 75% = $11.20 85% = $12.70
60506	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting less than 1 hour, not being a service associated with a service to which another item in this Table applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $63.75 **Benefit:** 75% = $47.85 85% = $54.20
60507	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting less than 1 hour, not being a service associated with a service to which another item in this Table applies (R) (NK) **Fee:** $31.90 **Benefit:** 75% = $23.95 85% = $27.15
60509	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this Table applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $98.90 **Benefit:** 75% = $74.20 85% = $84.10
60510	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this Table applies (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $49.45 **Benefit:** 75% = $37.10 85% = $42.05

I3. DIAGNOSTIC RADIOLOGY	16. PREPARATION FOR RADIOLOGICAL PROCEDURE
	Group I3. Diagnostic Radiology
	Subgroup 16. Preparation For Radiological Procedure
60918	ARTERIOGRAPHY (peripheral) or PHLEBOGRAPHY 1 vessel, when used in association with a service to which items 59903, 59912, 59925, 59970, 59971 59972, 59973 or 59974 applies, not being a service associated with a service to which items 60000 to 60079 inclusive apply (NR) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10
60927	SELECTIVE ARTERIOGRAM or PHLEBOGRAM, when used in association with a service to which items 59903, 59912, 59925, 59970, 59971 59972, 59973 or 59974 applies, not being a service associated with a service to which items 60000 to 60079 inclusive apply (NR) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.05 **Benefit:** 75% = $28.55 85% = $32.35

I3. DIAGNOSTIC RADIOLOGY	17. INTERVENTIONAL TECHNIQUES
	Group I3. Diagnostic Radiology
	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

I3. DIAGNOSTIC RADIOLOGY	17. INTERVENTIONAL TECHNIQUES
	which another item in this Table applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $258.90 **Benefit:** 75% = $194.20 85% = $220.10
61110	FLUOROSCOPY in an ANGIOGRAPHY SUITE with image intensification, in conjunction with a surgical procedure, using interventional techniques, not being a service associated with a service to which another item in this Table applies (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $129.45 **Benefit:** 75% = $97.10 85% = $110.05

I3. DIAGNOSTIC RADIOLOGY	18. MISCELLANEOUS
	Group I3. Diagnostic Radiology
	Subgroup 18. Miscellaneous
New 57541	Fee for a service rendered using first eligible x-ray procedure carried out during attendance at residential aged care facility, where the service has been requested by a medical practitioner who has attended the patient in person and the request identifies one or more of the following indications: d. the patient has experienced a fall and one or more of the following items apply to the service 57509, 57515, 57521, 57527, 57530, 57533, 57539, 57703, 57705, 57709, 57711, 57712, 57714, 57715, 57717, 58521, 58523, 58524, 58526, 58527, 58529, 57536; or e. pneumonia or heart failure is suspected and item 58503 or 58505 applies to the service; or f. acute abdomen or bowel obstruction is suspected and item 58903 or 58905 applies to the service. This call-out fee can be claimed once only per visit at a residential aged care facility irrespective of the number of patients attended. NOTE: If the service is bulked billed 95% of the fee is payable. The multiple services rule does not apply to this item. (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $73.65 **Benefit:** 75% = $55.25 85% = $62.65

I4. NUCLEAR MEDICINE IMAGING	1. NUCLEAR MEDICINE - NON PET
	Group I4. Nuclear Medicine Imaging
	Subgroup 1. Nuclear medicine - non PET
61302	SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - planar imaging (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.85 **Benefit:** 75% = $336.65 85% = $381.55
61303	SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - with single photon emission tomography and with planar imaging when undertaken (R)

	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $565.30 **Benefit:** 75% = $424.00 85% = $480.60
61306	COMBINED STRESS AND REST, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - planar imaging (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $709.70 **Benefit:** 75% = $532.30 85% = $625.00
61307	COMBINED STRESS AND REST, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - with single photon emission tomography and with planar imaging when undertaken (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $834.90 **Benefit:** 75% = $626.20 85% = $750.20
61310	MYOCARDIAL INFARCT-AVID-STUDY, with planar imaging and single photon emission tomography, OR planar imaging or single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $367.30 **Benefit:** 75% = $275.50 85% = $312.25
61311	Single stress or rest myocardial perfusion study—with PET (R) **Fee:** $565.30 **Benefit:** 75% = $424.00 85% = $480.60
61313	GATED CARDIAC BLOOD POOL STUDY, (equilibrium), with planar imaging and single photon emission tomography OR planar imaging or single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $303.35 **Benefit:** 75% = $227.55 85% = $257.85
61314	GATED CARDIAC BLOOD POOL STUDY, and first pass blood flow or cardiac shunt study, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $420.00 **Benefit:** 75% = $315.00 85% = $357.00
61316	GATED CARDIAC BLOOD POOL STUDY, with intervention, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $381.15 **Benefit:** 75% = $285.90 85% = $324.00
61317	GATED CARDIAC BLOOD POOL STUDY, with intervention and first pass blood flow study or cardiac shunt study, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $492.40 **Benefit:** 75% = $369.30 85% = $418.55
61320	CARDIAC FIRST PASS BLOOD FLOW STUDY OR CARDIAC SHUNT STUDY, not being a service to which another item in this Group applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $228.90 **Benefit:** 75% = $171.70 85% = $194.60
61328	LUNG PERFUSION STUDY, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R)

	(See para IN.0.19, IN.1.2 of explanatory notes to this Category) **Fee:** $227.65 **Benefit:** 75% = $170.75 85% = $193.55
61332	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 PET (R) **Fee:** $834.90 **Benefit:** 75% = $626.20 85% = $750.20
61333	Lung perfusion study and lung ventilation study using galligas or 68Ga-MAA, with PET (R) **Fee:** $443.35 **Benefit:** 75% = $332.55 85% = $376.85
61336	Cerebral perfusion study, with PET (R) **Fee:** $605.05 **Benefit:** 75% = $453.80 85% = $520.35
61337	Bone study—whole body, with PET, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) **Fee:** $479.80 **Benefit:** 75% = $359.85 85% = $407.85
61340	LUNG VENTILATION STUDY using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography OR planar imaging or single photon emission tomography (R) (See para IN.0.19, IN.1.2 of explanatory notes to this Category) **Fee:** $253.00 **Benefit:** 75% = $189.75 85% = $215.05
61341	Bone study—whole body and PET, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) **Fee:** $600.70 **Benefit:** 75% = $450.55 85% = $516.00
61344	Computed tomography performed at the same time and covering the same body area as positron emission tomography covered by items 61311, 61332, 61333, 61336, 61337 and 61341, for the purpose of anatomic localisation or attenuation correction if no separate diagnostic CT report is issued (R) **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00
61348	LUNG PERFUSION STUDY AND LUNG VENTILATION STUDY using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) (See para IN.0.19, IN.1.2 of explanatory notes to this Category) **Fee:** $443.35 **Benefit:** 75% = $332.55 85% = $376.85
61352	LIVER AND SPLEEN STUDY (colloid) - planar imaging (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $259.35 **Benefit:** 75% = $194.55 85% = $220.45
61353	LIVER AND SPLEEN STUDY (colloid), with single photon emission tomography and with planar imaging when undertaken (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $386.60 **Benefit:** 75% = $289.95 85% = $328.65
61356	RED BLOOD CELL SPLEEN OR LIVER STUDY, including single photon emission tomography when undertaken (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $392.80 **Benefit:** 75% = $294.60 85% = $333.90
61360	HEPATOBILIARY STUDY, including morphine administration or pre-treatment with a cholagogue

	when performed (R) (K) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.35 **Benefit:** 75% = $302.55 85% = $342.85
61361	HEPATOBILIARY STUDY with formal quantification following baseline imaging, using a cholagogue (R) (K) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $461.40 **Benefit:** 75% = $346.05 85% = $392.20
61364	BOWEL HAEMORRHAGE STUDY (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $496.95 **Benefit:** 75% = $372.75 85% = $422.45
61368	MECKEL'S DIVERTICULUM STUDY (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $223.10 **Benefit:** 75% = $167.35 85% = $189.65
61369	INDIUM-LABELLED OCTREOTIDE STUDY - including single photon emission tomography when undertaken, where: (a) there is a suspected gastro-entero-pancreatic endocrine tumour, based on biochemical evidence, with negative or equivocal conventional imaging; or (b) a surgically amenable gastro-entero-pancreatic endocrine tumour has been identified based on conventional techniques, in order to exclude additional disease sites. (R) **Fee:** $2,015.75 **Benefit:** 75% = $1511.85 85% = $1931.05
61372	SALIVARY STUDY (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $223.10 **Benefit:** 75% = $167.35 85% = $189.65
61373	GASTRO-OESOPHAGEAL REFLUX STUDY, including delayed imaging on a separate occasion when undertaken (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $489.70 **Benefit:** 75% = $367.30 85% = $416.25
61376	OESOPHAGEAL CLEARANCE STUDY (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $143.35 **Benefit:** 75% = $107.55 85% = $121.85
61381	GASTRIC EMPTYING STUDY, using single tracer (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $574.35 **Benefit:** 75% = $430.80 85% = $489.65
61383	COMBINED SOLID AND LIQUID GASTRIC EMPTYING STUDY using dual isotope technique or the same isotope on separate days (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $624.95 **Benefit:** 75% = $468.75 85% = $540.25

61384	RADIONUCLIDE COLONIC TRANSIT STUDY (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $687.70 **Benefit:** 75% = $515.80 85% = $603.00
61386	RENAL STUDY, including perfusion and renogram images and computer analysis OR cortical study with planar imaging (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $332.50 **Benefit:** 75% = $249.40 85% = $282.65
61387	RENAL CORTICAL STUDY, with single photon emission tomography and planar quantification (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $430.75 **Benefit:** 75% = $323.10 85% = $366.15
61389	SINGLE RENAL STUDY with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $370.55 **Benefit:** 75% = $277.95 85% = $315.00
61390	RENAL STUDY with diuretic administration following a baseline study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $409.95 **Benefit:** 75% = $307.50 85% = $348.50
61393	COMBINED EXAMINATION INVOLVING A RENAL STUDY following angiotensin converting enzyme (ACE) inhibitor provocation and a baseline study, in either order and related to a single referral episode (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $605.50 **Benefit:** 75% = $454.15 85% = $520.80
61397	CYSTOURETEROGRAM (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $246.85 **Benefit:** 75% = $185.15 85% = $209.85
61401	TESTICULAR STUDY (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $162.30 **Benefit:** 75% = $121.75 85% = $138.00
61402	CEREBRAL PERFUSION STUDY, with single photon emission tomography and with planar imaging when undertaken (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $605.05 **Benefit:** 75% = $453.80 85% = $520.35
61405	BRAIN STUDY WITH BLOOD BRAIN BARRIER AGENT, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $346.00 **Benefit:** 75% = $259.50 85% = $294.10
61409	CEREBRO-SPINAL FLUID TRANSPORT STUDY, with imaging on 2 or more separate occasions (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $873.50 **Benefit:** 75% = $655.15 85% = $788.80
61413	CEREBRO-SPINAL FLUID SHUNT PATENCY STUDY (R)

	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $225.95 **Benefit:** 75% = $169.50 85% = $192.10
61417	DYNAMIC BLOOD FLOW STUDY OR REGIONAL BLOOD VOLUME QUANTITATIVE STUDY, not being a service associated with a service to which another item in this Group applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $118.85 **Benefit:** 75% = $89.15 85% = $101.05
61421	BONE STUDY - whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $479.80 **Benefit:** 75% = $359.85 85% = $407.85
61425	BONE STUDY - whole body and single photon emission tomography, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $600.70 **Benefit:** 75% = $450.55 85% = $516.00
61426	WHOLE BODY STUDY using iodine (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $554.80 **Benefit:** 75% = $416.10 85% = $471.60
61429	WHOLE BODY STUDY using gallium (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $543.00 **Benefit:** 75% = $407.25 85% = $461.55
61430	WHOLE BODY STUDY using gallium, with single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $659.45 **Benefit:** 75% = $494.60 85% = $574.75
61433	WHOLE BODY STUDY using cells labelled with technetium (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $496.95 **Benefit:** 75% = $372.75 85% = $422.45
61434	WHOLE BODY STUDY using cells labelled with technetium, with single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $615.40 **Benefit:** 75% = $461.55 85% = $530.70
61437	WHOLE BODY STUDY using thallium (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $542.75 **Benefit:** 75% = $407.10 85% = $461.35
61438	WHOLE BODY STUDY using thallium, with single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $672.95 **Benefit:** 75% = $504.75 85% = $588.25
61441	BONE MARROW STUDY - whole body using technetium labelled bone marrow agents (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $489.70 **Benefit:** 75% = $367.30 85% = $416.25
61442	WHOLE BODY STUDY, using gallium - with single photon emission tomography of 2 or more body

	regions acquired separately (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $752.35 **Benefit:** 75% = $564.30 85% = $667.65
61445	BONE MARROW STUDY - localised using technetium labelled agent (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $286.80 **Benefit:** 75% = $215.10 85% = $243.80
61446	LOCALISED BONE OR JOINT STUDY, including when undertaken, blood flow, blood pool and repeat imaging on a separate occasion (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $333.55 **Benefit:** 75% = $250.20 85% = $283.55
61449	LOCALISED BONE OR JOINT STUDY and single photon emission tomography, including when undertaken, blood flow, blood pool and imaging on a separate occasion (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $456.20 **Benefit:** 75% = $342.15 85% = $387.80
61450	LOCALISED STUDY using gallium (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $397.55 **Benefit:** 75% = $298.20 85% = $337.95
61453	LOCALISED STUDY using gallium, with single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $514.70 **Benefit:** 75% = $386.05 85% = $437.50
61454	LOCALISED STUDY using cells labelled with technetium (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $348.10 **Benefit:** 75% = $261.10 85% = $295.90
61457	LOCALISED STUDY using cells labelled with technetium, with single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $470.45 **Benefit:** 75% = $352.85 85% = $399.90
61458	LOCALISED STUDY using thallium (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $396.95 **Benefit:** 75% = $297.75 85% = $337.45
61461	LOCALISED STUDY using thallium, with single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $527.85 **Benefit:** 75% = $395.90 85% = $448.70
61462	REPEAT PLANAR AND SINGLE PHOTON EMISSION TOMOGRAPHY IMAGING, OR REPEAT PLANAR IMAGING OR SINGLE PHOTON EMISSION TOMOGRAPHY IMAGING on an occasion subsequent to the performance of any one of items 61364, 61426, 61429, 61430, 61442, 61450, 61453, 61469, 61484 or 61485 where there is no additional administration of radiopharmaceutical and where the previous radionuclide scan was abnormal or equivocal. (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $129.00 **Benefit:** 75% = $96.75 85% = $109.65

61469	LYMPHOSCINTIGRAPHY (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $348.10 **Benefit:** 75% = $261.10 85% = $295.90
61473	THYROID STUDY including uptake measurement when undertaken (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $175.40 **Benefit:** 75% = $131.55 85% = $149.10
61480	PARATHYROID STUDY, planar imaging and single photon emission tomography when undertaken (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $386.85 **Benefit:** 75% = $290.15 85% = $328.85
61484	ADRENAL STUDY (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $880.85 **Benefit:** 75% = $660.65 85% = $796.15
61485	ADRENAL STUDY, with single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $999.20 **Benefit:** 75% = $749.40 85% = $914.50
61495	TEAR DUCT STUDY (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $223.10 **Benefit:** 75% = $167.35 85% = $189.65
61499	PARTICLE PERFUSION STUDY (intra-arterial) or Le Veen shunt study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $253.00 **Benefit:** 75% = $189.75 85% = $215.05
61505	CT scan performed at the same time and covering the same body area as single photon emission tomography for the purpose of anatomic localisation or attenuation correction where no separate diagnostic CT report is issued and only in association with items 61302 - 61650 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00
61650	LEUKOSCAN STUDY, for use in diagnostic imaging of the long bones and feet in patients with suspected osteomyelitis, and where patients do not have access to *ex-vivo WBC scanning.* (R) *Note* LeukoScan is only indicated for diagnostic imaging in patients suspected of infection in the long bones and feet, including those with diabetic ulcers. The descriptor does not cover patients who are being investigated for other sites of infection (See para IN.0.19 of explanatory notes to this Category) **Fee:** $878.70 **Benefit:** 75% = $659.05 85% = $794.00
61651	SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - planar imaging (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $224.45 **Benefit:** 75% = $168.35 85% = $190.80
61652	SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - with single photon emission

	tomography and with planar imaging when undertaken (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $282.65 **Benefit:** 75% = $212.00 85% = $240.30
61653	COMBINED STRESS AND REST, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - planar imaging (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $354.85 **Benefit:** 75% = $266.15 85% = $301.65
61654	COMBINED STRESS AND REST, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - with single photon emission tomography and with planar imaging when undertaken (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $417.45 **Benefit:** 75% = $313.10 85% = $354.85
61655	MYOCARDIAL INFARCT-AVID-STUDY, with planar imaging and single photon emission tomography, OR planar imaging or single photon emission tomography (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $183.65 **Benefit:** 75% = $137.75 85% = $156.15
61656	GATED CARDIAC BLOOD POOL STUDY, (equilibrium), with planar imaging and single photon emission tomography OR planar imaging or single photon emission tomography (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $151.70 **Benefit:** 75% = $113.80 85% = $128.95
61657	GATED CARDIAC BLOOD POOL STUDY, and first pass blood flow or cardiac shunt study, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $210.00 **Benefit:** 75% = $157.50 85% = $178.50
61658	GATED CARDIAC BLOOD POOL STUDY, with intervention, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $190.60 **Benefit:** 75% = $142.95 85% = $162.05
61659	GATED CARDIAC BLOOD POOL STUDY, with intervention and first pass blood flow study or cardiac shunt study, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $246.20 **Benefit:** 75% = $184.65 85% = $209.30
61660	CARDIAC FIRST PASS BLOOD FLOW STUDY OR CARDIAC SHUNT STUDY, not being a service to which another item in this Group applies (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $114.45 **Benefit:** 75% = $85.85 85% = $97.30
61661	LUNG PERFUSION STUDY, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $113.85 **Benefit:** 75% = $85.40 85% = $96.80

61662	LUNG VENTILATION STUDY using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography OR planar imaging or single photon emission tomography (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $126.50 **Benefit:** 75% = $94.90 85% = $107.55
61663	LUNG PERFUSION STUDY AND LUNG VENTILATION STUDY using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $221.70 **Benefit:** 75% = $166.30 85% = $188.45
61664	LIVER AND SPLEEN STUDY (colloid) - planar imaging (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $129.70 **Benefit:** 75% = $97.30 85% = $110.25
61665	LIVER AND SPLEEN STUDY (colloid), with single photon emission tomography and with planar imaging when undertaken (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $193.30 **Benefit:** 75% = $145.00 85% = $164.35
61666	RED BLOOD CELL SPLEEN OR LIVER STUDY, including single photon emission tomography when undertaken (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $196.40 **Benefit:** 75% = $147.30 85% = $166.95
61667	HEPATOBILIARY STUDY, including morphine administration or pre-treatment with a cholagogue when performed (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.70 **Benefit:** 75% = $151.30 85% = $171.45
61668	HEPATOBILIARY STUDY with formal quantification following baseline imaging, using a cholagogue (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $230.70 **Benefit:** 75% = $173.05 85% = $196.10
61669	BOWEL HAEMORRHAGE STUDY (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $248.50 **Benefit:** 75% = $186.40 85% = $211.25
61670	MECKEL'S DIVERTICULUM STUDY (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $111.55 **Benefit:** 75% = $83.70 85% = $94.85
61671	INDIUM-LABELLED OCTREOTIDE STUDY - including single photon emission tomography when undertaken, where: (a) there is a suspected gastro-entero-pancreatic endocrine tumour, based on biochemical evidence, with negative or equivocal conventional imaging; or (b) a surgically amenable gastro-entero-pancreatic endocrine tumour has been identified based on

	conventional techniques, in order to exclude additional disease sites. (Ministerial Determination) (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,007.90 **Benefit:** 75% = $755.95 85% = $923.20
61672	SALIVARY STUDY (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $111.55 **Benefit:** 75% = $83.70 85% = $94.85
61673	GASTRO-OESOPHAGEAL REFLUX STUDY, including delayed imaging on a separate occasion when undertaken (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $244.85 **Benefit:** 75% = $183.65 85% = $208.15
61674	OESOPHAGEAL CLEARANCE STUDY (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $71.70 **Benefit:** 75% = $53.80 85% = $60.95
61675	GASTRIC EMPTYING STUDY, using single tracer (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $287.20 **Benefit:** 75% = $215.40 85% = $244.15
61676	COMBINED SOLID AND LIQUID GASTRIC EMPTYING STUDY using dual isotope technique or the same isotope on separate days (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $312.50 **Benefit:** 75% = $234.40 85% = $265.65
61677	RADIONUCLIDE COLONIC TRANSIT STUDY (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $343.85 **Benefit:** 75% = $257.90 85% = $292.30
61678	RENAL STUDY, including perfusion and renogram images and computer analysis OR cortical study with planar imaging (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $166.25 **Benefit:** 75% = $124.70 85% = $141.35
61679	RENAL CORTICAL STUDY, with single photon emission tomography and planar quantification (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $215.40 **Benefit:** 75% = $161.55 85% = $183.10
61680	SINGLE RENAL STUDY with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $185.30 **Benefit:** 75% = $139.00 85% = $157.55
61681	RENAL STUDY with diuretic administration following a baseline study (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $205.00 **Benefit:** 75% = $153.75 85% = $174.25
61682	COMBINED EXAMINATION INVOLVING A RENAL STUDY following angiotensin converting

	enzyme (ACE) inhibitor provocation and a baseline study, in either order and related to a single referral episode (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $302.75 **Benefit:** 75% = $227.10 85% = $257.35
61683	CYSTOURETEROGRAM (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $123.45 **Benefit:** 75% = $92.60 85% = $104.95
61684	TESTICULAR STUDY (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $81.15 **Benefit:** 75% = $60.90 85% = $69.00
61685	CEREBRAL PERFUSION STUDY, with single photon emission tomography and with planar imaging when undertaken (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $302.55 **Benefit:** 75% = $226.95 85% = $257.20
61686	BRAIN STUDY WITH BLOOD BRAIN BARRIER AGENT, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $173.00 **Benefit:** 75% = $129.75 85% = $147.05
61687	CEREBRO-SPINAL FLUID TRANSPORT STUDY, with imaging on 2 or more separate occasions (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $436.75 **Benefit:** 75% = $327.60 85% = $371.25
61688	CEREBRO-SPINAL FLUID SHUNT PATENCY STUDY (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $113.00 **Benefit:** 75% = $84.75 85% = $96.05
61689	DYNAMIC BLOOD FLOW STUDY OR REGIONAL BLOOD VOLUME QUANTITATIVE STUDY, not being a service associated with a service to which another item in this Group applies (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $59.45 **Benefit:** 75% = $44.60 85% = $50.55
61690	BONE STUDY - whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $239.90 **Benefit:** 75% = $179.95 85% = $203.95
61691	BONE STUDY - whole body and single photon emission tomography, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $300.35 **Benefit:** 75% = $225.30 85% = $255.30
61692	WHOLE BODY STUDY using iodine (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $277.40 **Benefit:** 75% = $208.05 85% = $235.80

61693	WHOLE BODY STUDY using gallium (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $271.50 **Benefit:** 75% = $203.65 85% = $230.80
61694	WHOLE BODY STUDY using gallium, with single photon emission tomography (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $329.75 **Benefit:** 75% = $247.35 85% = $280.30
61695	WHOLE BODY STUDY using cells labelled with technetium (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $248.50 **Benefit:** 75% = $186.40 85% = $211.25
61696	WHOLE BODY STUDY using cells labelled with technetium, with single photon emission tomography (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $307.70 **Benefit:** 75% = $230.80 85% = $261.55
61697	WHOLE BODY STUDY using thallium (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $271.40 **Benefit:** 75% = $203.55 85% = $230.70
61698	WHOLE BODY STUDY using thallium, with single photon emission tomography (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $336.50 **Benefit:** 75% = $252.40 85% = $286.05
61699	BONE MARROW STUDY - whole body using technetium labelled bone marrow agents (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $244.85 **Benefit:** 75% = $183.65 85% = $208.15
61700	WHOLE BODY STUDY, using gallium - with single photon emission tomography of 2 or more body regions acquired separately (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $376.20 **Benefit:** 75% = $282.15 85% = $319.80
61701	BONE MARROW STUDY - localised using technetium labelled agent (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $143.40 **Benefit:** 75% = $107.55 85% = $121.90
61702	LOCALISED BONE OR JOINT STUDY, including when undertaken, blood flow, blood pool and repeat imaging on a separate occasion (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $166.80 **Benefit:** 75% = $125.10 85% = $141.80
61703	LOCALISED BONE OR JOINT STUDY and single photon emission tomography, including when undertaken, blood flow, blood pool and imaging on a separate occasion (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $228.10 **Benefit:** 75% = $171.10 85% = $193.90
61704	LOCALISED STUDY using gallium (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $198.80 **Benefit:** 75% = $149.10 85% = $169.00

61705	LOCALISED STUDY using gallium, with single photon emission tomography (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $257.35 **Benefit:** 75% = $193.05 85% = $218.75
61706	LOCALISED STUDY using cells labelled with technetium (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $174.05 **Benefit:** 75% = $130.55 85% = $147.95
61707	LOCALISED STUDY using cells labelled with technetium, with single photon emission tomography (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $235.25 **Benefit:** 75% = $176.45 85% = $200.00
61708	LOCALISED STUDY using thallium (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $198.50 **Benefit:** 75% = $148.90 85% = $168.75
61709	LOCALISED STUDY using thallium, with single photon emission tomography (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $263.95 **Benefit:** 75% = $198.00 85% = $224.40
61710	REPEAT PLANAR AND SINGLE PHOTON EMISSION TOMOGRAPHY IMAGING, OR REPEAT PLANAR IMAGING OR SINGLE PHOTON EMISSION TOMOGRAPHY IMAGING on an occasion subsequent to the performance of any one of items 61364, 61426, 61429, 61430, 61442, 61450, 61453, 61469, 61484, 61485, 61669, 61692, 61693, 61694, 61700, 61704, 61705, 61712, 61715 or 61716 where there is no additional administration of radiopharmaceutical and where the previous radionuclide scan was abnormal or equivocal. (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $64.50 **Benefit:** 75% = $48.40 85% = $54.85
61712	LYMPHOSCINTIGRAPHY (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $174.05 **Benefit:** 75% = $130.55 85% = $147.95
61713	THYROID STUDY including uptake measurement when undertaken (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $87.70 **Benefit:** 75% = $65.80 85% = $74.55
61714	PARATHYROID STUDY, planar imaging and single photon emission tomography when undertaken (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $193.45 **Benefit:** 75% = $145.10 85% = $164.45
61715	ADRENAL STUDY (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $440.45 **Benefit:** 75% = $330.35 85% = $374.40
61716	ADRENAL STUDY, with single photon emission tomography (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $499.60 **Benefit:** 75% = $374.70 85% = $424.70

I4. NUCLEAR MEDICINE IMAGING	1. NUCLEAR MEDICINE - NON PET
61717	TEAR DUCT STUDY (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $111.55 **Benefit:** 75% = $83.70 85% = $94.85
61718	PARTICLE PERFUSION STUDY (intra-arterial) or Le Veen shunt study (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $126.50 **Benefit:** 75% = $94.90 85% = $107.55
61719	CT scan performed at the same time and covering the same body area as single photon emission tomography for the purpose of anatomic localisation or attenuation correction where no separate diagnostic CT report is issued and only in association with items 61302 - 61729 (R) (NK) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $50.00 **Benefit:** 75% = $37.50 85% = $42.50
61729	LEUKOSCAN STUDY, for use in diagnostic imaging of the long bones and feet in patients with suspected osteomyelitis, and where patients do not have access to ex-vivo WBC scanning. (Ministerial Determination) (NK) Note LeukoScan is only indicated for diagnostic imaging in patients suspected of infection in the long bones and feet, including those with diabetic ulcers. The descriptor does not cover patients who are being investigated for other sites of infection (See para IN.0.19 of explanatory notes to this Category) **Fee:** $439.35 **Benefit:** 75% = $329.55 85% = $373.45

I4. NUCLEAR MEDICINE IMAGING	2. PET
	Group I4. Nuclear Medicine Imaging
	Subgroup 2. PET
61523	Whole body FDG PET study, performed for evaluation of a solitary pulmonary nodule where the lesion is considered unsuitable for transthoracic fine needle aspiration biopsy, or for which an attempt at pathological characterisation has failed.(R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
New 61524	Whole body FDG PET study, performed for the staging of locally advanced (Stage III) breast cancer, for a patient who is considered suitable for active therapy (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
New 61525	Whole body FDG PET study, performed for the evaluation of suspected metastatic or suspected locally or regionally recurrent breast carcinoma, for a patient who is considered suitable for active therapy (R)

	(Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61529	Whole body FDG PET study, performed for the staging of proven non-small cell lung cancer, where curative surgery or radiotherapy is planned (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61538	FDG PET study of the brain for evaluation of suspected residual or recurrent malignant brain tumour based on anatomical imaging findings, after definitive therapy (or during ongoing chemotherapy) in patients who are considered suitable for further active therapy. (R) **Fee:** $901.00 **Benefit:** 75% = $675.75 85% = $816.30
61541	Whole body FDG PET study, following initial therapy, for the evaluation of suspected residual, metastatic or recurrent colorectal carcinoma in patients considered suitable for active therapy (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61553	Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected metastatic or recurrent malignant melanoma in patients considered suitable for active therapy (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $999.00 **Benefit:** 75% = $749.25 85% = $914.30
61559	FDG PET study of the brain, performed for the evaluation of refractory epilepsy which is being evaluated for surgery (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $918.00 **Benefit:** 75% = $688.50 85% = $833.30
61565	Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected residual, metastatic or recurrent ovarian carcinoma in patients considered suitable for active therapy. (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61571	Whole body FDG PET study, for the further primary staging of patients with histologically proven carcinoma of the uterine cervix, at FIGO stage IB2 or greater by conventional staging, prior to planned radical radiation therapy or combined modality therapy with curative intent. (R) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61575	Whole body FDG PET study, for the further staging of patients with confirmed local recurrence of carcinoma of the uterine cervix considered suitable for salvage pelvic chemoradiotherapy or pelvic exenteration with curative intent. (R) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61577	Whole body FDG PET study, performed for the staging of proven oesophageal or GEJ carcinoma, in patients considered suitable for active therapy (R). **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61598	Whole body FDG PET study performed for the staging of biopsy-proven newly diagnosed or recurrent

	head and neck cancer (R). **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61604	Whole body FDG PET study performed for the evaluation of patients with suspected residual head and neck cancer after definitive treatment, and who are suitable for active therapy (R). **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61610	Whole body FDG PET study performed for the evaluation of metastatic squamous cell carcinoma of unknown primary site involving cervical nodes (R). **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61620	Whole body FDG PET study for the initial staging of newly diagnosed or previously untreated Hodgkin or non-Hodgkin lymphoma (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61622	Whole body FDG PET study to assess response to first line therapy either during treatment or within three months of completing definitive first line treatment for Hodgkin or non-Hodgkin lymphoma (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61628	Whole body FDG PET study for restaging following confirmation of recurrence of Hodgkin or non-Hodgkin lymphoma (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61632	Whole body FDG PET study to assess response to second-line chemotherapy if haemopoietic stem cell transplantation is being considered for Hodgkin or non-Hodgkin lymphoma (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $868.30
61640	Whole body FDG PET study for initial staging of patients with biopsy-proven bone or soft tissue sarcoma (excluding gastrointestinal stromal tumour) considered by conventional staging to be potentially curable. (R) **Fee:** $999.00 **Benefit:** 75% = $749.25 85% = $914.30
61646	Whole body FDG PET study for the evaluation of patients with suspected residual or recurrent sarcoma (excluding gastrointestinal stromal tumour) after the initial course of definitive therapy to determine suitability for subsequent therapy with curative intent. (R) **Fee:** $999.00 **Benefit:** 75% = $749.25 85% = $914.30
61647	Whole body ^{68}Ga-DOTA-peptide PET study (including any associated computed tomography scans for anatomic localisation and attenuation correction), if: (a) a gastro-entero-pancreatic neuroendocrine tumour is suspected on the basis of biochemical evidence with negative or equivocal conventional imaging; or (b) both: (i) a surgically amenable gastro-entero-pancreatic neuroendocrine tumour has been identified on the basis of conventional techniques; and

	(ii) the study is for excluding additional disease sites (R) (See para IN.0.19, IN.0.13 of explanatory notes to this Category) **Fee:** $1,053.00 **Benefit:** 75% = $789.75 85% = $968.30

I5. MAGNETIC RESONANCE IMAGING — 1. SCAN OF HEAD - FOR SPECIFIED CONDITIONS

	Group I5. Magnetic Resonance Imaging
	Subgroup 1. Scan Of Head - For Specified Conditions
63001	MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head for: - tumour of the brain or meninges (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63004	- inflammation of the brain or meninges (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63007	- skull base or orbital tumour (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63010	- stereotactic scan of brain, with Fiducials in place, for the sole purpose to allow planning for stereotactic neurosurgery (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $336.00 **Benefit:** 75% = $252.00 85% = $285.60
63013	MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head for: - tumour of the brain or meninges (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63014	- inflammation of the brain or meninges (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63016	- skull base or orbital tumour (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)

I5. MAGNETIC RESONANCE IMAGING	1. SCAN OF HEAD - FOR SPECIFIED CONDITIONS
	Fee: $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63017	- stereotactic scan of brain, with Fiducials in place, for the sole purpose to allow planning for stereotactic neurosurgery (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $168.00 **Benefit:** 75% = $126.00 85% = $142.80

I5. MAGNETIC RESONANCE IMAGING	2. SCAN OF HEAD - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 2. Scan Of Head - For Specified Conditions
	NOTE: Benefits are payable for each service included by Subgroup 2 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head for:
63040	- acoustic neuroma (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $336.00 **Benefit:** 75% = $252.00 85% = $285.60
63043	- pituitary tumour (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63046	- toxic or metabolic or ischaemic encephalopathy (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63049	- demyelinating disease of the brain (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63052	- congenital malformation of the brain or meninges (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63055	- venous sinus thrombosis (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63058	- head trauma (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

63061	- epilepsy (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63064	- stroke (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63067	- carotid or vertebral artery desection (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63070	- intracranial aneurysm (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63073	- intracranial arteriovenous malformation (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63074	NOTE: Benefits are payable for each service included by Subgroup 2 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head for: - acoustic neuroma (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $168.00 **Benefit:** 75% = $126.00 85% = $142.80
63075	- pituitary tumour (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35
63076	- toxic or metabolic or ischaemic encephalopathy (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63077	- demyelinating disease of the brain (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63078	- congenital malformation of the brain or meninges (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40

I5. MAGNETIC RESONANCE IMAGING	2. SCAN OF HEAD - FOR SPECIFIED CONDITIONS
63079	- venous sinus thrombosis (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63080	- head trauma (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63081	- epilepsy (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63082	- stroke (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63083	- carotid or vertebral artery desection (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63084	- intracranial aneurysm (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63085	- intracranial arteriovenous malformation (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40

I5. MAGNETIC RESONANCE IMAGING	3. SCAN OF HEAD AND NECK VESSELS - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 3. Scan Of Head And Neck Vessels - For Specified Conditions
	NOTE: Benefits are payable for each service included by Subgroup 3 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING AND MAGNETIC RESONANCE ANGIOGRAPHY of extra and/or intracranial circulation, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head and neck vessels for: - stroke (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)
63101	**Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90
63104	NOTE: Benefits are payable for each service included by Subgroup 3 on three occasions only in any 12

I5. MAGNETIC RESONANCE IMAGING	3. SCAN OF HEAD AND NECK VESSELS - FOR SPECIFIED CONDITIONS
	month period MAGNETIC RESONANCE IMAGING AND MAGNETIC RESONANCE ANGIOGRAPHY of extra and/or intracranial circulation, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head and neck vessels for: - stroke (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45
63117	MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head and cervical spine for: - tumour of the central nervous system or meninges (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45
63119	- inflammation of the central nervous system or meninges (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45

I5. MAGNETIC RESONANCE IMAGING	4. SCAN OF HEAD AND CERVICAL SPINE - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 4. Scan Of Head And Cervical Spine - For Specified Conditions
63111	MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head and cervical spine for: - tumour of the central nervous system or meninges (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90
63114	- inflammation of the central nervous system or meninges (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90

I5. MAGNETIC RESONANCE IMAGING	5. SCAN OF HEAD AND CERVICAL SPINE - FOR SPECIFIED CONDITIONS

	Group I5. Magnetic Resonance Imaging
	Subgroup 5. Scan Of Head And Cervical Spine - For Specified Conditions
63125	NOTE: Benefits are payable for each service included by Subgroup 5 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head and cervical spine for: - demyelinating disease of the central nervous system (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90
63128	- congenital malformation of the central nervous system or meninges (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90
63131	- syrinx (congenital or acquired) (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90
63134	NOTE: Benefits are payable for each service included by Subgroup 5 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head and cervical spine for: - demyelinating disease of the central nervous system (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45
63135	- congenital malformation of the central nervous system or meninges (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45
63136	- syrinx (congenital or acquired) (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45

I5. MAGNETIC RESONANCE IMAGING	6. SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 6. Scan Of Spine - One Region Or Two Contiguous Regions - For Specified Conditions
63151	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of one region or two contiguous regions of the spine for: - infection (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63154	- tumour (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63157	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of one region or two contiguous regions of the spine for: - infection (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35
63158	- tumour (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35

I5. MAGNETIC RESONANCE IMAGING	7. SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 7. Scan Of Spine - One Region Or Two Contiguous Regions - For Specified Conditions
63161	NOTE: Benefits are payable for each service included by Subgroup 7 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of one region or two contiguous regions of the spine for:

	- demyelinating (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63164	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63167	myelopathy (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63170	- syrinx (congenital or acquired) (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63173	- cervical radiculopathy (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63176	- sciatica (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63179	- spinal canal stenosis (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63182	- previous spinal surgery (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63185	- trauma (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63186	NOTE: Benefits are payable for each service included by Subgroup 7 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of one region or two contiguous regions of the spine for: - demyelinating (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)

I5. MAGNETIC RESONANCE IMAGING	7. SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS
	Fee: $179.20 **Benefit:** 75% = $134.40 85% = $152.35
63187	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35
63188	- myelopathy (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35
63189	- syrinx (congenital or acquired) (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35
63190	- cervical radiculopathy (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35
63191	- sciatica (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35
63192	- spinal canal stenosis (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35
63193	- previous spinal surgery (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35
63194	- trauma (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35

I5. MAGNETIC RESONANCE IMAGING	8. SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 8. Scan Of Spine - Three Contiguous Regions Or Two Non-Contiguous Regions - For Specified Conditions
63201	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of three contiguous regions or two non contiguous regions of the spine for: - infection (R) (Contrast) (Anaes.)

I5. MAGNETIC RESONANCE IMAGING	8. SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS
	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63204	- tumour (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63207	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of three contiguous regions or two non contiguous regions of the spine for: - infection (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
63208	- tumour (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40

I5. MAGNETIC RESONANCE IMAGING	9. SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 9. Scan Of Spine - Three Contiguous Regions Or Two Non-Contiguous Regions - For Specified Conditions
63219	NOTE: Benefits are payable for each service included by Subgroup 9 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of three contiguous regions or two non contiguous regions of the spine for: - demyelinating disease (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63222	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63225	- myelopathy (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)

I5. MAGNETIC RESONANCE IMAGING	9. SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS
	Fee: $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63228	- syrinx (congenital or acquired) (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63231	- cervical radiculopathy (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63234	- sciatica (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63237	- spinal canal stenosis (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63240	- previous spinal surgery (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63243	- trauma (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63257	NOTE: Benefits are payable for each service included by Subgroup 9 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of three contiguous regions or two non contiguous regions of the spine for: - demyelinating disease (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
63258	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
63259	- myelopathy (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40

I5. MAGNETIC RESONANCE IMAGING	9. SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS
63260	- syrinx (congenital or acquired) (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
63261	- cervical radiculopathy (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
63262	- sciatica (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
63263	- spinal canal stenosis (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
63264	- previous spinal surgery (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
63265	- trauma (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40

I5. MAGNETIC RESONANCE IMAGING	10. SCAN OF CERVICAL SPINE AND BRACHIAL PLEXUS - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 10. Scan Of Cervical Spine And Brachial Plexus - For Specified Conditions
	NOTE: Benefits are payable for each service included by Subgroup 10 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of cervical spine and brachial plexus for: - tumour (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)
63271	**Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90
63274	- trauma (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90

I5. MAGNETIC RESONANCE IMAGING	10. SCAN OF CERVICAL SPINE AND BRACHIAL PLEXUS - FOR SPECIFIED CONDITIONS
63277	- cervical radiculopathy (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90
63280	- previous surgery (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90
	NOTE: Benefits are payable for each service included by Subgroup 10 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of cervical spine and brachial plexus for:
63282	- tumour (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45
63283	- trauma (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45
63284	- cervical radiculopathy (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45
63285	- previous surgery (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45

I5. MAGNETIC RESONANCE IMAGING	11. SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 11. Scan Of Musculoskeletal System - For Specified Conditions
	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for:
63301	- tumour arising in bone or musculoskeletal system, this excludes tumours arising in breast, prostate or rectum (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)

I5. MAGNETIC RESONANCE IMAGING	11. SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS
	Fee: $380.80 **Benefit:** 75% = $285.60 85% = $323.70
63304	- infection arising in bone or musculoskeletal system, this excludes infection arising in breast, prostate or rectum (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $380.80 **Benefit:** 75% = $285.60 85% = $323.70
63307	- osteonecrosis (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $380.80 **Benefit:** 75% = $285.60 85% = $323.70
63310	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for: - tumour arising in bone or musculoskeletal system, this excludes tumours arising in breast, prostate or rectum (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $190.40 **Benefit:** 75% = $142.80 85% = $161.85
63311	- infection arising in bone or musculoskeletal system, this excludes infection arising in breast, prostate or rectum (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $190.40 **Benefit:** 75% = $142.80 85% = $161.85
63313	- osteonecrosis (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $190.40 **Benefit:** 75% = $142.80 85% = $161.85

I5. MAGNETIC RESONANCE IMAGING	12. SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 12. Scan Of Musculoskeletal System - For Specified Conditions
63322	NOTE: Benefits are payable for each service included by Subgroup 12 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for: - derangement of hip or its supporting structures (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

63325	- derangment of shoulder or its supporting structures (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63328	- derangment of knee or its supporting structures (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63331	- derangment of ankle and/or foot or its supporting structures (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63334	- derangment of one or both temporomandibular joints or their supporting structures (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $336.00 **Benefit:** 75% = $252.00 85% = $285.60
63337	- derangment of wrist and/or hand or its supporting structures (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63340	- derangment of elbow or its supporting structures (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	NOTE: Benefits are payable for each service included by Subgroup 12 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for:
63341	- derangement of hip or its supporting structures (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63342	- derangement of shoulder or its supporting structures (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63343	- derangement of knee or its supporting structures (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63345	- derangement of ankle and/or foot or its supporting structures (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40

I5. MAGNETIC RESONANCE IMAGING	12. SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS
63346	- derangement of one or both temporomandibular joints or their supporting structures (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $168.00 **Benefit:** 75% = $126.00 85% = $142.80
63347	- derangement of wrist and/or hand or its supporting structures (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
63348	- derangement of elbow or its supporting structures (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40

I5. MAGNETIC RESONANCE IMAGING	13. SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 13. Scan Of Musculoskeletal System - For Specified Conditions
63361	NOTE: Benefits are payable for each service included by Subgroup 13 on two occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for: - Gaucher disease (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63364	NOTE: Benefits are payable for each service included by Subgroup 13 on two occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for: - Gaucher disease (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40

I5. MAGNETIC RESONANCE IMAGING	14. SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS

	Group I5. Magnetic Resonance Imaging
	Subgroup 14. Scan Of Cardiovascular System - For Specified Conditions
	NOTE: Benefits are payable for each service included by Subgroup 14 on two occasions only in any 12 month period MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of cardiovascular system for: - congenital disease of the heart or a great vessel (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)
63385	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- tumour of the heart or a great vessel (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)
63388	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- abnormality of thoracic aorta (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)
63391	**Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	NOTE: Benefits are payable for each service included by Subgroup 14 on two occasions only in any 12 month period MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of cardiovascular system for: - congenital disease of the heart or a great vessel (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)
63392	**Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
	- tumour of the heart or a great vessel (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)
63393	**Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
	- abnormality of thoracic aorta (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)
63394	**Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63395	MRI scan of the cardiovascular system, performed by a person who is:

	(a) a specialist in diagnostic radiology or a consultant physician; and (b) recognised by the Conjoint Committee for Certification in Cardiac MRI for the assessment of myocardial structure and function involving: (a) dedicated right ventricular views; and (b) 3D volumetric assessment of the right ventricle; and (c) reporting of end-diastolic and end-systolic volumes, ejection fraction and BSA-indexed values; if the request for the scan indicates that: (d) the patient presented with symptoms consistent with arrhythmogenic right ventricular cardiomyopathy (ARVC); or (e) investigative findings in relation to the patient are consistent with ARVC NOTE: benefits are payable once in 12 months (R) (K) (Contrast) (Anaes.) (See para IN.0.19, IN.0.18 of explanatory notes to this Category) **Fee:** $855.20 **Benefit:** 75% = $641.40 85% = $770.50
63396	MRI scan of the cardiovascular system, performed by a person who is: (a) a specialist in diagnostic radiology or a consultant physician; and (b) recognised by the Conjoint Committee for Certification in Cardiac MRI for the assessment of myocardial structure and function involving: (a) dedicated right ventricular views; and (b) 3D volumetric assessment of the right ventricle; and (c) reporting of end-diastolic and end-systolic volumes, ejection fraction and BSA-indexed values;

if the request for the scan indicates that:

(d) the patient presented with symptoms consistent with arrhythmogenic right ventricular cardiomyopathy (ARVC); or

(e) investigative findings in relation to the patient are consistent with ARVC

NOTE: benefits are payable once in 12 months

(R) (NK) (Contrast)

(Anaes.)

(See para IN.0.18, IN.0.19 of explanatory notes to this Category)
Fee: $427.60 **Benefit:** 75% = $320.70 85% = $363.50

MRI scan of the cardiovascular system, performed by a person who is:

(a) a specialist in diagnostic radiology or a consultant physician; and

(b) recognised by the Conjoint Committee for Certification in Cardiac MRI

for the assessment of myocardial structure and function involving:

(a) dedicated right ventricular views; and

(b) 3D volumetric assessment of the right ventricle; and

(c) reporting of end-diastolic and end-systolic volumes, ejection fraction and BSA-indexed values;

if the request for the scan indicates that the patient:

(d) is asymptomatic; and

(e) has one or more first degree relatives diagnosed with confirmed arrhythmogenic right ventricular cardiomyopathy (ARVC)

NOTE: benefits are payable once in 36 months

63397

I5. MAGNETIC RESONANCE IMAGING	14. SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS
	(R) (K) (Contrast) (Anaes.) (See para IN.0.19, IN.0.18 of explanatory notes to this Category) **Fee:** $855.20 **Benefit:** 75% = $641.40 85% = $770.50
63398	MRI scan of the cardiovascular system, performed by a person who is: (a) a specialist in diagnostic radiology or a consultant physician; and (b) recognised by the Conjoint Committee for Certification in Cardiac MRI for the assessment of myocardial structure and function involving: (a) dedicated right ventricular views; and (b) 3D volumetric assessment of the right ventricle; and (c) reporting of end-diastolic and end-systolic volumes, ejection fraction and BSA-indexed values; if the request for the scan indicates that the patient: (d) is asymptomatic; and (e) has one or more first degree relatives diagnosed with confirmed arrhythmogenic right ventricular cardiomyopathy (ARVC) NOTE: benefits are payable once in 36 months (R) (NK) (Contrast) (Anaes.) (See para IN.0.19, IN.0.18 of explanatory notes to this Category) **Fee:** $427.60 **Benefit:** 75% = $320.70 85% = $363.50

I5. MAGNETIC RESONANCE IMAGING	15. MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 15. Magnetic Resonance Angiography - Scan Of Cardiovascular System - For Specified Conditions
	NOTE: Benefits are payable for each service included by Subgroup 15 on three occasions only in any 12 month period
63401	MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an

	eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - scan of cardiovascular system for: - vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63404	- obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63407	NOTE: Benefits are payable for each service included by Subgroup 15 on three occasions only in any 12 month period MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - scan of cardiovascular system for: - vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63408	- obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40

	Group I5. Magnetic Resonance Imaging
	Subgroup 16. Magnetic Resonance Angiography - For Specified Conditions - Person Under The Age Of 16 Years
63416	NOTE: Benefits are payable for each service included by Subgroup 16 on one occasion only in any 12 month period MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an

I5. MAGNETIC RESONANCE IMAGING	16. MAGNETIC RESONANCE ANGIOGRAPHY - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
	eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of person under the age of 16 for: - the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63419	NOTE: Benefits are payable for each service included by Subgroup 16 on one occasion only in any 12 month period MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of person under the age of 16 for: - the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (R) NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40

I5. MAGNETIC RESONANCE IMAGING	17. MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
	Group I5. Magnetic Resonance Imaging
	Subgroup 17. Magnetic Resonance Imaging - For Specified Conditions - Person Under The Age Of 16 Years
63425	NOTE: Benefits are payable for each service included by Subgroup 17 on two occasions only in any 12 month period, for previously diagnosed conditions MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of person under the age of 16 for: - post-inflammatory or post-traumatic physeal fusion (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63428	- Gaucher disease (R) (Anaes.)

I5. MAGNETIC RESONANCE IMAGING	17. MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	NOTE: Benefits are payable for each service included by Subgroup 17 on two occasions only in any 12 month period, for previously diagnosed conditions MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of person under the age of 16 for: - post-inflammatory or post-traumatic physeal fusion (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)
63432	**Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
	- Gaucher disease (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)
63433	**Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40

I5. MAGNETIC RESONANCE IMAGING	18. MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
	Group I5. Magnetic Resonance Imaging
	Subgroup 18. Magnetic Resonance Imaging - For Specified Conditions - Person Under The Age Of 16 Years
	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of person under the age of 16 for: - pelvic or abdominal mass (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)
63440	**Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	- mediastinal mass (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)
63443	**Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	- congenital uterine or anorectal abnormality (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)
63446	**Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63447	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician -

I5. MAGNETIC RESONANCE IMAGING	18. MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
	scan of person under the age of 16 for: - pelvic or abdominal mass (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63448	- mediastinal mass (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63449	- congenital uterine or anorectal abnormality (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40

I5. MAGNETIC RESONANCE IMAGING	19. SCAN OF BODY - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 19. Scan Of Body - For Specified Conditions
63454	MAGNETIC RESONANCE IMAGING scan of the pelvis or abdomen, where: (a) the patient is referred by a specialist obstetrician; and (b) the patient is pregnant at 18 weeks gestation or greater; and (c) a fetal central nervous system (CNS) abnormality is suspected; and (d) an ultrasound provided by, or on behalf of, or at the request of, a specialist who is practising in the specialty of obstetrics, has been performed and diagnosis is indeterminate or requires further examination. (R) (K) (Contrast) (Anaes.) (See para IN.0.19, IN.0.18 of explanatory notes to this Category) **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1115.30
63455	NOTE: Benefits are payable for each service included by Subgroup 19 on one occasion only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of body for: - adrenal mass in a patient with malignancy which is otherwise resectable (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35
63457	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible

provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where:

(a) a dedicated breast coil is used; and

(b) the request for scan identifies that the person is asymptomatic and is less than 50 years of age; and

(c) the request for scan identifies either:

(i) that the patient is at high risk of developing breast cancer, due to 1 of the following:

(A) 3 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer;

(B) 2 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer, if any of the following applies to at least 1 of the relatives:

- has been diagnosed with bilateral breast cancer;

- had onset of breast cancer before the age of 40 years;

- had onset of ovarian cancer before the age of 50 years;

- has been diagnosed with breast and ovarian cancer, at the same time or at different times;

- has Ashkenazi Jewish ancestry;

- is a male relative who has been diagnosed with breast cancer;

(C) 1 first or second degree relative diagnosed with breast cancer at age 45 years or younger, plus another first or second degree relative on the same side of the family with bone or soft tissue sarcoma at age 45 years or younger; or

(ii) that genetic testing has identified the presence of a high risk breast cancer gene mutation.

Scan of both breasts for:

- detection of cancer (R)

NOTE: Benefits are payable on one occasion only in any 12 month period

(NK) (Anaes.)

(See para IN.0.19 of explanatory notes to this Category)

	Fee: $345.00 **Benefit:** 75% = $258.75 85% = $293.25
63458	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a dedicated breast coil is used; and (b) the person has had an abnormality detected as a result of a service described in item 63464 or 63457 performed in the previous 12 months Scan of both breasts for: - detection of cancer (R) NOTE 1: Benefits are payable on one occasion only in any 12 month period NOTE 2: This item is intended for follow-up imaging of abnormalities diagnosed on a scan described by item 63464 or 63457 (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $345.00 **Benefit:** 75% = $258.75 85% = $293.25
63460	MAGNETIC RESONANCE IMAGING scan of the pelvis or abdomen, where: (a) the patient is referred by a specialist obstetrician; and (b) the patient is pregnant at 18 weeks gestation or greater; and (c) a fetal central nervous system (CNS) abnormality is suspected; and (d) an ultrasound provided by, or on behalf of, or at the request of, a specialist who is practising in the specialty of obstetrics, has been performed and diagnosis is indeterminate or requires further examination. (R) (NK) (Contrast) (Anaes.) (See para IN.0.18, IN.0.19 of explanatory notes to this Category) **Fee:** $600.00 **Benefit:** 75% = $450.00 85% = $515.30
63461	NOTE: Benefits are payable for each service included by Subgroup 19 on one occasion only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician -

	scan of body for: - adrenal mass in a patient with malignancy which is otherwise resecetable (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63464	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a dedicated breast coil is used; and (b) the request for scan identifies that the person is asymptomatic and is less than 50 years of age; and (c) the request for scan identifies either: (i) that the patient is at high risk of developing breast cancer, due to 1 of the following: (A) 3 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer; (B) 2 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer, if any of the following applies to at least 1 of the relatives: - has been diagnosed with bilateral breast cancer; - had onset of breast cancer before the age of 40 years; - had onset of ovarian cancer before the age of 50 years; - has been diagnosed with breast and ovarian cancer, at the same time or at different times; - has Ashkenazi Jewish ancestry; - is a male relative who has been diagnosed with breast cancer; (C) 1 first or second degree relative diagnosed with breast cancer at age 45 years or younger, plus another first or second degree relative on the same side of the family with bone or soft tissue sarcoma at age 45 years or younger; or (ii) that genetic testing has identified the presence of a high risk breast cancer gene mutation. Scan of both breasts for:

	- detection of cancer (R) NOTE: Benefits are payable on one occasion only in any 12 month period (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $690.00 **Benefit:** 75% = $517.50 85% = $605.30
63467	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a dedicated breast coil is used; and (b) the person has had an abnormality detected as a result of a service described in item 63464 performed in the previous 12 months Scan of both breasts for: - detection of cancer (R) NOTE 1: Benefits are payable on one occasion only in any 12 month period NOTE 2: This item is intended for follow-up imaging of abnormalities diagnosed on a scan described by item 63464 (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $690.00 **Benefit:** 75% = $517.50 85% = $605.30
63487	MRI-performed under the professional supervision of an eligible provider at an eligible location, if: (a) the patient is referred by a specialist or a consultant physician; and (b) a dedicated breast coil is used; and (c) the request for the scan identifies that: (i) the patient has been diagnosed with metastatic cancer restricted to the regional lymph nodes; and (ii) clinical examination and conventional imaging have failed to identify the primary cancer (R) (K) (Anaes) **Fee:** $690.00 **Benefit:** 75% = $517.50 85% = $605.30
63488	MRI-performed under the professional supervision of an eligible provider at an eligible location, if:

	(a) the patient is referred by a specialist or a consultant physician; and (b) a dedicated breast coil is used; and (c) the request for the scan identifies that: (i) the patient has been diagnosed with metastatic cancer restricted to the regional lymph nodes; and (ii) clinical examination and conventional imaging have failed to identify the primary cancer (R) (NK) (Anaes) **Fee:** $345.00 **Benefit:** 75% = $258.75 85% = $293.25
63489	MRI-guided biopsy, performed under the professional supervision of an eligible provider at an eligible location, if: (a) the patient is referred by a specialist or a consultant physician; and (b) a dedicated breast coil is used; and (c) the request for the scan identifies that: (i) the patient has a suspicious lesion seen on MRI but not on conventional imaging; and (ii) the lesion is not amenable to biopsy guided by conventional imaging; and (d) a repeat ultrasound scan of the affected breast is performed: (i) before the guided biopsy is performed; and (ii) as part of the service under this item (R) (K) (Anaes.) **Fee:** $1,440.00 **Benefit:** 75% = $1080.00 85% = $1355.30
63490	MRI-guided biopsy performed under the professional supervision of an eligible provider at an eligible location, if: (a) the patient is referred by a specialist or a consultant physician; and (b) a dedicated breast coil is used; and (c) the request for the scan identifies that: (i) the patient has a suspicious lesion seen on MRI but not on conventional imaging; and (ii) the lesion is not amenable to biopsy guided by conventional imaging; and (d) a repeat ultrasound scan of the affected breast is performed: (i) before the guided biopsy is performed; and (ii) as part of the service under this item (R) (NK) (Anaes.) **Fee:** $720.00 **Benefit:** 75% = $540.00 85% = $635.30
New 63531	MRI – scan of both breasts, performed under the supervision of a specialist in diagnostic radiology who is a participant of the Royal Australian and New Zealand College of Radiologists' (RANZCR) Quality

	and Accreditation Program at an eligible location, if: d. a dedicated breast coil is used; and e. the service has been requested by a specialist or consultant physician; and f. the request for the scan identifies that: a. the patient has a breast lesion; and b. the results of conventional imaging are inconclusive for the presence of breast cancer; and c. biopsy has not been possible. NOTE: This service can be provided on both full and partial MRI eligible equipment. There are no frequency restrictions for this item. (R) (K) (Anaes.) (Contrast) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $690.00 **Benefit:** 75% = $517.50 85% = $605.30
New 63532	MRI – scan of both breasts, performed under the supervision of a specialist in diagnostic radiology who is a participant of the Royal Australian and New Zealand College of Radiologists' (RANZCR) Quality and Accreditation Program at an eligible location, if: i. a dedicated breast coil is used; and j. the service has been requested by a specialist or consultant physician; and k. the request for the scan identifies that: a. the patient has a breast lesion; and b. the results of conventional imaging are inconclusive for the presence of breast cancer; and c. biopsy has not been possible. NOTE: This service can be provided on both full and partial MRI eligible equipment. There are no frequency restrictions for this item. (R) (NK) (Anaes.) (Contrast) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $345.00 **Benefit:** 75% = $258.75 85% = $293.25
New 63533	MRI – scan of both breasts, performed under the supervision of a specialist in diagnostic radiology who is a participant of the Royal Australian and New Zealand College of Radiologists' (RANZCR) Quality and Accreditation Program at an eligible location, if: j. a dedicated breast coil is used; and k. the service has been requested by a specialist or consultant physician; and l. the request for the scan identifies that: a. the patient has been diagnosed with a breast cancer; and b. there is a discrepancy between the clinical assessment and the conventional imaging assessment of the extent of the malignancy; and m. the results of breast MRI imaging may alter treatment planning. NOTE: This service can be provided on both full and partial MRI eligible equipment. There are no frequency restrictions for this item. (R) (K) (Anaes.) (Contrast)

	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $690.00 **Benefit:** 75% = $517.50 85% = $605.30

New
63534
	MRI – scan of both breasts, performed under the supervision of a specialist in diagnostic radiology who is a participant of the Royal Australian and New Zealand College of Radiologists' (RANZCR) Quality and Accreditation Program at an eligible location, if:
	
	• a dedicated breast coil is used; and
	• the service has been requested by a specialist or consultant physician; and
	• the request for the scan identifies that:
	  o the patient has been diagnosed with a breast cancer;and
	  o there is a discrepancy between the clinical assessment and the conventional imaging assessment of the extent of the malignancy; and
	• the results of breast MRI imaging may alter treatment planning.
	
	NOTE: This service can be provided on both full and partial MRI eligible equipment. There are no frequency restrictions for this item.
	
	(R) (NK) (Anaes.) (Contrast)
	
	(See para IN.0.19 of explanatory notes to this Category)
	Fee: $345.00 **Benefit:** 75% = $258.75 85% = $293.25

63541	Multiparametric Magnetic Resonance Imaging scan of the prostate for the detection of cancer, if the patient is referred by an urologist, radiation oncologist, or medical oncologist and the request for the scan identifies: that the patient is suspected of developing prostate cancer, due to one of the following: (i) a digital rectal examination which is suspicious for prostate cancer; or (ii) in a person under 70 years, at least two prostate specific antigen (PSA) tests performed within an interval of 1- 3 months are greater than 3.0 ng/ml, and the free/total PSA ratio is less than 25% or the repeat PSA exceeds 5.5 ng/ml; or (iii) in a person under 70 years, whose risk of developing prostate cancer based on relevant family history is at least double the average risk, at least two PSA tests performed within an interval of 1- 3 months are greater than 2.0 ng/ml, and the free/total PSA ratio is less than 25%; or (iv) in a person 70 years or older, at least two PSA tests performed within an interval of 1- 3 months are greater than 5.5ng/ml and the free/total PSA ratio is less than 25%. using a standardised image acquisition protocol involving T2 Weighted Imaging, Diffusion Weighted Imaging, and Dynamic Contrast Enhancement (unless contraindicated) (R) (K) Note: Benefits are payable on one occasion only in any 12 month period. Relevant family history is a first degree relative with prostate cancer, or suspected of carrying a BRCA 1 or BRCA 2 mutation. (Anaes.) (See para IN.0.19, IN.0.18 of explanatory notes to this Category) **Fee:** $450.00 **Benefit:** 75% = $337.50 85% = $382.50
63542	Multiparametric Magnetic Resonance Imaging scan of the prostate for the detection of cancer, if the patient is referred by an urologist, radiation oncologist, or medical oncologist and the request for the

	scan identifies: that the patient is suspected of developing prostate cancer, due to one of the following: (i) a digital rectal examination which is suspicious for prostate cancer; or (ii) in a person under 70 years, at least two prostate specific antigen (PSA) tests performed within an interval of 1- 3 months are greater than 3.0 ng/ml, and the free/total PSA ratio is less than 25% or the repeat PSA exceeds 5.5 ng/ml; or (iii) in a person under 70 years, whose risk of developing prostate cancer based on relevant family history is at least double the average risk, at least two PSA tests performed within an interval of 1- 3 months are greater than 2.0 ng/ml, and the free/total PSA ratio is less than 25%; or (iv) in a person 70 years or older, at least two PSA tests performed within an interval of 1- 3 months are greater than 5.5ng/ml and the free/total PSA ratio is less than 25%. using a standardised image acquisition protocol involving T2 Weighted Imaging, Diffusion Weighted Imaging, and Dynamic Contrast Enhancement (unless contraindicated) (R) (NK) Note: Benefits are payable on one occasion only in any 12 month period. Relevant family history is a first degree relative with prostate cancer, or suspected of carrying a BRCA 1 or BRCA 2 mutation. (Anaes.) (See para IN.0.18, IN.0.19 of explanatory notes to this Category) **Fee:** $225.00 **Benefit:** 75% = $168.75 85% = $191.25
63543	Multiparametric Magnetic Resonance Imaging scan of the prostate for the assessment of cancer, if the patient is referred by an urologist, radiation oncologist, or medical oncologist and: the request for the scan identifies: (i) the patient is under active surveillance following a confirmed diagnosis of prostate cancer by biopsy histopathology; and (ii) the patient is not planning or undergoing treatment for prostate cancer. using a standardised image acquisition protocol involving T2 Weighted Imaging, Diffusion Weighted Imaging, and Dynamic Contrast Enhancement (unless contraindicated) (R) (K) Note: Benefits are payable at the time of diagnosis of prostate cancer, 12 months following diagnosis and then every 3rd year thereafter or at any time, if there is a clinical concern, including PSA progression. This item is not to be used for the purposes of treatment planning or for monitoring after treatment. (Anaes.) (See para IN.0.18, IN.0.19 of explanatory notes to this Category) **Fee:** $450.00 **Benefit:** 75% = $337.50 85% = $382.50
63544	Multiparametric Magnetic Resonance Imaging scan of the prostate for the assessment of cancer, if the patient is referred by an urologist, radiation oncologist, or medical oncologist and: the request for the scan identifies: (i) the patient is under active surveillance following a confirmed diagnosis of prostate cancer by biopsy histopathology; and (ii) the patient is not planning or undergoing treatment for prostate cancer. using a standardised image acquisition protocol involving T2 Weighted Imaging, Diffusion Weighted Imaging, and Dynamic Contrast Enhancement (unless contraindicated)

I5. MAGNETIC RESONANCE IMAGING	19. SCAN OF BODY - FOR SPECIFIED CONDITIONS
	(R) (NK) Note: Benefits are payable at the time of diagnosis of prostate cancer, 12 months following diagnosis and then every 3rd year thereafter or at any time, if there is a clinical concern, including PSA progression. This item is not to be used for the purposes of treatment planning or for monitoring after treatment (Anaes.) (See para IN.0.19, IN.0.18 of explanatory notes to this Category) **Fee:** $225.00 **Benefit:** 75% = $168.75 85% = $191.25
63547	MRI scan of both breasts for the detection of cancer, if (a) a dedicated breast coil is used; and (b) the request for the scan identifies that: (i) the patient has a breast implant in situ; and (ii) anaplastic large cell lymphoma has been diagnosed NOTE: benefits are payable once in a patient's lifetime (R) (K) (Contrast) (Anaes.) (See para IN.0.18, IN.0.19 of explanatory notes to this Category) **Fee:** $690.00 **Benefit:** 75% = $517.50 85% = $605.30
63548	MRI scan of both breasts for the detection of cancer, if (a) a dedicated breast coil is used; and (b) the request for the scan identifies that: (i) the patient has a breast implant in situ; and (ii) anaplastic large cell lymphoma has been diagnosed NOTE: benefits are payable once in a patient's lifetime (R) (NK) (Contrast) (Anaes.) (See para IN.0.19, IN.0.18 of explanatory notes to this Category) **Fee:** $345.00 **Benefit:** 75% = $258.75 85% = $293.25

I5. MAGNETIC RESONANCE IMAGING	20. SCAN OF PELVIS AND UPPER ABDOMEN - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 20. Scan Of Pelvis And Upper Abdomen - For Specified Conditions
63470	NOTE: Benefits are payable for a service under items 63470 and 63473 on one occasion only.

	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where: (a) the patient is referred by a specialist or by a consultant physician and (b) the request for scan identifies that (i) a histological diagnosis of carcinoma of the cervix has been made and (ii) the patient has been diagnosed with cervical cancer at FIGO stage 1B or greater Scan of: - Pelvis for the staging of histologically diagnosed cervical cancer at FIGO stages 1B or greater (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63473	- Pelvis and upper abdomen, in a single examination, for the staging of histologically diagnosed cervical cancer at FIGO stages 1B or greater (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $627.20 **Benefit:** 75% = $470.40 85% = $542.50
63476	NOTE: benefits are payable for a service under item 63476 on one occasion only. MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a phased array body coil is used, and (b) the request for scan identifies that the indication is for the initial staging of rectal cancer (including cancer of the rectosigmoid and anorectum). Scan of: - Pelvis for the initial staging of rectal cancer (R) (contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63479	NOTE: Benefits are payable for a service included by Subgroup 20 on one occasion only. MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where:

	(a) the patient is referred by a specialist or by a consultant physician and (b) the request for scan identifies that (i) a histological diagnosis of carcinoma of the cervix has been made and (ii) the patient has been diagnosed with cervical cancer at FIGO stage 1B or greater Scan of: - Pelvis for the staging of histologically diagnosed cervical cancer at FIGO stages 1B or greater (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63481	- Pelvis and upper abdomen, in a single examination, for the staging of histologically diagnosed cervical cancer at FIGO stages 1B or greater (R) (NK) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $313.60 **Benefit:** 75% = $235.20 85% = $266.60
63484	NOTE: benefits are payable for a service included by Subgroup 20 on one occasion only. MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a phased array body coil is used, and (b) the request for scan identifies that the indication is for the initial staging of rectal cancer (including cancer of the rectosigmoid and anorectum). Scan of: - Pelvis for the initial staging of rectal cancer (R) (NK) (contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63740	MRI to evaluate small bowel Crohn's disease. Medicare benefits are only payable for this item if the service is provided to patients: (a) Evaluation of disease extent at time of initial diagnosis of Crohn's disease (b) Evaluation of exacerbation/suspected complications of known Crohn's disease (c) Evaluation of known or suspected Crohn's disease in pregnancy

	(d) Assessment of change to therapy in patients with small bowel Crohn's disease Assessment of change to therapy can only be claimed once in a 12 month period. (R) (K) (Contrast) **Fee:** $457.20 **Benefit:** 75% = $342.90 85% = $388.65
63741	MRI enteroclysis for Crohn's disease. Medicare benefits are only payable for this item if the service is related to item 63740. (R) (K) **Fee:** $265.25 **Benefit:** 75% = $198.95 85% = $225.50
63743	MRI for fistulising perianal Crohn's disease. Medicare benefits are only payable for this item if the service is provided to patients for: - Evaluation of pelvic sepsis and fistulas associated with established or suspected Crohn's disease - Assessment of change to therapy of pelvis sepsis and fistulas from Crohn's disease Assessment of change to therapy can only be claimed once in a 12 month period. (R) (K) (Contrast) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63744	MRI to evaluate small bowel Crohn's disease. Medicare benefits are only payable for this item if the service is provided to patients: (a) Evaluation of disease extent at time of initial diagnosis of Crohn's disease (b) Evaluation of exacerbation/suspected complications of known Crohn's disease (c) Evaluation of known or suspected Crohn's disease in pregnancy (d) Assessment of change to therapy in patients with small bowel Crohn's disease Assessment of change to therapy can only be claimed once in a 12 month period. (R) (NK) (Contrast) **Fee:** $228.60 **Benefit:** 75% = $171.45 85% = $194.35
63746	MRI enteroclysis for Crohn's disease. Medicare benefits are only payable for this item if the service is related to item 63744. (R) (NK) **Fee:** $132.65 **Benefit:** 75% = $99.50 85% = $112.80
63747	MRI for fistulising perianal Crohn's disease. Medicare benefits are only payable for this item if the service is provided to patients for: - Evaluation of pelvic sepsis and fistulas associated with established or suspected Crohn's disease - Assessment of change to therapy of pelvis sepsis and fistulas from Crohn's disease Assessment of change to therapy can only be claimed once in a 12 month period. (R) (NK) (Contrast) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40

	Group I5. Magnetic Resonance Imaging
	Subgroup 21. Scan Of Body - For Specified Conditions
63482	NOTE: Benefits are only payable for each service included by Subgroup 21 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of pancreas and biliary tree for: - suspected biliary or pancreatic pathology (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63486	NOTE: Benefits are only payable for each service included by Subgroup 21 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of pancreas and biliary tree for: - suspected biliary or pancreatic pathology (R) (NK) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63545	Note: Benefits are payable on only one occasion in any 12-month period MAGNETIC RESONANCE IMAGING with a contrast agent – multiphase scans of the liver (including delayed imaging, when performed) - performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or consultant physician - for characterisation or intervention planning, in a patient with: • known colorectal carcinoma; and • known, suspected, or possible liver metastasis; and • previous computed tomography or ultrasound imaging has identified a mass lesion in the liver. For use with HEPATOBILIARY-SPECIFIC CONTRAST AGENT (item 63496). If a patient has known or suspected clinical indication/s considered by a specialist or consultant physician to indicate the need for imaging with an extracellular contrast agent, the modifying MRI item 63491 can be used with this item. Fee: $550 Benefit: 75% = $412.50 85% = $467.50 (R) (K) (Anaes.) (See IN.0.18, IN.0.19 of explanatory notes to this category) (Anaes.) (See para IN.0.18, IN.0.19 of explanatory notes to this Category) **Fee:** $550.00 **Benefit:** 75% = $412.50 85% = $467.50

I5. MAGNETIC RESONANCE IMAGING	21. SCAN OF BODY - FOR SPECIFIED CONDITIONS
	Note: Benefits are payable on only one occasion in any 12-month period MAGNETIC RESONANCE IMAGING with a contrast agent – multiphase scans of the liver (including delayed imaging, when performed) - performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or consultant physician – for diagnosis or staging, in a patient with known or suspected hepatocellular carcinoma, and: • chronic liver disease, that has been confirmed by a specialist or consultant physician; and • liver function identified as Child-Pugh class A or B; and • an identified hepatic lesion over 10 mm in diameter. For use with HEPATOBILIARY-SPECIFIC CONTRAST AGENT (item 63496). If a patient has known or suspected clinical indication/s considered by a specialist or consultant physician to indicate the need for imaging with an extracellular contrast agent, the modifying MRI item 63491 can be used with this item. Fee: $550 Benefit: 75% = $412.50 85% = $467.50 (R) (K) (Anaes.) (See IN.0.18, IN.0.19 of explanatory notes to this category) (Anaes.) (See para IN.0.19, IN.0.18 of explanatory notes to this Category)
63546	**Fee:** $550.00 **Benefit:** 75% = $412.50 85% = $467.50

I5. MAGNETIC RESONANCE IMAGING	22. MODIFYING ITEMS
	Group I5. Magnetic Resonance Imaging
	Subgroup 22. Modifying Items
	NOTE: Benefits in Subgroup 22 are only payable for modifying items where claimed simultaneously with MRI services. Modifiers for sedation and anaesthesia may not be claimed for the same service. Modifying items for use with MAGNETIC RESONANCE IMAGING or MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an eligible provider at an eligible location where the service requested by a medical practitioner. Scan performed: - involves the use of contrast agent for eligible Magnetic Resonance Imaging items (Note: (Contrast) denotes an item eligible for use with this item) (See para IN.0.19 of explanatory notes to this Category)
63491	**Fee:** $44.80 **Benefit:** 75% = $33.60 85% = $38.10
	- involves use of intravenous or intramuscular sedation on a patient (See para IN.0.19 of explanatory notes to this Category)
63494	**Fee:** $44.80 **Benefit:** 75% = $33.60 85% = $38.10
	NOTE: Benefits in Subgroup 22 are only payable for modifying items where claimed simultaneously with MRI services. Modifiers for sedation and anaesthesia may not be claimed for the same service. Modifying item for use with MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the service requested by a specialist or
63496	

	by a consultant and the scan performed involves the use of HEPATOBILIARY SPECIFIC contrast agent, as clinically indicated for eligible MRI items 64545 and 64546. (See para IN.0.18, IN.0.19 of explanatory notes to this Category) **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50
63497	- on a patient under anaesthetic in the presence of a medical practitioner qualified to perform an anaesthetic (See para IN.0.19 of explanatory notes to this Category) **Fee:** $156.80 **Benefit:** 75% = $117.60 85% = $133.30
63498	MRI service to which item 63501, 63502, 63504 or 63505 applies if: (a) the service is performed in accordance with the determination; and (b) the service is performed on a person using intravenous or intra muscular sedation (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.80 **Benefit:** 75% = $33.60 85% = $38.10
63499	MRI service to which item 63501, 63502, 63504 or 63505 applies if: (a) the service is performed in accordance with the determination; and (b) the service is performed on a person under anaesthetic in the presence of a medical practitioner who is qualified to perform an anaesthetic. (See para IN.0.19 of explanatory notes to this Category) **Fee:** $156.80 **Benefit:** 75% = $117.60 85% = $133.30

	Group I5. Magnetic Resonance Imaging
	Subgroup 32. Magnetic Resonance Imaging - Pip Breast Implant
63501	MRI - scan of one or both breasts for the evaluation of implant integrity where: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient: (i) has or is suspected of having a silicone breast implant manufactured by Poly Implant Prosthese (PIP); and (ii) the result of the scan confirms a loss of integrity of the implant (R) Note: Benefits are payable on one occasion only in any 12 Month Period (See para IN.0.19 of explanatory notes to this Category) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00
63502	MRI - scan of one or both breasts for the evaluation of implant integrity where:

I5. MAGNETIC RESONANCE IMAGING	32. MAGNETIC RESONANCE IMAGING - PIP BREAST IMPLANT
	(a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient: (i) has or is suspected of having a silicone breast implant manufactured by Poly Implant Prosthese (PIP); and (ii) the result of the scan does not demonstrate a loss of integrity of the implant (R) Note: Benefits are payable on one occasion only in any 12 Month Period (See para IN.0.19 of explanatory notes to this Category) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00
63504	MRI - scan of one or both breasts for the evaluation of implant integrity where: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient: (i) has or is suspected of having a silicone breast implant manufactured by Poly Implant Prosthese (PIP); and (ii) presents with symptoms where implant rupture is suspected; and (iii) the result of the scan confirms a loss of integrity of the implant (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00
63505	MRI - scan of one or both breasts for the evaluation of implant integrity where: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient: (i) has or is suspected of having a silicone breast implant manufactured by Poly Implant Prosthese (PIP); and (ii) presents with symptoms where implant rupture is suspected; and (iii) the result of the scan does not demonstrate a loss of integrity of the implant (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00

I5. MAGNETIC RESONANCE IMAGING	33. MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16YRS
	Group I5. Magnetic Resonance Imaging
	Subgroup 33. Magnetic Resonance Imaging - For Specified Conditions - Person Under The Age Of 16yrs

63507	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of head for a patient under 16 years for any of the following: - unexplained seizure(s) (R) (Contrast) (Anaes.); or - unexplained headache where significant pathology is suspected (R) (Contrast) (Anaes.); or - paranasal sinus pathology which has not responded to conservative therapy (R) (Contrast) (Anaes.) (See para IN.0.18 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63508	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of head for a patient under 16 years for any of the following: - unexplained seizure(s) (R) (NK) (Contrast) (Anaes.); or - unexplained headache where significant pathology is suspected (R) (NK) (Contrast) (Anaes.); or - paranasal sinus pathology which has not responded to conservative therapy (R) (NK) (Contrast) (Anaes.) (See para IN.0.18 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63510	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine for a patient under 16 years following radiographic examination for: - significant trauma (R) (Contrast) (Anaes.); or - unexplained neck or back pain with associated neurological signs (R) (Contrast) (Anaes.); or - unexplained back pain where significant pathology is suspected (R) (Contrast) (Anaes.) (See para IN.0.18 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63511	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine for a patient under 16 years following radiographic examination for: - significant trauma (R) (NK) (Contrast) (Anaes.); or - unexplained neck or back pain with associated neurological signs (R) (NK) (Contrast) (Anaes.); or - unexplained back pain where significant pathology is suspected (R) (NK) (Contrast) (Anaes.) (See para IN.0.18 of explanatory notes to this Category) **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
63513	MRI - referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of knee for a patient aged under 16 years for internal joint derangement (R) (K) (Contrast) (Anaes.) (See para IN.0.19, IN.0.18 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63514	MRI - referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of

	knee for a patient aged under 16 years for internal joint derangement (R) (NK) (Contrast) (Anaes.) (See para IN.0.18, IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63516	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of hip for a patient under 16 years following radiographic examination for: - suspected septic arthritis (R) (Contrast) (Anaes.); or - suspected slipped capital femoral epiphysis (R) (Contrast) (Anaes.); or - suspected Perthes disease (R) (Contrast) (Anaes.) (See para IN.0.18 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63517	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of hip for a patient under 16 years following radiographic examination for: - suspected septic arthritis (R) (NK) (Contrast) (Anaes.); or - suspected slipped capital femoral epiphysis (R) (NK) (Contrast) (Anaes.); or - suspected Perthes disease (R) (NK) (Contrast) (Anaes.) (See para IN.0.18 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63519	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of elbow for a patient under 16 years following radiographic examination where a significant fracture or avulsion injury is suspected that will change management (R) (Contrast) (Anaes.) (See para IN.0.18 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63520	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of elbow for a patient under 16 years following radiographic examination where a significant fracture or avulsion injury is suspected that will change management (R) (NK) (Contrast) (Anaes.) (See para IN.0.18 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63522	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of wrist for a patient under 16 years following radiographic examination where scaphoid fracture is suspected (R) (Contrast) (Anaes.) (See para IN.0.18 of explanatory notes to this Category) **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63523	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of wrist for a patient under 16 years following radiographic examination where scaphoid fracture is suspected (R) (NK) (Contrast) (Anaes.) (See para IN.0.18 of explanatory notes to this Category) **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40

	Group I5. Magnetic Resonance Imaging
	Subgroup 34. Magnetic Resonance Imaging - For Specified Conditions
63551	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of head for a patient 16 years or older for any of the following: - unexplained seizure(s) (R) (Contrast) (Anaes.) - unexplained chronic headache with suspected intracranial pathology (R) (Contrast) (Anaes.) (See para IN.0.18 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63552	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of head for a patient 16 years or older for any of the following: - unexplained seizure(s) (R) (NK) (Contrast) (Anaes.) - unexplained chronic headache with suspected intracranial pathology (R) (NK) (Contrast) (Anaes.) (See para IN.0.18 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63554	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine for a patient 16 years or older for suspected: - cervical radiculopathy (R) (Contrast) (Anaes.) (See para IN.0.18 of explanatory notes to this Category) **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63555	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine for a patient 16 years or older for suspected: - cervical radiculopathy (R) (NK) (Contrast) (Anaes.) (See para IN.0.18 of explanatory notes to this Category) **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35
63557	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine for a patient 16 years or older for suspected: - cervical spine trauma (R) (Contrast) (Anaes.) (See para IN.0.18 of explanatory notes to this Category) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90

63558	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine for a patient 16 years or older for suspected: - cervical spine trauma (R) (NK) (Contrast) (Anaes.) (See para IN.0.18 of explanatory notes to this Category) **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45
63560	MRI - scan of knee following acute knee trauma, after referral by a medical practitioner (other than a specialist or consultant physician), for a patient aged 16 to 49 years with: h. inability to extend the knee suggesting the possibility of acute meniscal tear; or i. clinical findings suggesting acute anterior cruciate ligament tear. (R) (K) (Contrast) (Anaes.) (See para IN.0.18, IN.0.19 of explanatory notes to this Category) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63561	MRI - scan of knee following acute knee trauma, after referral by a medical practitioner (other than a specialist or consultant physician), for a patient aged 16 to 49 years with: h. inability to extend the knee suggesting the possibility of acute meniscal tear; or i. clinical findings suggesting acute anterior cruciate ligament tear. (R) (NK) (Contrast) (Anaes.) (See para IN.0.18, IN.0.19 of explanatory notes to this Category) **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40

I6. MANAGEMENT OF BULK-BILLED SERVICES

	Group I6. Management Of Bulk-Billed Services
64990	A diagnostic imaging service to which an item in this table (other than this item or item 64991) applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in respect of the fees for: (i) this item; and (ii) the other item in this table applying to the service (See para IN.0.19, IN.0.14 of explanatory notes to this Category) **Fee:** $7.05 **Benefit:** 85% = $6.00
64991	A diagnostic imaging service to which an item in this table (other than this item or item 64990) applies

if:

(a) the service is an unreferred service; and

(b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and

(c) the person is not an admitted patient of a hospital; and

(d) the service is bulk-billed in respect of the fees for:

(i) this item; and

(ii) the other item in this table applying to the service; and

(e) the service is provided at, or from, a practice location in:

(i) a regional, rural or remote area; or

(ii) Tasmania; or

(iii) A geographical area included in any of the following SSD spatial units:

(A) Beaudesert Shire Part A

(B) Belconnen

(C) Darwin City

(D) Eastern Outer Melbourne

(E) East Metropolitan, Perth

(F) Frankston City

(G) Gosford-Wyong

(H) Greater Geelong City Part A

(I) Gungahlin-Hall

(J) Ipswich City (part in BSD)

(K) Litchfield Shire

(L) Melton-Wyndham

(M) Mornington Peninsula Shire

(N) Newcastle

(O) North Canberra

(P) Palmerston-East Arm

(Q) Pine Rivers Shire

(R) Queanbeyan

(S) South Canberra

(T) South Eastern Outer Melbourne

(U) Southern Adelaide

(V) South West Metropolitan, Perth

(W) Thuringowa City Part A

(X) Townsville City Part A

(Y) Tuggeranong

(Z) Weston Creek-Stromlo

(ZA) Woden Valley

(ZB) Yarra Ranges Shire Part A; or

(iv) the geographical area included in the SLA spatial unit of Palm Island (AC)

(See para IN.0.19, IN.0.14 of explanatory notes to this Category)
Fee: $10.65 **Benefit:** 85% = $9.10

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CATEGORY 6: PATHOLOGY SERVICES

SUMMARY OF CHANGES FROM 01/11/2019

The 01/11/2019 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

Description Amended

73832

Amendment to Pathology Services Table Item 73832

Item 73832 has been amended to ensure that the same requirements that apply for performance of item 73805 also apply to item 73832.

Amendment to Pathology Services Table Item 72860

This item has been amended to clarify that the retrieval and review of archived formalin fixed paraffin embedded block(s) to determine the appropriate sample(s) for the purposes of further genetic testing does not apply if the subsequent genetic test(s) is performed in the same laboratory. The item will apply if the subsequent genetic test(s) is performed in a different laboratory, including laboratories within the same laboratory network provided the laboratories are at separate locations.

PATHOLOGY SERVICES NOTES

PN.0.1 Changes to the Pathology Services Table

Health Insurance Regulations

The *Health Insurance Act 1973* allows the Minister for Health to determine an appropriate Pathology Services Table which is then prescribed by Regulation.

The Minister has established the Pathology Services Table Committee (PSTC) to assist in determining changes to the Table (except new medical services and technologies - see below). Any person or organisation seeking to make a submission to this Committee can contact the PSTC Secretariat on (02) 6289 4080 or e-mail pstc.secretariat@health.gov.au and/or write to: Secretary, PSTC, MDP 107, Department of Health and Ageing, GPO Box 9848, CANBERRA ACT 2601.

Pathology submissions relating to new medical services and technologies should be forwarded to the Medical Services Advisory Committee (MSAC). MSAC has been established to advise the Minister on the strength of evidence pertaining to new and emerging medical technologies and procedures in relation to their safety, effectiveness and cost effectiveness, and under what circumstances public funding should be supported.

Any person or organisation seeking to make a submission to MSAC can contact the MSAC Secretariat on (02) 6289 7550 or email msac.secretariat@health.gov.au and/or write to: MSAC Secretariat, Australian Government, Department of Health, MDP 106, GPO Box 9848, CANBERRA ACT 2601. The application form and guidelines for applying can also be obtained from MSAC's website - www.msac.gov.au

PN.0.2 Explanatory Notes - Definitions

Excessive Pathology Service

This means a pathology service for which a Medicare benefit has become or may become payable and which is not reasonably necessary for the adequate medical or dental care of the patient concerned.

PN.0.3 Group of Practitioners

This means:

(i) a practitioner conducting a medical practice or a dental practice, or a participating nurse practitioner practice, or a participating midwife practice together with another practitioner, or other practitioners, participating (whether as employees or otherwise) in the provision of professional services as part of that practice; or

(ii) two or more practitioners conducting a medical practice or a dental practice, or a participating nurse practitioner practice, or a participating midwife practice as partners; or

(iii) those partners together with any other practitioner who participates (whether as an employee or otherwise) in the provision of professional services as part of that practice.

PN.0.4 Initiate

In relation to a pathology service this means to request the provision of pathology services for a patient.

PN.0.5 Patient Episode

A patient episode comprises a pathology service or services specified in one or more items which are provided for a single patient, the need for which was determined under subsection 16A(1) of the Act on the same day, whether they were provided by one or more approved pathology practitioners on one day or over several days and whether they are requested by one or more treating practitioners. Even if a treating practitioner writes separate request forms to cover the collection of specimens at different times, where the decision to collect the multiple specimens was made at the same time, the multiple tests are deemed to belong to the same patient episode. In addition, if more than one

request is made, on the same or different days, for tests on the same specimen within 14 days, they are part of the same patient episode.

Rule 4 of the Pathology Services Table provides an exemption to the above and enables services requested on one day which are performed under strictly limited circumstances for seriously or chronically ill patients with certain specified conditions to each be classified as a patient episode. See PD.2 for further information on exemptions.

Rule 14.(8) also provides that only a single patient episode initiation fee will be payable for all the specimens collected on one day from one patient in or by one Approved Pathology Authority.

PN.0.7 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.

PN.0.8 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.

PN.0.9 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.

PN.0.10 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.

PN.0.11 Designated Pathology Service

This means a pathology service specified in items 65150, 65175 66650, 66695, 66711, 66722, 66785, 66800, 66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165. Where one Approved Pathology Practitioner in an Approved Pathology Authority has performed some but not all the estimations in a coned item and has requested another Approved Pathology Practitioner in another Approved Pathology Authority to do the rest, the service provided by the second practitioner is deemed to be the "designated pathology service". Thus the first practitioner claims under the appropriate item for the services which he/she provides while the second practitioner claims one of items 65150, 65175, 66650, 66695, 66711, 66722, 66785, 66800, 66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165. Where one Approved Pathology Practitioner in an Approved Pathology Authority has performed some, but not all estimations and has requested another Approved Pathology Practitioner in another Approved Pathology Authority to do the remainder, the first Approved Pathology Practitioner can raise a "patient episode initiation fee". The second Approved Pathology Practitioner who receives the specimen can raise a "specimen referred fee".

PN.0.12 Interpretation of The Schedule - Items Referring to 'The Detection Of'

Items that contain the term 'detection of' should be taken to mean 'testing for the presence of'.

PN.0.13 Blood Grouping - (Item 65096)
Where a request includes 'Group and Hold' or 'Group and Save', the appropriate item is 65096.

PN.0.14 Glycosylated Haemoglobin - (Item 66551)
The requirement of "established diabetes" in this item may be satisfied by:

(a) a statement of the diagnosis by the ordering practitioner on the current request form or on a previous request form held in the database of the Approved Pathology Authority; or

(b) two or more blood glucose levels that are in the diabetic range and is contained in the database of the Approved Pathology Authority; or

(c) an oral glucose tolerance test result that is in the diabetic range and is contained in the database of the Approved Pathology Authority.

PN.0.15 Iron Studies - (Item 66596)
Where a request includes 'Iron Studies', 'IS', 'Fe', '% saturation' or 'Iron', the relevant item is 66596.

PN.0.16 Faecal Occult Blood - (Items 66764 to 66770)

PN.0.17 Antibiotics/Antimicrobial Chemotherapeutic Agents
A test for the quantitation of antibiotics/antimicrobial chemotherapeutic agents is claimable under item 66800 or 66812 - 'quantitation of a drug being used therapeutically'.

PN.0.18 Human Immunodeficiency Virus (HIV) Diagnostic Tests - (Iincluded in Items 69384, 69387, 69390, 69393, 69396, 69405, 69408, 69411, 69413 and 69415)
Prior to ordering an HIV diagnostics tests (included in items 69384, 69387, 69390, 69393, 69396, 69405, 69408, 69411, 69413, 69415) the ordering practitioner should ensure that the patient has given informed consent. Appropriate discussion should be provided to the patient. Further discussion may be necessary upon receipt of the test results.

PN.0.19 Hepatitis - (Item 69481)
Benefits for item 69481 are payable only if the request from the ordering practitioner indicates in writing that the patient is suspected of suffering from acute or chronic hepatitis; either by the use of the provisional diagnosis of hepatitis or by relevant clinical or laboratory information eg "hepatomegaly", "jaundice" or "abnormal liver function tests".

PN.0.20 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.

PN.0.21 Tissue Pathology and Cytology - (Items 72813 to 73061)
When services described in Group P5 need to be performed upon material which is submitted for cytology items listed in Group P6 only the fee for the P6 item can be claimed.

PN.0.22 Cervical and Vaginal Screening - (Items 73070 to 73076)
It is the responsibility of the treating healthcare practitioner to determine if the sample is being collected as part of the routine screening program under 73070 or 73071 or represents a sample falling under 73072 or 73073 or 73074 or 73075 or 73076, and to indicate this on the request form. Unless a co-test is specifically requested, requiring the pathology laboratory to perform both a human papillomavirus (HPV) test and a liquid based cytology (LBC) test on

the same specimen, the pathology laboratory will by default perform an HPV test and then only undertake reflex LBC testing if oncogenic HPV (any type) is detected. The pathology laboratory will issue the HPV test result, the LBC test result and overall screening risk rating as a combined report as prescribed by the National Pathology Accreditation Advisory Council (NPAAC) Requirements for Laboratories reporting tests for the National Cervical Screening Program (NPAAC Requirements).

The test used for detecting oncogenic HPV must allow partial HPV genotyping to identify HPV16, HPV18 with or without HPV45 as well as meet the criteria for a population based screening test as prescribed by the NPAAC Requirements.

When used together, the self-collection device and the HPV test must meet the NPAAC Requirements, including the HPV test must be a polymerase chain reaction (PCR) test.

73070 applies to an HPV test on a cervical specimen for primary screening purposes and collected by a healthcare practitioner (or an accredited test provider under the supervision of a healthcare practitioner) from an asymptomatic patient as part of routine five yearly screening recommended by the National Cervical Screening Program. 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, this includes HPV testing that is performed in accordance with the policy of the National Cervical Screening Program (available at www.cancerscreening.gov.au). This policy provides for a screening interval of five years for an asymptomatic patient commencing at 24 years and 9 months of age and for a patient aged between 70 to 74 years of age to cease cervical screening if the last test result is normal (i.e. low risk). A patient aged 75 years of age or older who has never had a cervical screening test or has not had one in the previous five years, may request a cervical screening test and be screened.

In accordance with the national policy for the National Cervical Screening Program, where oncogenic HPV (any type) is detected, the pathology laboratory will conduct reflex LBC automatically under 73076 (a) without requiring an additional request by the treating healthcare professional.

73071 only applies to HPV tests for primary screening purposes requested by a healthcare practitioner on a self-collected vaginal specimen if a specimen collected by a healthcare practitioner has been declined.

HPV testing on self collected vaginal specimens carried out under 73071 should be in accordance with the agreed National Cervical Screening Program Self Collection Policy. The Policy allows self collection where a patient is ≥ 30 years of age and has either never screened or is under screened (i.e. overdue for cervical screening by at least two years, being greater than 7 years since the patient's last HPV screening test). A patient aged 75 years of age or older who has never had a cervical screening test or has not had one in the previous seven years, may request a self collected vaginal sample and be screened.

During the early years of the transition, this may include a patient who is overdue since the patient's last conventional Pap test (i.e. greater than four years since last conventional Pap).

It is the intention of the National Cervical Screening Program where oncogenic HPV has previously been detected under this Item, the healthcare practitioner collected liquid based sample from the cervix that follows, can be claimed under 73076 (a) with a further request by the treating healthcare practitioner.

73072 applies to HPV tests where the specimen has been collected in accordance with the National Cervical Screening Program: Guidelines for the Management of Screen Detected Abnormalities, Screening in Specific Populations and Investigation of Abnormal Vaginal Bleeding (2016 Guidelines) which provides for:

(a) an HPV test (and reflex LBC) performed on a patient within a specific population suggestive of a higher risk of pre cancerous or cancerous cervical changes. HPV tests carried out in specific populations under Item 73072 should be in accordance with the 2016 Guidelines including:

(i) screening with a primary HPV test (and reflex LBC) every 3 years for an immune-deficient patient; or

(ii) a single HPV test between 20 and 24 years of age could be considered by healthcare practitioners on a case by case basis for a patient who experienced first sexual activity at a young age (less than 14 years of age) and who has not received the HPV vaccine before sexual debut; or

(b) an HPV test (and reflex LBC) performed for the follow up management of previously detected oncogenic HPV infection with a negative or possible/low grade squamous intraepithelial lesion (LSIL) cytology result; or

(c) a co-test (HPV+LBC) for the investigation of symptoms of cervical cancer, most commonly abnormal vaginal bleeding; or

(d) co-test (HPV+LBC) for the management of a patient following treatment of high grade squamous intraepithelial lesions (HSIL) of the cervix as part of a 'test of cure' process performed at 12 months after treatment and annually thereafter, until receiving a negative co-test on two separate consecutive occasions, then the patient can return to routine five yearly screening. In accordance with the 2016 Guidelines this also applies to a patient undergoing follow up or post-treatment for a glandular abnormality as part of annual surveillance performed indefinitely; or

(e) a co-test (HPV+LBC) for the follow up management of glandular abnormalities; or

(f) a co-test (HPV+LBC) for screening a patient exposed to diethylstilbestrol (DES) in utero and daughters of patients exposed to DES in utero, if requested.

A co-test requires both HPV and LBC tests to be performed irrespective of the HPV test result. A reflex LBC is only required if oncogenic HPV (any type) is detected; where oncogenic HPV (any type) has been detected in a liquid based sample from the cervix by a healthcare professional, the pathology laboratory will conduct LBC automatically without requiring an additional request.

73073 applies to the management of a patient with previously detected oncogenic HPV (any type) infection on a self collected vaginal sample if a specimen collected by a healthcare practitioner has been declined. It may only be claimed when the test is performed within in a 21 month period following detection of oncogenic HPV (any type) associated with 73071.

It is expected that most patients who are undergoing follow up, after detection of oncogenic HPV (any type) on a self collected vaginal sample, will agree to have a clinician collected cervical sample at the follow up visit. Some patients may decline and this Item applies to this group of patients. It is the intention of the National Cervical Screening Program where oncogenic HPV has previously been detected under this Item, the healthcare practitioner collected liquid based sample from the cervix that follows, can be claimed under 73076 (a) with a further request by the treating healthcare practitioner.

73074 applies to an HPV test on a vaginal vault specimen collected by a healthcare practitioner (or an accredited test provider under the supervision of a healthcare practitioner) from a patient with past history of total hysterectomy, in accordance with the 2016 Guidelines which provides for:

(a) an HPV test for a patient who has no evidence of cervical pathology and the patient's screening history is not available, performed at 12 months following a total hysterectomy and annually thereafter until a patient has two negative HPV tests (i.e. oncogenic HPV not detected) on two separate consecutive occasions and can be advised that no further testing is required; or

(b) a co-test (HPV+LBC) for a patient who has had a total hysterectomy, performed at 12 months following a total hysterectomy and annually thereafter until two consecutive co-tests are negative:

(i) if unexpected LSIL or HSIL is identified in the cervix at the time of total hysterectomy after completed 'test of cure' process; or

(ii) if the total hysterectomy was for treatment of high-grade cervical intraepithelial neoplasia in the presence of benign gynaecological disease; or

(iii) if the total hysterectomy was after histologically confirmed HSIL without Test of Cure and there is no cervical pathology; or

(c) indefinite co-testing (HPV+LBC) for a patient who has had a total hysterectomy, performed at 12 months after treatment and annually thereafter if the total hysterectomy was after adenocarcinoma in situ (AIS).

73075 applies to HPV tests repeated due to an unsatisfactory HPV test under 73070 or 73071 or 73072 or 73073 or 73074.

73076 applies to a liquid-based cytology (LBC) test on a cervical or vaginal vault specimen:

(a) as part of a reflex test following detection of oncogenic HPV described in the national policy and 2016 Guidelines associated with items 73070 or 73071 or 73072 (a) or (b) or 73073 or 73074 or 73075; or

(b) as part of a co-test described in the national policy and 2016 Guidelines under 73072 (c) or (d) or (e) of (f) or 73074; or

(c) where the previous specimen collected is unsatisfactory; or

(d) for the follow up management of a patient with a past history of total hysterectomy for endometrial adenocarcinoma.

PN.0.23 Detection of mutation tests (Items 73297, 73300, 73305, 73334, 73339 and 73340)

Prior to ordering these tests (73297, 73300, 73305, 73334, 73339 and 73340) the ordering practitioner should ensure the patient (or approximate proxy) has given informed consent. Testing should only be performed after genetic counselling. Appropriate genetic counselling should be provided to the patient either by the specialist treating practitioner, a genetic counselling service or a clinical geneticist on referral. Further counselling may be necessary upon receipt of the test results.

PN.0.24 Additional Bulk Billing Payment for Pathology Services - (Item 74990 and 74991)

Item 74990 operates in the same way as item 10990 and item 74991 operates in the same way as item 10991, apart from the following differences:

· Item 74990 and 74991 can only be used in conjunction with items in the Pathology Services Table of the MBS;

· Item 74990 and 74991 applies to unreferred pathology services performed by a medical practitioner which are included in Group P9 of the Pathology Services Table, and unreferred pathology services provided by category M laboratories;

· Item 74990 and item 74991 applies to pathology services self determined by general practitioners and specialists with dual qualifications acting in their capacity as general practitioners;

· Specialists and consultant physicians who provide pathology services are not able to claim item 74990 or item 74991 unless, for the purposes of the Health Insurance Act, the medical practitioner is also a general practitioner and the service provided by the medical practitioner has not been referred to that practitioner by another medical practitioner or person with referring rights.

Rules 3 and 18 of the *Health Insurance (Pathology Services Table) Regulations 2003* have been amended to exclude item 74990 and 74991 from the Multiple Services Rule and the Coning Rule.

Item 74991 can only be used where the service is provided at, or from, a practice location in a regional, rural or remote area (RRMA 3 to 7 under the Rural Remote Metropolitan Areas classification system), or in all of Tasmania.

PN.0.25 Transfer of Existing Items from Group P1 (Haematology) to Group P7 Genetics Effective 1 May 2006.

P16.14 has been created to note the transfer of existing items from Group P1 (Haematology) items 65168, 65174, 65200 and item 66794 from Group P2 (Chemistry) to Group P7 (Genetics) as items 73308, 73311, 73314, 73317 and the introduction of the new item in Group P7 (Genetics) item 73320 HLA-B27 typing by nucleic acid amplification (NAA) which was effective as of 1 May 2006.

PN.0.26 RAS gene mutation status (Item 73338)

Item 73338 provides for testing of RAS mutations to limit subsidy of anti-EGFR antibodies to only those patients demonstrated to have no RAS mutations.

For a Medicare benefit to be payable, the test must be conducted for all clinically relevant mutations on KRAS exons 2, 3 and 4 and NRAS exons 2, 3 and 4, or until a RAS mutation is found.

Enabling the requirements of the item descriptor to be met once any RAS mutation is found means that once the test indicates that the patient is not RAS wild-type and therefore not suitable for access to cetuximab and panitumumab under the PBS, a pathologist is not required to continue testing for other clinically relevant mutations.

PN.0.27 Germline BRCA gene mutation tests (Items 73295, 73296 and 73333)

Patients who are found to have any form of affected allele should be referred for post-test genetic counselling as there may be implications for other family members. Appropriate genetic counselling should be provided to the patient either by the specialist treating practitioner, a genetic counselling service or a clinical geneticist on referral.

PN.0.28 Abbreviations, Groups of Tests

As stated at P3.2 of the Outline, details that must be recorded on accounts, receipts or assignment forms of an Approved Pathology Practitioner/Authority include a description of the pathology service that is of sufficient detail to identify the specific service rendered. The lists of abbreviations for group tests are contained in PQ.4. The lists of abbreviations for individual tests are contained in the Index to this Section. The abbreviations are provided to allow users to identify and refer to particular pathology services, or particular groups of pathology services, more accurately and conveniently.

The above requirements may be used for billing purposes but treating practitioners requesting pathology services are encouraged to use the approved abbreviations. In this regard treating practitioners should note that:

- pathology services cannot be self determined by a rendering pathologist responding to a request. This places the onus for medical necessity on the treating practitioner who, in normal circumstances would, if he or she was unclear in deciding the appropriate test for a clinical situation, consult a pathologist for assistance; and

- Approved Pathology Practitioners/Authorities undertake not to issue accounts etc unless the pathology service was rendered in response to an unambiguous request.

PN.0.29 Tests not Listed

Tests which are not listed in the Pathology Services Table do not attract Medicare benefits. As explained at PN.1 of the Outline, changes to the Pathology Services Table can only be made by the Minister for Health and Ageing.

PN.0.30 Audit of Claims

The Department of Human Services is undertaking routine audits of claims for pathology benefits against requested services to ensure compliance with the provisions of the Health Insurance Act 1973.

PN.0.31 Groups of Tests

For the purposes of recording a description of the pathology service on accounts etc, an Approved Pathology Practitioner /Authority may use group abbreviations or group descriptions for the following specified groups of

tests. These groups consist of two or more tests within the same item. These groups exclude abbreviations such as MBA and TORCH.

Treating practitioners are encouraged to use these group abbreviations or group descriptions where appropriate.

For ease of identification of group tests, it is recommended that practitioners use the following abbreviations. Tests requested individually may attract Medicare benefits.

Group	**Estimations included in Group**	**Group Abbreviation**	**Item Numbers**
Cardiac enzymes or cardiac markers	Creatine kinase isoemzymes, Myoglobin, Troponin	CE / CM	66518, 66519
Coagulation studies	Full blood count, Prothrombin time, Activated partial thromboplastin time and two or more of the following tests - Fibrinogen, Thrombin, Clotting time, Fibrinogen degradation products, Fibrin monomer, D-dimer factor XIII screening tests	COAG	65129, 65070
Electrolytes	Sodium (NA), Potassium (K), Chloride (CL) and Bicarbonate (HCO3)	E	66509
Full Blood Examination	Erythrocyte count, Haematocrit, Haemoglobin, Platelet count, Red cell count, Leucocyte count, Manual or instrument generated differential, Morphological assessment of blood film where appropriate	FBE, FBC, CBC	65070
Lipid studies	Cholesterol (CHOL) and Triglycerides (TRIG)	FATS	66503
Liver function tests	Alkaline phosphatase (ALP), Alanine aminotransferase (ALT), Aspartate aminotransferase (AST), Albumin (ALB), Bilirubin (BIL), Gamma glutamyl transpeptidase (GGT), Lactate dehydrogenase (LDH), and Protein (PROT)	LFT	66512
Syphilis serology	Rapid plasma regain test (RPR), or Venereal disease research laboratory test (VDRL), and Treponema pallidum haemagglutination test (TPHA), or Fluorescent treponemal antibody-absorption test (FTA)	STS	69387
Urea, Electrolytes, Creatinine	Urea, Electrolytes, Creatinine	U&E	66512

PN.0.32 Complexity Levels for Histopathology Items

Only one of these histopathology examination items (72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838) can be claimed in a patient episode.

The remaining items (72844, 72846, 72847, 72848, 72849, 72850, 72851, 72852, 72855, 72856 and 72857) are add-on items, covering enzyme histochemistry and immunohistochemistry, electron microscopy and frozen sections, which can be claimed in addition to the main item.

The list of complexity levels by type of specimen are contained at the back of this Section.

PN.0.33 Pathology Services Table

Rules for the Interpretation of the Pathology Services Table

Please note that in the Health Insurance (Pathology Services Table) Regulations 2010 (effective 1 November 2010) rules and sub-rules are referred to as clauses and sub-clauses. In addition in the Regulations a rule that refers to specific items within a pathology group, for example Group P1 Haemotology, is listed directly above the Schedule of Services for that group. A table cross referencing the following rules with the clauses in the Regulations is at the end of this section.

1. (1) In this table

patient episode means:

(a) a pathology service or pathology services (other than a pathology service to which paragraph 1 (1) (b) refers) provided for a single patient whose need for the service or services was determined under section 16A of the Act:

(i) on the same day; or

(ii) if more than 1 test is performed on the 1 specimen within 14 days - on the same or different days;

whether the services:

(iii) are requested by 1 or more practitioners; or

(iv) are described in a single item or in more than 1 item; or

(v) are rendered by 1 approved pathology practitioner or more than 1 approved pathology practitioner; or

(vi) are rendered on the same or different days; or

(b) a pathology service to which rule 4 refers that is provided in the circumstances set out in that rule that relates to the service.

receiving APP means an approved pathology practitioner in an approved pathology authority who performs one or more pathology services in respect of a single patient episode following receipt of a request for those services from a referring APP.

recognised pathologist means a medical practitioner recognised as a specialist in pathology by a determination under section 3D, 3DB or 3E of the Act.

referring APP means an approved pathology practitioner in an approved pathology authority who:

(i) has been requested to render 1 or more pathology services, all of which are requested in a single patient episode; and

(ii) is unable, because of the lack of facilities in, or expertise or experience of the staff of, the laboratory of the authority, to render 1 or more of the pathology services; and

(iii) requests an approved pathology practitioner (the ***receiving APP***) in another approved pathology authority to render the pathology service or services that the referring APP is unable to render; and

(iv) renders each pathology service (if any) included in that patient episode, other than the pathology service or services in respect of which the request mentioned in subparagraph (iii) is made.

serial examinations means a series of examinations requested on 1 occasion whether or not:

(a) the materials are received on different days by the approved pathology practitioner; or

(b) the examinations or cultures were requested on 1 or more request forms by the treating practitioner.

***the* Act** means the *Health Insurance Act 1973.*

1. (2) In these rules, a reference to a request to an approved pathology practitioner includes a reference to a request for a pathologist-determinable service to which subsection 16A (6) of the Act applies.

1. (3) A reference in this table by number to an item that is not included in this table is a reference to the item that has that number in the general medical services table or the diagnostic imaging services table, as the case requires.

1. (4) A reference to a **Group** in the table includes every item in the Group and a reference to a **Subgroup** in the table includes every item in the Subgroup.

Precedence of items

2. (1) If a service is described:

(a) in an item in general terms; and

(b) in another item in specific terms;

only the item that describes the service in specific terms applies to the service.

2. (2) Subject to subrule (3), if:

(a) subrule (1) does not apply; and

(b) a service is described in 2 or more items;

only the item that provides the lower or lowest fee for the service applies to the service.

2. (3) If an item is expressed to include a pathology service that is described in another item, the other item does not apply to the service in addition to the first-mentioned item, whether or not the services described in the 2 items are requested separately.

Application of item 74990 and 74991

2. (4) Despite subrules (1), (2) and (3):

(a) if the pathology service described in item 74991 is provided to a person, either that item or item 74990, but not both those items, applies to the service; and

(b) if item 74990 or 74991 applies to a pathology service, the fee specified in that item applies in addition to the fee specified in any other item in the table that applies to the service.

2. (5) For items 74990 and 74991:

bulk-billed, in relation to a pathology service, means:

(a) a medicare benefit is payable to a person in respect of the service; and

(b) under an agreement entered into under section 20A of the Act:

(i) the person assigns to the practitioner by whom, or on whose behalf, the service is provided, his or her right to the payment of the medicare benefit; and

(ii) the practitioner accepts the assignment in full payment of his or her fee for the service provided.

Commonwealth concession card holder means a person who is a concessional beneficiary within the meaning given by subsection 84(1) of the *National Health Act 1953*.

unreferred service means a pathology service that:

(a) is provided to a person by, or on behalf of, a medical practitioner, being a medical practitioner who is not a consultant physician, or specialist, in any speciality (other than a medical practitioner who is, for the purposes of the Act, both a general practitioner and a consultant physician, or specialist, in a particular speciality); and

(b) has not been referred to the medical practitioner by another medical practitioner or person with referring rights.

2. (6) For item 74991:

ASGC means the document titled Australian Standard Geographical Classification (ASGC) 2002, published by the Australian Bureau of Statistics, as in force on 1 July 2002.

practice location, in relation to the provision of a pathology service, means the place of practice in respect of which the practitioner by whom, or on whose behalf, the service is provided, has been allocated a provider number by the Commission**.**

Regional, rural or remote area means an area classified as RRMAs 3-7 under the Rural, Remote and Metropolitan Areas Classification.

Rural, Remote and Metropolitan Areas Classification has the meaning given by subrule 3 (1) of Part 2 of Schedule 1 to the general medical services table**.**

SLA means a Statistical Local Area specified in the ASGC.

SSD mean a Statistical Subdivision specified in the ASGC.

Circumstances in which services rendered following 2 requests to be taken to have been rendered following 1 request

3. (1) In subrule 3(2), ***service*** includes assay, estimation and test.

3. (2) Two or more pathology services (other than services to which, under rule 4, this rule does not apply) rendered for a patient following 2 or more requests are taken to have been rendered following a single request if:

(a) the services are listed in the same item; and

(ab) that item is not item 74990 or 74991; and

(b) the patient's need for the services was determined under subsection 16A (1) of the Act on the same day even if the services are rendered by an approved pathology practitioner on more than one day.

Services to which rule 3 does not apply

4. (1) Rule 3 does not apply to a pathology service described in item 65060, 65070, 65120, 65123, 65126, 65129, 65150, 65153, 65156, 66500, 66503, 66506, 66509, 66512, 66584 or 66800, if:

(a) the service is rendered in relation to one or more specimens taken on each of not more than 6 separate occasions in a period of 24 hours; and

(b) the service is rendered to an inpatient in a hospital; and

(c) each service must be rendered as soon as possible after collection and after authorization of the result of the previous specimen; and

(d) the account for the service is endorsed 'Rule 3 Exemption'.

4. (2) Rule 3 does not apply to any of the following pathology services:

(a) estimation of prothrombin time (INR) in respect of a patient undergoing anticoagulant therapy;

(b) quantitative estimation of lithium in respect of a patient undergoing lithium therapy;

(c) a service described in item 65070 in relation to a patient undergoing chemotherapy for neoplastic disease or immunosuppressant therapy;

(d) a service described in item 65070 in relation to clozaril, ticlopidine hydrochloride, methotrexate, gold, sulphasalazine or penicillamine therapy of a patient;

(e) a service described in item 66500 - 66512 in relation to methotrexate or leflunomide therapy of a patient;

(f) quantitative estimation of urea, creatinine and electrolytes in relation to:

(i) cis-platinum or cyclosporin therapy of a patient; or

(ii) chronic renal failure of a patient being treated in a dialysis program conducted by a recognised hospital;

(g) quantitative estimation of albumin and calcium in relation to therapy of a patient with vitamin D, its metabolites or analogues;

(h) quantitative estimation of calcium, phosphate, magnesium, urea, creatinine and electrolytes in cancer patients receiving bisphosphonate infusions.

if:

(i) under a request for a service, other than a request for a service described in paragraph (a), no more than 6 tests are requested; and

(ii) the tests are performed within 6 months of the request; and

(iii) the account for the service is endorsed "Rule 3 Exemption".

4. (3) Rule 3 does not apply to a pathology service described in items 65109 or 65110 if:

(a) The service is rendered on not more than 5 separate occasions in the case of item 65109 and 2 separate occasions in the case of item 65110 in a period of 24 hours; and

(b) The service is rendered in response to a written request separated in time from the previous request; and

(c) The account for the service is endorsed "Rule 3 Exemption".

Item taken to refer only to the first service of a particular kind

5. (1) For an item in Group P1 (Haematology):

(a) if pathology services of a kind referred to in item 65090 or 65093 are rendered for a patient during a period when the patient is in hospital, the item applies only to the first pathology service of that kind rendered for the patient during the period; and

(b) if:

(i) tests (except tests mentioned in item 65099, 65102, 65105 and 65108) are carried out in relation to a patient episode; and

(ii) specimen material from the patient episode is stored; and

(iii) in response to a request made within 14 days of the patient episode, further tests (except tests mentioned in item 65099, 65102, 65105 and 65108) are carried out on the stored material; the later tests and the earlier tests are taken to be part of one patient episode.

5. (2) Benefits for items 65102 and 65108 are payable only if a minimum of 6 units are issued for the patient's care in any 1 day.

5.(3) For items 65099 and 65102:

compatibility tests by crossmatch means that, in addition to all the tests described in paragraphs (a) and (b) of the item, donor red cells from each unit must have been tested directly against the serum of the patient by 1 or more accepted crossmatching techniques.

Certain items not to apply to a service referred by one pathology practitioner to another

6. (1) In this rule:

designated pathology service means a pathology service in respect of tests relating to a single patient episode that are tests of the kind described in item 65150, 65175, 66650, 66695, 66711, 66722, 66785, 66800, 66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165.

6. (2) This rule applies in respect of a designated pathology service where:

(a) an approved pathology practitioner ***(practitioner A)*** in an approved pathology authority:

(i) has been requested to render the designated pathology service; and

(ii) is unable, because of the lack of facilities in, or expertise or experience of the staff of, the laboratory of the authority, to render 1 or more of the tests included in the service; and

(iii) requests an approved pathology practitioner ***(practitioner B)*** in another approved pathology authority to render the test or tests that practitioner A is unable to render; and

(iv) renders each test (if any) included in the service, other than the test or tests in respect of which the request mentioned in subparagraph (iii) is made; and

(b) the tests mentioned in subparagraph (a) (iv) that practitioner A renders are not tests constituting a service described in item 65156, 65179, 66653, 66712, 66734, 66788, 66806, 66815, 66822, 66828, 69496, 71093, 71159 or 71168.

6. (3) If this rule applies in respect of a designated pathology service:

(a) item 65150, 65153, 65175, 65176, 65177, 65178, 66650, 66695, 66698, 66701, 66704, 66707, 66711, 66722, 66725, 66728, 66731, 66785, 66800, 66803, 66812, 66819, 66825, 69384, 69387, 69390, 69393, 69396, 69494, 69495, 71089, 71091, 71153, 71155, 71157, 71165, 71166 or 71167 (as the case requires) applies in respect of the test or tests rendered by practitioner A; and

(b) where practitioner B renders a service under a request referred to in subparagraph (2) (a) (iii) and:

(i) practitioner A has rendered one or more of the tests that the service comprises - subject to subrule (4), the amount specified in item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 (as the case requires) shall be taken to be the fee for each test that the service comprises; or

(ii) practitioner A has not rendered any of the tests that the service comprises -

(A) the amount specified in item 65157, 65180, 66651, 66696, 66714, 66723, 66789, 66804, 66816, 66820, 66826, 69400, 69497, 71090, 71154 or 71169 (as the case requires) shall be taken to be the fee for the first test that the service comprises; and

(B) subject to subrule (4), the amount specified in item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 (as the case requires) shall be taken to be the fee for each subsequent test that the service comprises.

6. (4) For paragraph (3) (b), the maximum number of tests to which item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 applies is:

(a) for item 66652, 66715, 66790, 66817, 66821 or 66827:

2 - X; and

(b) for item 65158, 66805, 69498 or 71092:

3 - X; and

(c) for item 71156 or 71170:

4 - X; and

(d) for item 65181 or 66724:

5 - X; and

where X is the number of tests rendered by practitioner A in relation to the designated pathology service in respect of which the request mentioned in that paragraph is made.

6. (5) Items in Group P10 (Patient episode initiation) do not apply to the second mentioned approved pathology practitioner in subrule (2).

Items not to be split

7. Except as stated in rule 6, the amount specified in an item is payable only to one approved pathology practitioner in respect of a single patient episode.

Creatinine ratios - Group P2 (chemical)

8. A pathology service mentioned in an item (except item 66500) in Group P2 (chemical) that:

(a) involves the measurement of a substance in urine; and

(b) requires calculation of a substance/creatinine ratio;

is taken to include the measurement of creatinine necessary for the calculation.

Thyroid function testing

9. (1) For item 66719:

abnormal level of TSH means a level of TSH that is outside the normal reference range in respect of the particular method of assay used to determine the level.

9. (2) Except where paragraph (a) of item 66719 is satisfied, the amount specified in the item is not payable in respect of a pathology service described in the item unless the pathologist who renders the service has a written statement from the medical practitioner who requested the service that satisfies subrule (3).

9. (3) The written statement from the medical practitioner must indicate:

(a) that the tests are required for a particular purpose, being a purpose specified in paragraph (b) of item 66719; or

(b) that the medical practitioner who requested the tests suspects the patient has pituitary dysfunction; or

(c) that the patient is on drugs that interfere with thyroid hormone metabolism or function.

Meaning of "serial examinations or cultures"

10. For an item in Group P3 (Microbiology):

(a) ***serial examinations or cultures*** means a series of examinations or cultures requested on 1 occasion whether or not:

(i) the materials are received on different days by the approved pathology practitioner; or

(ii) the examinations or cultures were requested on 1 or more request forms by the treating practitioner; and

(b) if:

(i) tests are carried out in relation to a patient episode; and

(ii) specimen material from the patient episode is stored; and

(iii)in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;

the later tests and the earlier tests are taken to be part of one patient episode.

Investigation for hepatitis serology

11. A medicare benefit is not payable in respect of more than one of items 69475, 69478 and 69481 in a patient episode.

Tests in Group P4 (Immunology) relating to antibodies

12. For items in Group P4 (Immunology), in items 71119, 71121, 71123 and 71125, if:

(a) tests are carried out in relation to a patient episode; and

(b) specimen material from the patient episode is stored; and

(c) in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;

the later tests and the earlier tests are taken to be part of one patient episode.

Tests on biopsy material - Group P5 (Tissue pathology) and Group P6 (Cytology)

13. (1) For items in Group P5 (Tissue pathology):

(a) ***biopsy material*** means all tissue received by the Approved Pathology Practitioner:

(i) from a medical procedure or group of medical procedures performed on a patient at the same time; or

(ii) after being expelled spontaneously from a patient.

(b) ***cytology*** means microscopic examination of 1 or more stained preparations of cells separated naturally or artificially from their normal environment by methods recognised as adequate to demonstrate their structure to a degree sufficient to enable an opinion to be formed about whether they are likely to be normal, abnormal but benign, or abnormal and malignant but, in accordance with customary laboratory practice, does not include examination of a blood film and a bone marrow aspirate; and

(c) ***separately identified specimen*** means an individual specimen collected, identified so that it is clearly distinguished from any other specimen, and sent for testing by or on behalf of the treating practitioner responsible for the procedure in which the specimen was taken.

13. (2) For Groups P5 and P6 of the pathology services table, services in Group P6 include any services described in Group P5 on the material submitted for a test in Group P6.

13. (3) For subrule (2), any sample submitted for cytology from which a cell block is prepared does not qualify for a Group P5 item.

13.(4) If more than 1 of the services mentioned in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 are performed in a single patient episode, only the fee for the item performed having the highest specified fee is applicable to the services.

13.(5) If more than 1 histopathological examinations are performed on separate specimens, of different complexity levels, from a single patient episode, a medicare benefit is payable only for the examination that has the highest schedule fee.

13.(6) In items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 a reference to a ***complexity level*** is a reference to the level given to a specimen type mentioned in Part 4 of this Table.

13.(7) If more than 1 of the services mentioned in items 72846, 72847, 72848; 72849 and 72850 or 73059, 73060, 73061, 73064 and 73065 are performed in a single patient episode, a medicare benefit is payable only for the item performed that has the highest scheduled fee.

13.(8) If more than 1 of the services mentioned in items 73049, 73051, 73062, 73063, 73066 and 73067 are performed in a single patient episode, only the fee for the item performed having the higher or highest specified fee applies to the services.

Items in Groups P10 (Patient episode initiation) and P11 (Specimen referred) not to apply in certain circumstances

14. (1) For this rule and items in Groups P10 (Patient episode initiation) and P11 (Specimen referred):

approved collection centre has the same meaning as in Part IIA of the Act.

institution means a place at which residential accommodation or day care is, or both residential accommodation and day care are, made available to:

(a) disadvantaged children; or

(b) juvenile offenders; or

(c) aged persons; or

(d) chronically ill psychiatric patients; or

(e) homeless persons; or

(f) unemployed persons; or

(g) persons suffering from alcoholism; or

(h) persons addicted to drugs; or

(i) physically or mentally handicapped persons;

but does not include:

(j) a hospital; or

(k) a residential aged care home; or

(l) accommodation for aged persons that is attached to a residential aged care home or situated within a residential aged care home.

prescribed laboratory means a laboratory operated by:

(a) the Australian Government; or

(b) an authority of the Commonwealth; or

(c) a State or internal Territory; or

(d) an authority of a State or internal Territory; or

(e) an Australian tertiary education institution.

specimen collection centre has the same meaning as in Part IIA of the Act.

treating practitioner has the same meaning as in paragraph 16A(1)(a) of the Act.

14. (2) If a service described in an item in Group P10 is rendered by, or on behalf of, an approved pathology practitioner who is a recognised pathologist, the relevant one of those items does not apply to the service if:

(a) the service is rendered upon a request made in the course of a service provided to a public patient in a recognised hospital or when attending an outpatient service of a recognised hospital.

14. (3) An item in Group P10 or P11 does not apply to a pathology service to which subsection 16A(7) of the Act applies.

14. (4) An item in Group P10 or P11 does not apply to a pathology service unless at least 1 item in Groups P1 to P8 also applies to the service.

14. (5) Subject to subrule (7), if one item in Group P10 applies to a patient episode, no other item in the Group applies to the patient episode.

14. (6) An item in Group P11 applies only to the approved pathology practitioner or approved pathology authority to whom the specimen mentioned in the item was referred.

14. (7) If, in respect of the same patient episode:

(a) services referred to in 1 or more items in Group P5 and 1 or more of Groups P1, P2, P3, P4, P6, P7 and P8 are rendered by an approved pathology practitioner in the laboratory of another approved pathology authority; or

(b) services referred to in 1 or more items in Group P6 and 1 or more of Groups P1, P2, P3, P4, P5, P7 and P8 are rendered by another approved pathology practitioner in the laboratory of another approved pathology authority;

the fee specified in the applicable item in Group P10 is payable to both approved pathology practitioners.

14. (8) If more than one specimen is collected from a person on the same day for the provision of pathology services:

(a) in accordance with more than 1 request; and

(b) in or by a single approved pathology authority;

the fee specified in the applicable item in Group P10 applies once only to the services unless an exemption listed in Rule 4 applies or an exemption has been granted under Rule 3 "S4B(3)".

14. (9) The amount specified in item 73940 is payable only once in respect of a single patient episode.

Application of an item in Group P11 (Specimen referred) to a service excludes certain other items

15. If item 73940 applies to a patient episode, none of the items in Group P10 applies to any pathology service rendered by the approved pathology authority or approved pathology practitioner who claimed item 73940 in respect of the patient episode.

Circumstances in which an item in Group P11 (Specimen referred) does not apply

16. (1) An item in Group P11 does not apply to a referral if:

(a) a service in respect of the same patient episode has been carried out by the referring approved pathology authority; and

(b) the approved pathology authority to which the referral is made is related to the referring approved pathology authority.

16. (2) An approved pathology authority is ***related to*** another approved pathology authority for subrule (1) if:

(a) both approved pathology authorities are employed (including employed under contract) by the same person, whether or not the person is also an approved pathology authority; or

(b) either of the approved pathology authorities is employed (including employed under contract) by the other; or

(c) both approved pathology authorities are corporations and are related corporations within the meaning of the Corporations Act; or

(d) the approved pathology authorities are partners (whether or not either or both of the approved pathology authorities are individuals and whether or not other persons are in partnership with either or both of the approved pathology authorities; or

(e) both approved pathology authorities are operated by the Commonwealth or an authority of the Commonwealth; or

(f) both approved pathology authorities are operated by the same State or internal Territory or an authority of the same State or internal Territory.

16. (3) An item in Group P11 does not apply to a referral if the following common tests are referred either singly or in combination (except if the following items are referred in combination with other items not similarly specified): 65060, 65070, 65120, 66500, 66503, 66506, 66509, 66512, 66536, 66596, 69300, 69303, 69333 or 73527.

Abbreviations

17. (1) The abbreviations in Part 4 of this table may be used to identify particular pathology services or groups of pathology services.

17. (2) The names of services or drugs not listed in Part 4 of this table must be written in full.

Certain pathology services to be treated as 1 service

18. (1) In this rule:

general practitioner means a medical practitioner who:

(a) is not a consultant physician in any specialty; and

(b) is not a specialist in any specialty.

set of pathology services means a group of pathology services:

(a) that consists of services that are described in at least 4different items; and

(b) all of which are requested in a single patient episode; and

(c) each of which relates to a patient who is not an admitted patient of a hospital; and

(d) excludes services referred to in an item in Group P10, Group P11, Group P12 or

Group P13, items 66900, 69484, 73070, 73071, 73072, 73073, 73074, 73075 or 73076; and

(e) excludes services described in the following items:

65079, 65082, 65157, 65158, 65166, 65180, 65181, 66606, 66610, 66639, 66642, 66651, 66652, 66663, 66666, 66696, 66697, 66714, 66715, 66723, 66724, 66780, 66783, 66789, 66790, 66792, 66804, 66805, 66816, 66817, 66820, 66821, 66826, 66827, 66832, 66834, 66837, 69325, 69328, 69331, 69379, 69383, 69400, 69401, 69451, 69500, 69484, 69489, 69492, 69497, 69498, 71076, 71090, 71092, 71096, 71148, 71154, 71156, 71169, 71170, 73309, 73312, 73315, 73318, 73321 and 73324;

where those services are performed by an approved pathology practitioner in an accredited pathology laboratory of an approved pathology authority following referral by another approved pathology practitioner in an accredited pathology laboratory of an approved pathology authority which is not **related to** the first mentioned approved pathology authority.

(1A) An approved pathology authority is **related to** another approved pathology authority for the purposes of paragraph 18(1)(e) if that approved pathology authority would be related to the other approved pathology authority for the purposes of rule 16(2).

18. (2) If a general practitioner requests a set of pathology services, the pathology services in the set are to be treated as individual pathology services in accordance with this rule.

18. (3) If the fee specified in 1 item that describes any of the services in the set of pathology services is higher than the fees specified in the other items that describe the services in the set:

(a) the pathology service described in the first-mentioned item is to be treated as 1 pathology service; and

(b) either:

(i) the pathology service in the set that is described in the item that specifies the second-highest fee is to be treated as 1 pathology service; or

(ii) if 2 or more items that describe any of those services specify the second-highest fee¿ the pathology service described in the item that specifies the second-highest fee, and has the lowest item number, is to be treated as 1 pathology service; and

(c) the pathology services in the set, other than the services that are to be treated as 1 pathology service under paragraphs (a) and (b), are to be treated as 1 pathology service.

18. (4) If the fees specified in 2 or more items that describe any of the services in the set of pathology services are the same, and higher than the fees specified in the other items that describe the services in the set:

(a) the pathology service in the set that is described in the item that specifies the highest fee, and has the lowest item number, is to be treated as 1 pathology service; and

(b) the pathology service in the set that is described in the item that specifies the highest fee, and has the second-lowest item number, is to be treated as 1 pathology service; and

(c) the pathology services in the set, other than the services that are to be treated as 1 pathology service under paragraphs (a) and (b), are to be treated as 1 pathology service.

18. (5) If pathology services are to be treated as 1 pathology service under paragraph (3)(c) or (4)(c), the fee for the 1 pathology service is the highest fee specified in any of the items that describe the pathology services that are to be treated as the 1pathology service.

Hepatitis C viral RNA testing

19. For item 69499 and 69500:

Hepatitis C sero-positive, for a patient, means 2 different assays of Hepatitis C antibodies are positive.

serological status is uncertain, for a patient, means any result where 2 different assays of Hepatitis C antibodies are inconclusive.

Haemochromatosis testing

20. For items 73317 and 73318:

elevated serum ferritin for a patient, means a level of ferritin above the normal reference range in respect of the particular method of assay used to determine the level.

Nutritional and toxicity metals testing

22. (1) For this rule:

nutritional metals testing group means items 66819, 66820, 66821 and 66822.

metal toxicity testing group means items 66825, 66826, 66827, 66828, 66831 and 66832.

22. (2) An item in the nutritional metals testing group or the metal toxicity testing group does not apply in relation to a service performed if medicare benefits are paid or payable for tests that are performed for the same patient in 3 patient episodes requested within 6 months before the request for that service, under any of:

(a) that item; or

(b) the other item in the same group; or

(c) an item in the other group.

Antineutrophil Cytoplasmic Antibody

23. A request for Antineutrophil Cytoplasmic Antibody immunofluorescence test (ANCA) shall be deemed to include requests for antineutrophil proteinase 3 antibody test (PR-3 ANCA) and antimyeloperoxidase antibody test (MPO ANCA) where the immunofluorescence test for ANCA is abnormal, or has been abnormal, or those specific antibodies have been previously detected.

Satisfying Requirements Described in Items

24. Unless stated elsewhere in these rules, where an item contains a requirement, this requirement is satisfied if:

(a) The requirement/s as stipulated in the item descriptor are contained in the request form; or

(b) The requirement/s as stipulated in the item descriptor were supplied previously in writing to the APA and this documentation is retained by the APA; or

(c) The results of other laboratory tests performed in the same episode meet the requirement/s as stipulated in the item descriptor; or

(d) The results of laboratory tests that meet the requirement/s as stipulated in the item descriptor are supplied on the request form; or

The results of laboratory tests that meet the requirement/s as stipulated in the item descriptor are contained in the APA's records.

Limitation on certain items

25. (a) For any particular patient, items 66539, 66605, 66606, 66607, 66610, 69380, 69488, 69489, 71075, 71127, 71135 or 71137 is applicable not more than twice in a 12 month period.

(b) For any particular patient, item 66626 is applicable not more than 36 times in a 12 month period.

(c) For any particular patient, items 66655, 66659, 66838, 66841, 69482, 69491, 69499 or 69500 are applicable not more than once in a 12 month period.

(d) For any particular patient, item 66750 or 66751 is applicable not more than once in a pregnancy.

(e) For any particular patient, item 69336 is applicable not more than once in each period of 7 days.

(f) For any particular patient, items 66551, 66660, 69445, 69451, 69483, 71079 or 73523 are applicable not more than 4 times in a 12 month period.

(g) For any particular patient, items 66554, 66830 and 71077 are applicable not more than 6 times in a 12 month period.

(h) For any particular patient, item 66819, 66820, 66821, 66822, 66825, 66826, 66827 or 66828 is applicable not more than 3 times in a 6 month period.

(i) For any particular patient, items 73339 and 73340 are applicable not more than once.

Antigen Detection - Group P3 (Microbiology)

26. If the service listed in 69316, 69317, 69319, 69494, 69495, 69496, 69497 or 69498 is a pathologist determinable service the specialist pathologist is required to record the reasons for determining the need for this service.

27. If the service rendered in 71148, 73320 or 73321 is a pathologist determinable service, the specialist pathologist is required to record the reason for determining the need for this service including the result of the service in 71147.

Second Opinion morphology, limitations on items 72858 and 72859

28.1 Items 72858 and 72859 apply:

(a) only to a service that is covered by:

(i) item 65084 or 65087; or

(ii) item 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 or 72838; or

(iii) an item in Group P6 (other than item 73070, 73071, 72072, 73073, 73074, 73075 or 73076); and

(b) only if the treating practitioner and the approved pathology practitioner who provided the original opinion on the patient specimen agree that a second opinion is reasonably necessary for diagnostic purposes.

28.2 Items72858 and 72859 do not apply if the accredited pathology laboratory in which the second opinion is provided is the same laboratory in which the original opinion was provided.

Table for Cross Referencing Rules and Clauses appearing in Regulations

1 Nov 2010 MBS Book Rules	**Health Insurance (Pathology Services Table) Regulations 2010 Clauses**					
1	Dictionary					
2	1.2.1	2.12.1				
3	1.2.2					
4	1.2.3	2.1.1	2.2.2			
5	2.1.2					
6	1.2.4					
7	1.2.5					
8	2.2.1					
9	2.2.5					
10	2.3.1					
11	2.3.3					
12	2.4.2					
13	2.5.1	2.6.1				
14	2.10.1	2.11.1				
15	2.11.2					
16	2.11.3					
17	1.1.1					
18	1.2.6					
18A	1.2.7					
19	2.3.5					
20	2.7.1					
21	2.2.4					
22	2.2.7					
23	2.4.4					
24	1.2.8	2.4.5				
25	2.2.3	2.2.6	2.2.7	2.3.4	2.4.1	2.8.1
26	2.3.2					
27	2.4.3	2.7.2				

PN.1.1 Pathology Services in Relation to Medicare Benefits - Outline of Arrangements

Basic Requirements

Determination of Necessity of Service

The treating practitioner must determine that the pathology service is necessary.

Request for Service

The service may only be provided:

(i) in response to a request from the treating practitioner, including a participating midwife or a participating nurse practitioner, or from another Approved Pathology Practitioner and the request must be in writing (or, if oral, confirmed in writing within fourteen days); or

(ii) if determined to be necessary by an Approved Pathology Practitioner who is treating the patient.

Services requested by participating midwives and participating nurse practitioners:

(i) A participating midwife can request the following services:

Items 65060, 65070, 65090 to 65099 (inclusive), 65114, 66500 to 66512 (inclusive), 66545, 66548, 66566, 66743, 66750, 66751, 69303 to 69317 (inclusive), 69324, 69384 to 69415 (inclusive), 73070, 73071, 73075, 73076 and 73529.

(ii) A participating nurse practitioner can request items in the range 65060 to 73529 (inclusive).

Provision of Service

The following conditions relate to provision of services:

(i) the service has to be provided by or on behalf of an Approved Pathology Practitioner;

(ii) the service has to be provided in a pathology laboratory accredited for that kind of service;

(iii) the proprietor of the laboratory where the service is performed must be an Approved Pathology Authority;

(iv) the Approved Pathology Practitioner providing the service must either be the proprietor of the laboratory or party to an agreement, either by way of contract of employment or otherwise, with the proprietor of the laboratory in which the service is provided; and

(v) no benefit will be payable for services provided by an Approved Pathology Practitioner on behalf of an Approved Pathology Authority if they are not performed in the laboratories of that particular Approved Pathology Authority.

Therapeutic Goods Act 1989

For any service listed in the MBS to be eligible for a Medicare rebate, the service must be rendered in accordance with the provisions of the relevant Commonwealth and State and Territory laws. Approved Pathology Practitioners have the responsibility to ensure that the supply of medicines or medical devices used in the provision of pathology services is strictly in accordance with the provisions of the *Therapeutic Goods Act 1989*.

PN.1.2 Exemptions to Basic Requirements

Satisfying requirements described in pathology service

Unless the contrary intention appears, a requirement contained in the description of a pathology service in Part 2 is satisfied if:

(a) for a requirement for information - the information:

(i) is included in the request for the service; or

(ii) was supplied in writing on an earlier occasion to the approved pathology authority that rendered the service, and has been kept by the approved pathology authority; or

(b) for a requirement for laboratory test results ¿ the results are:

(i) included in the request for the service; or

(ii) obtained from another laboratory test performed in the same patient episode; or

(iii) included in results from an earlier laboratory test that have been kept by the approved pathology authority.

Services Where Request Not Required

(i) a pathologist determinable service. A pathologist-determinable service is a pathology service:

(a) that is rendered by or on behalf of an approved pathology practitioner for a person who is a patient of that approved pathology practitioner who has determined that the service is necessary; or

(b) that is specified in item 73332, 73336, 73337, 73341, 73342, 73344 or only one immunohistochemistry items 72846, 72847, 72848, 72849 and 72850, or electronmicroscopy items 72851 and 72852 or immunocytochemistry items 73059, 73060 or 73061 and is considered necessary by the approved pathology practitioner as a consequence of information resulting from a pathology service contained in tissue examination items 72813 - 72838 or cytology items 73045 - 73051 respectively.

Please note: a written request is required for a service contained in items 72813 to 72838 and items 73045 to 73051.

(c) that is specified in one of the antigen detection items 69494, 69495 or 69496 is considered necessary by the approved pathology practitioner as a consequence of information provided by the requesting practitioner or by the nature or appearance of the specimen or as a consequence of information resulting from a pathology service contained in items 69303, 69306, 69312, 69318, 69321 and 69345.

Please note: a written request is required for a service contained in items 69303, 69306, 69312, 69318, 69321 and 69345.

(d) that is specified in item 73320, HLA-B27 typing by nucleic acid amplification, and is considered necessary by the approved pathology practitioner because the results of HLA-B27 typing described in item 71147 are unsatisfactory.

(e) that is specified in item 73305, detection of mutation of the FMRI gene by Southern Blot analysis where the results in item 73300 are inconclusive.

PN.1.3 Circumstances Where Medicare Benefits Not Attracted

Services Rendered by Disqualified Practitioner

Medicare benefits are not payable for pathology services if at the time the service is rendered, the person, by or on whose behalf the service is rendered, is a person in relation to whom a determination is in force in relation to that class of services. That is, where an Approved Pathology Practitioner has breached an undertaking, and a determination has been made that Medicare benefits should not be paid during a specified period (of up to five years) in respect of specified pathology services rendered by the practitioner.

Note: An Approved Pathology Practitioner may be disqualified for reasons other than a breach of undertaking.

Certain Pathology Tests Do Not Attract Medicare Benefits

Certain tests of public health significance do not qualify for payment of Medicare benefits. Examples of services in this category are:

- examination by animal inoculation;
- Guthrie test for phenylketonuria;
- neonatal screening for hypothyroidism (T4/TSH estimation);
- neonatal screening for Cystic Fibrosis;
- neonatal screening for Galactosemia;
- pathology services used with the intention of monitoring the performance enhancing effects of any substance;
- pathology tests carried out on specimens collected from persons occupationally exposed to sexual transmission of disease where the purpose of the collection of specimens is for testing in accordance with conditions determined by the health authority of the State or Territory in which the service is performed.

In addition to the above, certain other tests do not qualify for payment of Medicare benefits. These include:

- cytotoxic food testing;
- pathology services performed for the purposes of control estimation, repeat tests (eg. for confirmation of earlier tests on the same specimen, etc);
- preparation of autogenous vaccines;
- tissue banking and preparation procedures;
- pathology services performed on stillborn babies or cadavers;
- pathology services which are performed routinely in association with the termination of pregnancy without there being any indication for the necessity of the services.

However, benefits will be paid for the following pathology tests:

- item 65060 - haemoglobin estimation;
- item 65090 - blood grouping ABO and Rh (D antigen);
- item 65096 - examination of serum for Rh and other blood group antibodies.

PN.2.1 Responsibilities of Treating/Requesting Practitioners

Form of Request

A treating practitioner may request a pathology service either orally or in writing but oral requests must be confirmed in writing within fourteen days from the day when the oral request was made.

Pathology request forms and combined pathology request/offer to assign forms which are prepared by the pathologists and distributed to requesting practitioners on or after 1 August 2012 must include the minimum information detailed under P.2.2.

All written requests for pathology services should contain the following particulars:

(i) a description of the individual pathology services, or recognised groups of pathology tests to be rendered (see P.17.4 and the Index for acceptable terms and abbreviations). The description must be sufficient to enable the item in which the service is specified to be identified;

(ii) the date of request;

(iii) the name of the requesting practitioner and their practice address or provider number;

(iv) the patient's name and address;

(v) details of the hospital status of the patient, as follows (for benefit rate assessment). That is, whether the patient was or will be, at the time of the service and when the specimen is obtained:

(a) a private patient in a private hospital, or approved day hospital facility;

(b) a private patient in a recognised hospital;

(c) a public patient in a recognised hospital;

(d) an outpatient of a recognised hospital;

Offence Not to Confirm an Oral Request

A requesting practitioner who, without reasonable excuse, does not confirm in writing an oral request within fourteen days of making the oral request is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine not exceeding $1,100 (10 Penalty Units in accordance with the Crimes Act 1914), and the request is deemed never to have been made.

The Department of Human Services (DHS) has developed a Health Practitioner Guideline to substantiate that a valid request existed (pathology or diagnostic imaging) which is located on the DHS website.

PN.2.2 Responsibilities of Approved Pathology Practitioners

Form of Request

There is no official "request in writing" form, and the requesting practitioner's own stationery, or pre-printed forms supplied by Approved Pathology Practitioners/Authorities are acceptable.

For the purposes of Medicare eligible services, the minimum information requirements for a pre-printed pathology request and combined pathology request/offer to assign are detailed within the: *Health Insurance Act 1973*; *Health Insurance Regulations 2018*; and the *Privacy Act 1988*.

The following table presents the minimum details that pre-printed pathology request forms and combined pathology request/offer to assign forms must contain for the purposes of a subsequent Medicare claim:

Requesting Practitioner
a) name
b) practice address or provider number
Patient Details
a) name - surname, first name
b) address
c) date of birth
d) sex
e) Medicare card number

f) hospital status Two acceptable versions are as follows: State the patient's status at the time of the service or when the specimen was collected: OR cross out the statements that do not apply Was or will the patient be, at the time of the service or when the specimen is obtained: (a) a private patient in a private hospital or approved day hospital facility (b) a private patient in a recognised hospital (c) a public patient in a recognised hospital (d) an outpatient of a recognised hospital
Tests Requested
a) an area titled "Tests Requested"
Self Determined (SD)
A tick box is required for SD. This is used when the APP determines that pathologist-determinable tests are necessary. This tick box can be put in the Clinical Notes area.
Mandatory patient advisory statement
One of the following statements: 'Your doctor has recommended that you use (insert name of pathology provider). You are free to choose your own pathology provider. However, if your doctor has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your doctor.' 'Your treating practitioner has recommended that you use (insert name of pathology provider). You are free to choose your own pathology provider. However, if your treating practitioner has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your treating practitioner.'
Privacy Note
The wording of the note must be: "Privacy Note: The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administration of government health programs, and may be used to update enrolment records. Its collection is authorised by the provisions of the *Health Insurance Act 1973*. The information may be disclosed to the Department of Health or to a person in the medical practice associated with this claim, or as authorised/required by law." The placement of the note is only necessary on the patient's copy and could be incorporated into the clinical notes area. Alternatively, the back of the patient copy could be used if that is more practicable.

The Department of Human Services (DHS) has developed a Health Practitioner Guideline to substantiate that a valid request existed (pathology or diagnostic imaging) which is located on the DHS website.

Combined Request/Assignment form only
Offer to Assign and Reference to Section 20A
An example of a Section 20A Offer to Assign is as follows: "Medicare Agreement (Section 20A of the Health Insurance Act 1973) I offer to assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner. Patient signature _____ Date / / /
Practitioners Use Only

A text box is also required for 'Practitioner's Use Only' this section is used where the patient is unable to sign and an appropriate person endorses on behalf of patient, eg. Practitioner's Use Only _____ (Reason patient cannot sign)

An Approved Pathology Practitioner or Approved Pathology Authority who, without reasonable excuse, provides to practitioners (directly or indirectly) combined request/assignment forms which are not in accordance with the legislation is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine not exceeding $1,100 (10 Penalty Units in accordance with the Crimes Act 1914).

Patient Copy

Assignment of benefits requires the patient to receive a copy of the request. The doctor must cause the particulars relating to the professional service (tests requested) to be set out on the assignment form, before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it.

Authority to lodge a Patient Claim electronically

Where an Approved Pathology Practitioner or Approved Pathology Authority renders a service and the patient has not assigned the benefit the Approved Pathology Practitioner or Approved Pathology Authority can lodge a claim electronically to the Department of Human Services on behalf of the patient where consent is provided. This consent can be provided verbally.

Combined Online Patient Claiming Authority

Authority for APP/APA to submit an electronic patient claim on behalf of the claimant

An example of wording that could be used is:
'I authorise the approved pathology practitioner who will render the requested pathology services, and any further pathology services which the practitioner determines to be necessary, to submit my unpaid account to Medicare, so that Medicare can assess my claim and issue me a cheque made payable to the practitioner, for the Medicare benefit.'

Patient Signature_____ Date_____/_____/_____

Verbal consent was provided by patient to submit unpaid account to Medicare. No signature available.

Request to Approved Pathology Authority

It is acceptable for a request to be made to an Approved Pathology Authority who is the proprietor or one of the proprietors of a laboratory instead of making the request to the Approved Pathology Practitioner who renders the service or on whose behalf the service is rendered.

Holding, Retention, Recording and Production of Request Forms

Approved Pathology Practitioners must hold a request in writing for all services requested by any other practitioner before billing patients. An Approved Pathology Practitioner is required to retain written requests/confirmation of requests for pathology services for 2 years 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 2 years). If all tests were referred, the second pathologist would retain the original request.

If the written request or written confirmation has been recorded on film or other magnetic medium approved by the Minister for Health and Ageing, for the purposes of storage and subsequent retrieval, the record so made shall be

deemed to be a retention of the request or confirmation. The production or reproduction of such a record shall be deemed to be a production of the written request or written confirmation.

An Approved Pathology Practitioner or an Approved Pathology Authority is required to produce, on request from the Department of Human Services CEO, no later than the end of the day following the request from the CEO, a written request or written confirmation retained pursuant to the above paragraphs. An employee of the Department of Human Services is authorised to make and retain copies of or take and retain extracts from written requests or written confirmations.

Offences in Relation to Retaining and Producing Request Forms

The following offences are punishable upon conviction by a fine not exceeding $1000:

- an Approved Pathology Practitioner who, without reasonable excuse, does not keep request forms for 18 months;
- an Approved Pathology Practitioner who, without reasonable excuse, does not produce a request form to an employee of the Department of Human Services before the end of the day following the day of the Department of Human Services CEO's request.

Referral From An Approved Pathology Practitioner To Another Approved Pathology Practitioner

Where an Approved Pathology Practitioner refers some or all services requested to another Approved Pathology Practitioner not associated with the same Approved Pathology Authority the following apply:

- 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;
- 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:
  - name and provider number of the original requesting practitioner; and
  - date of original request;

- under the item coning rules (which limit benefits for multiple services) only one Medicare benefit is payable for services included in coned items except for estimations covered by Rule 6 entitled "designated pathology services". The exemption allows payment of more than one Medicare benefit where various components of the one item number from the same request e.g. drug assays (items 66800 and 66812) are performed by two Approved Pathology Authorities.

Although the provisions concerning designated pathology services in Rule 6 permit similar services (e.g. hormone estimations) to be performed by 2 or more laboratories, with different Approved Pathology Authorities, the sum of the Medicare benefit payable for services provided by the laboratories concerned will not exceed the maximum amount payable under the item coning rules when a single laboratory performs all the estimations.

Notes:

- the patient should be billed by each Approved Pathology Practitioner only for those services rendered by or on his/her behalf;
- photocopies of requests are not acceptable;
- in the case of "designated pathology services" 65150, 65175, 66650, 66695, 66711, 66722, 66785, 66800,66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165 a patient episode initiation fee (PEI) is payable for the services provided by the laboratory which receives the original request and performs one or more of the estimations. However, no PEI is payable for services provided by the other laboratory which

performs the remainder of the estimations. A "specimen referred fee" is payable instead.One Approved Pathology Practitioner cannot claim both a PEI and a "specimen referred fee" in relation to the same patient episode.

Offence Not To Confirm An Oral Request

An Approved Pathology Practitioner who, without reasonable excuse, does not confirm in writing an oral request to another Approved Pathology Practitioner within fourteen days of making the oral request is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine not exceeding $1000, and the request is deemed never to have been made.

PN.2.3 Pathology Tests not Covered by Request

An Approved Pathology Practitioner, who has been requested to perform one or more pathology services, may consider it necessary, in the interest of the patient, that additional tests to those requested be carried out. The Approved Pathology Practitioner must discuss this need with the requesting practitioner, and if the requesting practitioner determines that additional tests are necessary, the Approved Pathology Practitioner must arrange with the requesting practitioner to forward an amended or second request for those services. The account will then be issued in the ordinary way and the additional services will attract benefits providing the Approved Pathology Practitioner is a recognised specialist pathologist.

PN.3.1 Details Required on Accounts, Receipts or Assignment Forms

General

Medicare benefit is not payable in respect of a pathology service unless specified details are provided, by the practitioner rendering the service, on his or her account, receipt or assignment form.

PN.3.2 Approved Pathology Practitioners

In addition to holding a request in writing from the treating medical or dental practitioner or from another Approved Pathology Practitioner, the following additional details must be recorded on the account, receipt or assignment form of the Approved Pathology Practitioner providing the service:

(i) the surname and initials of the Approved Pathology Practitioner who performed the service and either his/her practice address or the provider number for the address;

(ii) the name of the person to whom the service was rendered;

(iii) the date on which the service was rendered;

(iv) the name of the requesting practitioner; or in the case of a referred test, the name of the original requesting practitioner;

(v) the date on which the request was made; or in the case of a referred test, the date on which the original request was made;

(vi) the requesting practitioner's provider number;

(vii) a description of the pathology service in words which are derived from the item description in the Schedule and are of sufficient detail to identify the specific test in the Schedule that was rendered. Instead of such a full description, the abbreviations contained in the index and the group abbreviations listed at PQ.4 are acceptable alternatives (see PQ.1);

(viii) where the Approved Pathology Practitioner determines or provides a pathology service on his/her own patient, the account must be endorsed "sd"; and

(ix) provide collection centre identification number if the specimen was collected in a licensed collection centre (or approved pathology collection centre).

Where some services are referred from one Approved Pathology Practitioner to another Approved Pathology Practitioner, the request details to be shown on the second Approved Pathology Practitioner's account, receipt or assignment form must be identical to those of the original requesting practitioner including the date of request.

PN.3.3 Prescribed Pathology Services

For Prescribed Pathology Services (that is, pathology items in Group P9) the medical practitioner who renders the service must ensure his or her account, receipt or assignment form includes his or her name, address or provider number, the date of the service, and a description to clearly identify the service in the Schedule that was rendered.

If the service was determined necessary by another medical practitioner who is a member of the same group practice as the practitioner who rendered the service, the name of the requesting practitioner, sufficient to identify the practitioner from other practitioners in the same group practice with the same surname, must also be included together with the date on which the request was made.

PN.3.4 Interferon Gamma Release Assay (IGRA) for detection of latent tuberculosis - (Item 69471)

Before undertaking testing it is advisable to consult with a medical practitioner experienced in the management of tuberculosis. Neither IGRA tests or the tuberculin skin test (Mantoux) can absolutely exclude latent tuberculosis and following close contact exposure preventative therapy should always be considered in young children and immunosuppressed patients.

IGRA testing for the diagnosis of latent tuberculosis should be requested in compliance with recommendations made by the National Tuberculosis Advisory Committee in 2016 or later.
http://www.health.gov.au/internet/main/publishing.nsf/Content/cdna-ntac-pubs.htm including:

- IGRAs have no place in the initial investigation of active TB disease and cannot and should not be used to exclude suspected TB disease.
- IGRA should not be used for the purpose of screening prior to BCG vaccination.
- While IGRA tests can be used in children less than 5 years of age, there may be a higher proportion of indeterminate test results and tuberculin skin testing is preferred, unless there is a history of BCG.

At least eight weeks should elapse following last possible TB exposure before testing of a contact of a confirmed case of active tuberculosis – testing of contacts should be performed only after discussion with appropriate State or Territory public health authorities.

PN.4.1 Inbuilt Multiple Services Rule

The term "Multiple Services Rule" (Rule 3 of the Pathology Services Table) describes an arrangement which places limits on the benefits payable for items in the Pathology Services Table depending on the range of services performed during a single patient episode. A patient episode is defined in PO.4 of these notes.

PN.4.2 Exemptions

Under Rule 4 of the Pathology Services Table, exemptions to the multiple services rule have been granted for certain specified tests. In some circumstances tests which are repeated up to 6 times over a 24 hour period, or tests which are requested up to 6 times on a single request form and are performed within 6 months of the date of request may be eligible for separate Medicare benefits. The services to which the exemptions apply are listed under Rule 4.(1 and 2) and cover seriously or chronically ill patients who require particular tests under specified circumstances. In order to claim the exemptions, accounts should be endorsed "Rule 3 Exemption".

Where a practitioner seeks an exemption to the multiple services rule for a patient whose condition requires a series of pathology investigations at various times throughout any one day or over a longer period of time, and the services required are not exempted under Rule 4, an application for exemption can be made which is endorsed "S4B(3)".

Some factors that the delegate of the Minister may take into consideration in approving an exemption are: the patient is seriously ill; there are distinct and separate collections and performances of tests; and the services involve substantial additional expenses for the Approved Pathology Practitioner. These, and other clinical details, should be supplied by the practitioner when seeking an S4B(3) exemption.

If Rule 3 exemptions are endorsed "S4B(3)", claim assessment could take longer as all S4B(3) claims are passed to the delegate for assessment. S4B(3) covers all exemptions to the multiple services rule but, where applicable, specific "Rule 3 exemption" endorsements will speed up the payment of claims. Rule 3 and S4B(3) exemptions cannot be used to overcome time based restrictions within items e.g. "-. each test to a maximum of 4 tests in a 12 month period".

PN.5.1 Episode Cone

Description of Rule 18

The term "Episode Cone" describes an arrangement under which Medicare benefits payable in a patient episode for a set of pathology services, containing more than three items, ordered by a general practitioner for a non-hospitalised patient, will be equivalent to the sum of the benefits for the three items with the highest Schedule fees. Further information on the episode coning arrangements is provided in PO.5 of these notes.

PN.5.2 Exemptions

Some items are not included in the count of the items performed when applying episode coning. The items which have been exempted from the cone include all the items identified in Rule 18.(1)(d) and (e).

PN.6.1 Bulk Billing Incentives for Episodes Consisting of a P10 Service

P19.1

Pathology Services Table

Rules for the Interpretation of the Pathology Services Table

Please note that in the Health Insurance (Pathology Services Table) Regulations 2010 (effective 1 November 2010) rules and sub-rules are referred to as clauses and sub-clauses. In addition in the Regulations a rule that refers to specific items within a pathology group, for example Group P1 Haemotology, is listed directly above the Schedule of Services for that group. A table cross referencing the following rules with the clauses in the Regulations is at the end of this section.

- **(1)** In this table

patient episode means:

(a) a pathology service or pathology services (other than a pathology service to which paragraph 1 (1) (b) refers) provided for a single patient whose need for the service or services was determined under section 16A of the Act:

(i) on the same day; or

(ii) if more than 1 test is performed on the 1 specimen within 14 days - on the same or different days;

whether the services:

(iii) are requested by 1 or more practitioners; or

(iv) are described in a single item or in more than 1 item; or

(v) are rendered by 1 approved pathology practitioner or more than 1 approved pathology practitioner; or

(vi) are rendered on the same or different days; or

(b) a pathology service to which rule 4 refers that is provided in the circumstances set out in that rule that relates to the service.

receiving APP means an approved pathology practitioner in an approved pathology authority who performs one or more pathology services in respect of a single patient episode following receipt of a request for those services from a referring APP.

recognised pathologist means a medical practitioner recognised as a specialist in pathology by a determination under section 3D, 3DB or 3E of the Act.

referring APP means an approved pathology practitioner in an approved pathology authority who:

(i) has been requested to render 1 or more pathology services, all of which are requested in a single patient episode; and

(ii) is unable, because of the lack of facilities in, or expertise or experience of the staff of, the laboratory of the authority, to render 1 or more of the pathology services; and

(iii) requests an approved pathology practitioner (the ***receiving APP***) in another approved pathology authority to render the pathology service or services that the referring APP is unable to render; and

(iv) renders each pathology service (if any) included in that patient episode, other than the pathology service or services in respect of which the request mentioned in subparagraph (iii) is made.

serial examinations means a series of examinations requested on 1 occasion whether or not:

(a) the materials are received on different days by the approved pathology practitioner; or

(b) the examinations or cultures were requested on 1 or more request forms by the treating practitioner.

the **Act** means the *Health Insurance Act 1973.*

k. **(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.

l. **(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.

v. **(4)** A reference to a **Group** in the table includes every item in the Group and a reference to a **Subgroup** in the table includes every item in the Subgroup.

Precedence of items

iv. **(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.

k. **(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.

vi. **(3)** If an item is expressed to include a pathology service that is described in another item, the other item does not apply to the service in addition to the first-mentioned item, whether or not the services described in the 2 items are requested separately.

Application of item 74990 and 74991

vi. **(4)** Despite subrules (1), (2) and (3):

(a) if the pathology service described in item 74991 is provided to a person, either that item or item 74990, but not both those items, applies to the service; and

(b) if item 74990 or 74991 applies to a pathology service, the fee specified in that item applies in addition to the fee specified in any other item in the table that applies to the service.

g. **(5)** For items 74990 and 74991:

bulk-billed, in relation to a pathology service, means:

(a) a medicare benefit is payable to a person in respect of the service; and

(b) under an agreement entered into under section 20A of the Act:

(i) the person assigns to the practitioner by whom, or on whose behalf, the service is provided, his or her right to the payment of the medicare benefit; and

(ii) the practitioner accepts the assignment in full payment of his or her fee for the service provided.

Commonwealth concession card holder means a person who is a concessional beneficiary within the meaning given by subsection 84 (1) of the *National Health Act 1953*.

unreferred service means a pathology service that:

(a) is provided to a person by, or on behalf of, a medical practitioner, being a medical practitioner who is not a consultant physician, or specialist, in any speciality (other than a medical practitioner who is, for the purposes of the Act, both a general practitioner and a consultant physician, or specialist, in a particular speciality); and

(b) has not been referred to the medical practitioner by another medical practitioner or person with referring rights.

n. **(6)** For item 74991:

ASGC means the document titled Australian Standard Geographical Classification (ASGC) 2002, published by the Australian Bureau of Statistics, as in force on 1 July 2002.

practice location, in relation to the provision of a pathology service, means the place of practice in respect of which the practitioner by whom, or on whose behalf, the service is provided, has been allocated a provider number by the Commission**.**

Regional, rural or remote area means an area classified as RRMAs 3-7 under the Rural, Remote and Metropolitan Areas Classification.

Rural, Remote and Metropolitan Areas Classification has the meaning given by subrule 3 (1) of Part 2 of Schedule 1 to the general medical services table**.**

SLA means a Statistical Local Area specified in the ASGC.

SSD mean a Statistical Subdivision specified in the ASGC.

Circumstances in which services rendered following 2 requests to be taken to have been rendered following 1 request

i. **(1)** In subrule 3(2), ***service*** includes assay, estimation and test.

vi. **(2)** Two or more pathology services (other than services to which, under rule 4, this rule does not apply) rendered for a patient following 2 or more requests are taken to have been rendered following a single request if:

(a) the services are listed in the same item; and

(ab) that item is not item 74990 or 74991; and

(b) the patient's need for the services was determined under subsection 16A (1) of the Act on the same day even if the services are rendered by an approved pathology practitioner on more than one day.

Services to which rule 3 does not apply

vi. **(1)** Rule 3 does not apply to a pathology service described in item 65060, 65070, 65120, 65123, 65126, 65129, 65150, 65153, 65156, 66500, 66503, 66506, 66509, 66512, 66584 or 66800, if:

(a) the service is rendered in relation to one or more specimens taken on each of not more than 6 separate occasions in a period of 24 hours; and

(b) the service is rendered to an inpatient in a hospital; and

(c) each service must be rendered as soon as possible after collection and after authorization of the result of the previous specimen; and

(d) the account for the service is endorsed 'Rule 3 Exemption'.

ix. **(2)** Rule 3 does not apply to any of the following pathology services:

(a) estimation of prothrombin time (INR) in respect of a patient undergoing anticoagulant therapy;

(b) quantitative estimation of lithium in respect of a patient undergoing lithium therapy;

(c) a service described in item 65070 in relation to a patient undergoing chemotherapy for neoplastic disease or immunosuppressant therapy;

(d) a service described in item 65070 in relation to clozaril, ticlopidine hydrochloride, methotrexate, gold, sulphasalazine or penicillamine therapy of a patient;

(e) a service described in item 66500 - 66512 in relation to methotrexate or leflunomide therapy of a patient;

(f) quantitative estimation of urea, creatinine and electrolytes in relation to:

(i) cis-platinum or cyclosporin therapy of a patient; or

(ii) chronic renal failure of a patient being treated in a dialysis program conducted by a recognised hospital;

(g) quantitative estimation of albumin and calcium in relation to therapy of a patient with vitamin D, its metabolites or analogues;

(h) quantitative estimation of calcium, phosphate, magnesium, urea, creatinine and electrolytes in cancer patients receiving bisphosphonate infusions.

if:

(i) under a request for a service, other than a request for a service described in paragraph (a), no more than 6 tests are requested; and

(ii) the tests are performed within 6 months of the request; and

(iii) the account for the service is endorsed "Rule 3 Exemption".

k. **(3)** Rule 3 does not apply to a pathology service described in items 65109 or 65110 if:

(a) The service is rendered on not more than 5 separate occasions in the case of item 65109 and 2 separate occasions in the case of item 65110 in a period of 24 hours; and

(b) The service is rendered in response to a written request separated in time from the previous request; and

(c) The account for the service is endorsed "Rule 3 Exemption".

Item taken to refer only to the first service of a particular kind

j. **(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.

n. **(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

f. **(1)** In this rule:

designated pathology service means a pathology service in respect of tests relating to a single patient episode that are tests of the kind described in item 65150, 65175, 66650, 66695, 66711, 66722, 66785, 66800, 66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165.

f. **(2)** This rule applies in respect of a designated pathology service where:

(a) an approved pathology practitioner ***(practitioner A)*** in an approved pathology authority:

(i) has been requested to render the designated pathology service; and

(ii) is unable, because of the lack of facilities in, or expertise or experience of the staff of, the laboratory of the authority, to render 1 or more of the tests included in the service; and

(iii) requests an approved pathology practitioner ***(practitioner B)*** in another approved pathology authority to render the test or tests that practitioner A is unable to render; and

(iv) renders each test (if any) included in the service, other than the test or tests in respect of which the request mentioned in subparagraph (iii) is made; and

(b) the tests mentioned in subparagraph (a) (iv) that practitioner A renders are not tests constituting a service described in item 65156, 65179, 66653, 66712, 66734, 66788, 66806, 66815, 66822, 66828, 69496, 71093, 71159 or 71168.

g. **(3)** If this rule applies in respect of a designated pathology service:

(a) item 65150, 65153, 65175, 65176, 65177, 65178, 66650, 66695, 66698, 66701, 66704, 66707, 66711, 66722, 66725, 66728, 66731, 66785, 66800, 66803, 66812, 66819, 66825, 69384, 69387, 69390, 69393, 69396, 69494, 69495, 71089, 71091, 71153, 71155, 71157, 71165, 71166 or 71167 (as the case requires) applies in respect of the test or tests rendered by practitioner A; and

(b) where practitioner B renders a service under a request referred to in subparagraph (2) (a) (iii) and:

(i) practitioner A has rendered one or more of the tests that the service comprises - subject to subrule (4), the amount specified in item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 (as the case requires) shall be taken to be the fee for each test that the service comprises; or

(ii) practitioner A has not rendered any of the tests that the service comprises -

(A) the amount specified in item 65157, 65180, 66651, 66696, 66714, 66723, 66789, 66804, 66816, 66820, 66826, 69400, 69497, 71090, 71154 or 71169 (as the case requires) shall be taken to be the fee for the first test that the service comprises; and

(B) subject to subrule (4), the amount specified in item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 (as the case requires) shall be taken to be the fee for each subsequent test that the service comprises.

g. **(4)** For paragraph (3) (b), the maximum number of tests to which item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 applies is:

(a) for item 66652, 66715, 66790, 66817, 66821 or 66827:

2 - X; and

(b) for item 65158, 66805, 69498 or 71092:

3 - X; and

(c) for item 71156 or 71170:

4 - X; and

(d) for item 65181 or 66724:

5 - X; and

where X is the number of tests rendered by practitioner A in relation to the designated pathology service in respect of which the request mentioned in that paragraph is made.

l. **(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

n. Except as stated in rule 6, the amount specified in an item is payable only to one approved pathology practitioner in respect of a single patient episode.

Creatinine ratios - Group P2 (chemical)

- 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

- **(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.

- **(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).

j. **(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"

j. For an item in Group P3 (Microbiology):

(a) ***serial examinations or cultures*** means a series of examinations or cultures requested on 1 occasion whether or not:

(i) the materials are received on different days by the approved pathology practitioner; or

(ii) the examinations or cultures were requested on 1 or more request forms by the treating practitioner; and

(b) if:

(i) tests are carried out in relation to a patient episode; and

(ii) specimen material from the patient episode is stored; and

(iii)in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;

the later tests and the earlier tests are taken to be part of one patient episode.

Investigation for hepatitis serology

xvi. A medicare benefit is not payable in respect of more than one of items 69475, 69478 and 69481 in a patient episode.

Tests in Group P4 (Immunology) relating to antibodies

- 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)

- **(1)** For items in Group P5 (Tissue pathology):

(a) ***biopsy material*** means all tissue received by the Approved Pathology Practitioner:

(i) from a medical procedure or group of medical procedures performed on a patient at the same time; or

(ii) after being expelled spontaneously from a patient.

(b) ***cytology*** means microscopic examination of 1 or more stained preparations of cells separated naturally or artificially from their normal environment by methods recognised as adequate to demonstrate their structure to a degree sufficient to enable an opinion to be formed about whether they are likely to be normal, abnormal but benign, or abnormal and malignant but, in accordance with customary laboratory practice, does not include examination of a blood film and a bone marrow aspirate; and

(c) ***separately identified specimen*** means an individual specimen collected, identified so that it is clearly distinguished from any other specimen, and sent for testing by or on behalf of the treating practitioner responsible for the procedure in which the specimen was taken.

- **(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.

- **(3)** For subrule (2), any sample submitted for cytology from which a cell block is prepared does not qualify for a Group P5 item.

13.(4) If more than 1 of the services mentioned in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 are performed in a single patient episode, only the fee for the item performed having the highest specified fee is applicable to the services.

13.(5) If more than 1 histopathological examinations are performed on separate specimens, of different complexity levels, from a single patient episode, a medicare benefit is payable only for the examination that has the highest schedule fee.

13.(6) In items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 a reference to a ***complexity level*** is a reference to the level given to a specimen type mentioned in Part 4 of this Table.

13.(7) If more than 1 of the services mentioned in items 72846, 72847, 72848; 72849 and 72850 or 73059, 73060, 73061, 73064 and 73065 are performed in a single patient episode, a medicare benefit is payable only for the item performed that has the highest scheduled fee.

13.(8) If more than 1 of the services mentioned in items 73049, 73051, 73062, 73063, 73066 and 73067 are performed in a single patient episode, only the fee for the item performed having the higher or highest specified fee applies to the services.

Items in Groups P10 (Patient episode initiation) and P11 (Specimen referred) not to apply in certain circumstances

- **(1)** For this rule and items in Groups P10 (Patient episode initiation) and P11 (Specimen referred):

approved collection centre has the same meaning as in Part IIA of the Act.

institution means a place at which residential accommodation or day care is, or both residential accommodation and day care are, made available to:

(a) disadvantaged children; or

(b) juvenile offenders; or

(c) aged persons; or

(d) chronically ill psychiatric patients; or

(e) homeless persons; or

(f) unemployed persons; or

(g) persons suffering from alcoholism; or

(h) persons addicted to drugs; or

(i) physically or mentally handicapped persons;

but does not include:

(j) a hospital; or

(k) a residential aged care home; or

(l) accommodation for aged persons that is attached to a residential aged care home or situated within a residential aged care home.

prescribed laboratory means a laboratory operated by:

(a) the Australian Government; or

(b) an authority of the Commonwealth; or

(c) a State or internal Territory; or

(d) an authority of a State or internal Territory; or

(e) an Australian tertiary education institution.

s***pecimen 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.

- **(2)** If a service described in an item in Group P10 is rendered by, or on behalf of, an approved pathology practitioner who is a recognised pathologist, the relevant one of those items does not apply to the service if:

(a) the service is rendered upon a request made in the course of a service provided to a public patient in a recognised hospital or when attending an outpatient service of a recognised hospital.

- **(3)** An item in Group P10 or P11 does not apply to a pathology service to which subsection 16A (7) of the Act applies.

- **(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.

- **(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.

- **(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.

- **(7)** If, in respect of the same patient episode:

(a) services referred to in 1 or more items in Group P5 and 1 or more of Groups P1, P2, P3, P4, P6, P7 and P8 are rendered by an approved pathology practitioner in the laboratory of another approved pathology authority; or

(b) services referred to in 1 or more items in Group P6 and 1 or more of Groups P1, P2, P3, P4, P5, P7 and P8 are rendered by another approved pathology practitioner in the laboratory of another approved pathology authority;

the fee specified in the applicable item in Group P10 is payable to both approved pathology practitioners.

- **(8)** If more than one specimen is collected from a person on the same day for the provision of pathology services:

(a) in accordance with more than 1 request; and

(b) in or by a single approved pathology authority;

the fee specified in the applicable item in Group P10 applies once only to the services unless an exemption listed in Rule 4 applies or an exemption has been granted under Rule 3 "S4B(3)".

- **(9)** The amount specified in item 73940 is payable only once in respect of a single patient episode.

Application of an item in Group P11 (Specimen referred) to a service excludes certain other items

- If item 73940 applies to a patient episode, none of the items in Group P10 applies to any pathology service rendered by the approved pathology authority or approved pathology practitioner who claimed item 73940 in respect of the patient episode.

Circumstances in which an item in Group P11 (Specimen referred) does not apply

- **(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.

- **(2)** An approved pathology authority is ***related to*** another approved pathology authority for subrule (1) if:

(a) both approved pathology authorities are employed (including employed under contract) by the same person, whether or not the person is also an approved pathology authority; or

(b) either of the approved pathology authorities is employed (including employed under contract) by the other; or

(c) both approved pathology authorities are corporations and are related corporations within the meaning of the Corporations Act; or

(d) the approved pathology authorities are partners (whether or not either or both of the approved pathology authorities are individuals and whether or not other persons are in partnership with either or both of the approved pathology authorities; or

(e) both approved pathology authorities are operated by the Commonwealth or an authority of the Commonwealth; or

(f) both approved pathology authorities are operated by the same State or internal Territory or an authority of the same State or internal Territory.

- **(3)** An item in Group P11 does not apply to a referral if the following common tests are referred either singly or in combination (except if the following items are referred in combination with other items not similarly specified): 65060, 65070, 65120, 66500, 66503, 66506, 66509, 66512, 66536, 66596, 69300, 69303, 69333 or 73527.

Abbreviations

- **(1)** The abbreviations in Part 4 of this table may be used to identify particular pathology services or groups of pathology services.

- **(2)** The names of services or drugs not listed in Part 4 of this table must be written in full.

Certain pathology services to be treated as 1 service

- (1) In this rule:

general practitioner means a medical practitioner who:

(a) is not a consultant physician in any specialty; and

(b) is not a specialist in any specialty.

set of pathology services means a group of pathology services:

(a) that consists of services that are described in at least 4 different items; and

(b) all of which are requested in a single patient episode; and

(c) each of which relates to a patient who is not an admitted patient of a hospital; and

(d) excludes services referred to in an item in Group P10, Group P11, Group P12 or

Group P13, items 66900, 69484, 73053, 73055 and 73069; and

(e) excludes services described in the following items:
65079, 65082, 65157, 65158, 65166, 65180, 65181, 66606, 66610, 66639, 66642, 66651, 66652, 66663, 66666, 66696, 66697, 66714, 66715, 66723, 66724, 66780, 66783, 66789, 66790, 66792, 66804, 66805, 66816, 66817, 66820, 66821, 66826, 66827, 66832, 66834, 66837, 69325, 69328, 69331, 69379, 69383, 69400, 69401, 69451,

69500, 69484, 69489, 69492, 69497, 69498, 71076, 71090, 71092, 71096, 71148, 71154, 71156, 71169, 71170, 73309, 73312, 73315, 73318, 73321 and 73324;
where those services are performed by an approved pathology practitioner in an accredited pathology laboratory of an approved pathology authority following referral by another approved pathology practitioner in an accredited pathology laboratory of an approved pathology authority which is not **related to** the first mentioned approved pathology authority.

(1A) An approved pathology authority is **related to** another approved pathology authority for the purposes of paragraph 18(1)(e) if that approved pathology authority would be related to the other approved pathology authority for the purposes of rule 16(2).

- **(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.

- **(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.

- **(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.

- **(5)** If pathology services are to be treated as 1 pathology service under paragraph (3) (c) or (4) (c), the fee for the 1 pathology service is the highest fee specified in any of the items that describe the pathology services that are to be treated as the 1 pathology service.

Hepatitis C viral RNA testing

- For item 69499 and 69500:

Hepatitis C sero-positive, for a patient, means 2 different assays of Hepatitis C antibodies are positive.

serological status is uncertain, for a patient, means any result where 2 different assays of Hepatitis C antibodies are inconclusive.

Haemochromatosis testing

- For items 73317 and 73318:

elevated serum ferritin for a patient, means a level of ferritin above the normal reference range in respect of the particular method of assay used to determine the level.

Nutritional and toxicity metals testing

- **(1)** For this rule:

nutritional metals testing group means items 66819, 66820, 66821 and 66822.

metal toxicity testing group means items 66825, 66826, 66827, 66828, 66831 and 66832.

- **(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

- A request for Antineutrophil Cytoplasmic Antibody immunofluorescence test (ANCA) shall be deemed to include requests for antineutrophil proteinase 3 antibody test (PR-3 ANCA) and antimyeloperoxidase antibody test (MPO ANCA) where the immunofluorescence test for ANCA is abnormal, or has been abnormal, or those specific antibodies have been previously detected.

Satisfying Requirements Described in Items

- Unless stated elsewhere in these rules, where an item contains a requirement, this requirement is satisfied if:

(a) The requirement/s as stipulated in the item descriptor are contained in the request form; or

(b) The requirement/s as stipulated in the item descriptor were supplied previously in writing to the APA and this documentation is retained by the APA; or

(c) The results of other laboratory tests performed in the same episode meet the requirement/s as stipulated in the item descriptor; or

(d) The results of laboratory tests that meet the requirement/s as stipulated in the item descriptor are supplied on the request form; or

The results of laboratory tests that meet the requirement/s as stipulated in the item descriptor are contained in the APA's records.

Limitation on certain items

- (a) For any particular patient, items 66539, 66605, 66606, 66607, 66610, 69380, 69488, 69489, 71075, 71127, 71135 or 71137 is applicable not more than twice in a 12 month period.

  (b) For any particular patient, item 66626 is applicable not more than 36 times in a 12 month period.

(c) For any particular patient, items 66655, 66659, 66838, 66841, 69482, 69491, 69499 or 69500 are applicable not more than once in a 12 month period.

(d) For any particular patient, item 66750 or 66751 is applicable not more than once in a pregnancy.

(e) For any particular patient, item 69336 is applicable not more than once in each period of 7 days.

(f) For any particular patient, items 66551, 66660, 69445, 69451, 69483, 71079 or 73523 are applicable not more than 4 times in a 12 month period.

(g) For any particular patient, items 66554, 66830 and 71077 are applicable not more than 6 times in a 12 month period.

(h) For any particular patient, item 66819, 66820, 66821, 66822, 66825, 66826, 66827 or 66828 is applicable not more than 3 times in a 6 month period.

(i) For any particular patient, items 73339 and 73340 are applicable not more than once.

Antigen Detection - Group P3 (Microbiology)

- If the service listed in 69316, 69317, 69319, 69494, 69495, 69496, 69497 or 69498 is a pathologist determinable service the specialist pathologist is required to record the reasons for determining the need for this service.
- If the service rendered in 71148, 73320 or 73321 is a pathologist determinable service, the specialist pathologist is required to record the reason for determining the need for this service including the result of the service in 71147.

Second Opinion morphology, limitations on items 72858 and 72859

28.1 Items 72858 and 72859 apply:

(a) only to a service that is covered by:

(i) item 65084 or 65087; or

(ii) item 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 or 72838; or

(iii) an item in Group P6 (other than item 73070, 73071, 73072, 73073, 73074, 73075 or 73076); and

(b) only if the treating practitioner and the approved pathology practitioner who provided the original opinion on the patient specimen agree that a second opinion is reasonably necessary for diagnostic purposes.

28.2 Items 72858 and 72859 do not apply if the accredited pathology laboratory in which the second opinion is provided is the same laboratory in which the original opinion was provided.

PN.6.2 Patient Episode Initiation Fees (PEIs)

Items in Groups P10 of the Pathology Services Table are only applicable to services performed:

(i) by or on behalf of an Approved Pathology Practitioner who is a recognised specialist pathologist; and

(ii) in private practice.

Accordingly, these fees are not payable for pathology services rendered by an Approved Pathology Practitioner, being a specialist pathologist when requested for a privately referred out-patient of a recognised hospital.

The patient episode initiation fees (PEIs) will be applicable on an episodic basis i.e. a claim may be made for the provision of pathology services requested by a practitioner in respect of one individual on the same day. For example, if a practitioner orders three pathology tests for a person on the one day, Medicare benefits will be payable for each of those tests but only one PEI will be applicable.

This Rule applies even when the treating practitioner has requested pathology tests from two or more Approved Pathology Practitioners. Thus a PEI will only be paid for the first account submitted unless an exemption listed in Rule 4 or 14.(7) applies or an exemption has been granted under "S4B(3)".

Under Rule 14.(7) two PEIs are payable in relation to the same patient episode where a referring practitioner refers two different specimens to two different Approved Pathology Authorities in the following circumstances:

- a tissue pathology specimen and any other non-tissue pathology specimen; or

- a cytopathology specimen and any other non-cytopathology specimen.

Rule 14.(8) also provides that only one PEI will be paid for the collection of specimens from a patient on one day in or by a single Approved Pathology Authority.

The patient episode initiation benefits are two-tiered. Higher benefits are paid for the collection of specimens from patients who are not private inpatients or private outpatients of a recognised hospital where the specimens are tested in a private laboratory.

A lower and uniform PEI benefit is paid where patients are private patients associated with a recognised hospital and the specimens are tested in a private laboratory or where the testing is performed by a prescribed laboratory on specimen collected from a patient eligible to claim Medicare benefits.

PN.6.3 Patient Episode Initiation Fees for Certain Tissue Pathology and Screening Items

Tissue Pathology items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72830 and 72836 and Cervical screening items 73070, 73071, 73072, 73073, 73074, 73075, 73076 will be subject to a different patient episode initiation fee structure - items 73922 to 73939 refer.

PN.6.4 Hospital, Government etc Laboratories

The following laboratories have been prescribed for the purposes of payment of Medicare benefits as outlined in paragraphs PF.2 and PF.3:

(i) laboratories operated by the Australian Government (these include health laboratories operated by the Australian Government Department of Health as well as the laboratories operated by other Departments, e.g. the Departments of Defence and Veterans' Affairs operate laboratories from which pathology services are provided);

(ii) laboratories operated by a State Government or authority of a State (laboratories operated or associated with recognised hospitals are also included);

(iii) laboratories operated by the Northern Territory and the Australian Capital Territory; and

(iv) laboratories operated by Australian tertiary education institutions eg Universities.

PN.7.1 Assignment of Medicare Benefits - Patient Assignment

In addition to the general arrangements relating to the assignment of benefits, as outlined at paragraph 7 of the "General Explanatory Notes" in Section 1 of this book, it should be noted that, where the treating practitioner requests pathology services but the patient does not physically attend the Approved Pathology Practitioner, the patient may complete an assignment voucher at the time of the visit to the requesting doctor offering to assign benefits for the Approved Pathology Practitioner's services.

If an Approved Pathology Practitioner refers some of the tests requested by the treating practitioner to another Approved Pathology Authority, he/she should provide the second Approved Pathology Authority with a photocopy of the patient's assignment voucher so that the second Approved Pathology Authority can also direct-bill Medicare.

PN.7.2 Approved Pathology Practitioner Eligibility

If a practitioner requests an Approved Pathology Practitioner to perform a necessary pathology service, that Approved Pathology Practitioner must personally perform the service or have it performed on his/her behalf in order to be eligible to receive benefits by way of assignment. If, however, the first Approved Pathology Practitioner arranges for the service to be rendered by a second Approved Pathology Practitioner with the same Approved Pathology Authority, the second Approved Pathology Practitioner and not the first, is eligible to receive an assignment of the Medicare benefit for the service in question.

PN.7.3 Cystic fibrosis gene testing

(1) For any particular patient, item 73345, 73347, 73348 and 73349 is applicable not more than once in a lifetime.

(2) For any particular patient, item 73346 and 73350 is applicable not more than once in a pregnancy.

(3) The testing laboratory used to undertake tests for items 73345, 73346, 73347, 73348, 73349 and 73350 must use a cystic fibrosis transmembrane conductance regulator methodology appropriate to the clinical setting with:

(a) sufficient diagnostic range and sensitivity to detect at least 95% of pathogenic cystic fibrosis transmembrane conductance regulator variants likely to be present in the patient; and

(b) with at least 25 of the most frequently encountered cystic fibrosis transmembrane conductance regulator variants in the Australian population.

PN.8.1 Accredited Pathology Laboratories - Need for Accreditation

A pathology service will not attract Medicare benefits unless that service is provided in a pathology laboratory which is accredited for that kind of service. Details of the administration of the pathology laboratory accreditation arrangements are set out below.

PN.8.2 Applying for Accreditation

To become an Accredited Pathology Laboratory it is necessary to lodge a completed application form with the Manager, Pathology Section, the Department of Human Services, PO Box 1001, TUGGERANONG ACT 2901. The prescribed fees for Approved Pathology Laboratories are:

- $2500 for Category GX labs
- $2000 for Category GY labs
- $1500 for Category B labs
- $ 750 for Category M & S labs.

It is necessary for an application for inspection be made to the National Association of Testing Authorities (NATA) NATA is the independent body chosen to act on the Australian Government's behalf as the primary inspection agency. The Royal Australian College of General Practitioners (RACGP) has also been appointed to inspect laboratories in Category M (general practitioner) in Victoria only.

Details of laboratory categories and associated supervisory requirements can be found on the Department's internet site (www.health.gov.au/pathology).

PN.8.3 Effective Period of Accreditation

Accreditation takes effect from the date of approval by the Minister for Health and Ageing. The Minister has no power to backdate an approval. Transitional accreditation may be given pending full accreditation. An application and fee are required annually.

PN.8.4 Assessment of Applications for Accreditation

The principles of accreditation for pathology laboratories as determined by the Minister are used to assess applications for accreditation. These principles also require pathology laboratories to address National Pathology Accreditation Advisory Council standards. Copies of the principles and standards are available from the Secretariat, National Pathology Accreditation Advisory Council (see PH.6) on (02) 6289 4017 or email npaac@health.gov.au.

PN.8.5 Refusal of Accreditation and Right of Review

An applicant who has been notified of the intention to refuse accreditation may, within 28 days of being notified, provide further information to the Minister which may be taken into consideration prior to a final decision being made.

Applicants refused accreditation or any person affected by the decision have the right to appeal to the Administrative Appeals Tribunal.

PN.8.6 National Pathology Accreditation Advisory Council (NPAAC)

NPAAC was established in 1979. Its functions are to develop policy for accreditation of pathology laboratories, introduce and maintain uniform standards of practice in pathology services throughout Australia and initiate and coordinate educational programs in relation to pathology practice. The agencies used to inspect laboratories on the Australian Government's behalf are required to conduct inspections using the standards set down by NPAAC. For further information the NPAAC Secretariat can be contacted on (02) 6289 4017 or email npaac@health.gov.au.

PN.8.7 Change of Address/Location

Laboratories are accredited for the particular premises given on the application form. Where a laboratory is relocated to other premises, any previously issued approvals for that Accredited Pathology Laboratory lapse. Medicare benefits are not payable for any pathology services performed at the new location until a new application has been approved by the Minister for Health and Ageing. Paragraph PH.2 sets out the method for applying for accreditation.

PN.8.8 Change of Ownership of a Laboratory

Part of the assessment of an application for an Accredited Pathology Laboratory relates to the Approved Pathology Authority status. Where the ownership, or some other material change occurs affecting the laboratory, the Minister for Health and Ageing must be provided with those changed details. Medicare benefits will not be payable for any pathology services performed on any premises other than those premises for which approval has been given.

PN.8.9 Approved Collection Centres (ACC)

New arrangements for specimen collection centres commenced on 1 December 2001 and replaced the Licensed Collection Centre (LCC) Scheme.

To enable the payment of Medicare benefits for pathology services performed on pathology specimens collected in a collection centre, the centre must first be approved. The exception to this rule is collection centres on the premises of recognised hospitals (recognised hospital in this context means the same as "recognized hospital" in Part 1 Section 3 of the Health Insurance Act 1973) as they do not need approval.

In order for a collection centre to be approved, a public or private Approved Pathology Authority must submit a completed application form to the Department of Human Services including details of the type of application (renewal, new or cancellation of collection centre), the location of the premises, the owner, and any leasing arrangements.

Application forms can be accessed by going to the Department of Human Services website. Completed application forms and any enquiries should be forwarded to Pathology Registration, PO Box 9822 MELBOURNE VIC 3001.

PN.9.1 Approved Pathology Practitioners

Introduction

A pathology service will not attract Medicare benefits unless that service is provided by or on behalf of an Approved Pathology Practitioner. (Approved Pathology Practitioners must be registered medical practitioners.) Set out below is information which relates to Approved Pathology Practitioner requirements.

PN.9.2 Applying for Acceptance of the Approved Pathology Practitioner Undertaking

To apply for acceptance of an Approved Pathology Practitioner Undertaking, it is necessary to send:

(i) a completed application for acceptance of an Approved Pathology Practitioner Undertaking; and

(ii) a signed Approved Pathology Practitioner Undertaking to the Pathology Registration, the Department of Human Services,

PO Box 9822, Melbourne Victoria 3001.

An application form, undertaking and associated literature can be obtained from the Pathology Registration Coordinator.

Payment of Acceptance Fee

On receipt of advice that the Minister has accepted an undertaking, a cheque for $500 should be sent to the Pathology Registration Coordinator. Applicants are required to pay this fee within 14 days of the notice being given. As there is no discretion under the *Health Insurance Act 1973* to accept late payments, failure to pay the fee within the required time means that:

(i) acceptance of the undertaking will be revoked;

(ii) a new application must be completed;

(iii) acceptance of the new undertaking cannot be backdated; and

(iv) there will therefore be a period during which Medicare benefits cannot be paid.

PN.9.3 Undertakings

Consideration of Undertakings

The Minister is unable to accept an undertaking from a person in respect of whom there is a determination in force that the person has breached the undertaking, or from a person who, if the undertaking were accepted, would be likely to carry on the business of a prescribed person or would enable a person to avoid the financial consequences of the disqualification (or likely disqualification) of that prescribed person. A 'prescribed person' includes, amongst other things, fully or partially disqualified persons (or persons likely to be so disqualified).

Similarly an undertaking cannot be accepted unless the Minister is satisfied that the person giving such undertaking is a fit and proper person to be an Approved Pathology Practitioner.

When an undertaking has been given, the Minister may require the person giving the undertaking to provide additional information within a fixed period of time and if the person does not comply the Minister may refuse to accept the undertaking.

Refusal of Undertaking and Rights of Review

Where the Minister refuses to accept an undertaking, for any of the reasons shown above, the Minister must notify the person of the decision. The notification must include advice of a right of internal review of the decision and a right of further appeal to the Administrative Appeals Tribunal if the internal review upholds the original decision to refuse the undertaking.

Effective Period of Undertaking

The following applies:

(i) Date of Effect the earliest day from which the Minister or delegate can accept an undertaking is the day of the decision in respect of the undertaking. The day the undertaking is signed is to be the day it is actually signed and must not be backdated;

(ii) Period of Effect in determining the period of effect of the undertaking the Minister shall, unless the Minister considers that special circumstances exist, determine that the period of effect shall be twelve months from the day on which the undertaking comes into force. There is a requirement for the Minister to notify persons giving undertakings of the period of time for which the undertaking is to have effect, and the notice is to advise persons whose interests are affected by the decision of their rights of appeal to the Administrative Appeals Tribunal against the Minister's decision;

(iii) Renewals when an undertaking is given and accepted by the Minister while a former undertaking is current, the new undertaking does not take effect until the former undertaking ceases to be in force. When an undertaking is given while a former undertaking is current and the date on which the former undertaking is to expire passes without the Minister giving notice to accept or reject the new undertaking, the former undertaking remains in force until the Minister gives such notification. This provision does not apply when the renewal application is not received by the Department of Human Services until after the expiry of the existing undertaking. Under these circumstances there will be a period during which Medicare benefits cannot be paid unless the new application can be backdated to the expiry of the previous undertaking. This is a limited discretion for periods up to one month and special conditions apply; and

(iv) Cessation of Undertaking the undertaking ceases to be in force if it is terminated, if the Minister revokes acceptance of the undertaking, or if the period of effect for the undertaking expires whichever event first occurs.

An Approved Pathology Practitioner may terminate an undertaking at any time providing that the practitioner gives at least 30 days notice of his/her intention to do so.

PN.9.4 Obligations and Responsibilities of Approved Pathology Practitioners

The requirements of the legislation and the undertaking impose a number of obligations and responsibilities on Approved Pathology Practitioners and the Minister. The more complex of these not already dealt with are considered in PK, PL and PM dealing with Breaches of Undertakings, Excessive Pathology Services and Personal Supervision.

PN.10.1 Approved Pathology Authorities

Introduction

A pathology service will not attract Medicare benefits unless the proprietor of the laboratory in which the pathology service is performed is an Approved Pathology Authority. Following is information which relates to Approved Pathology Authority requirements.

PN.10.2 Applying for Acceptance of an Approved Pathology Authority Undertaking

To apply for acceptance of an Approved Pathology Authority Undertaking, it is necessary to send:

(i) a completed application for acceptance of an Approved Pathology Authority Undertaking; and

(ii) a signed Approved Pathology Authority Undertaking to the Pathology Registration, the Department of Human Services,

PO Box 9822, Melbourne Victoria 3001.

An application form, undertaking and associated literature can be obtained from the Pathology Registration Coordinator.

Payment of Acceptance Fee

On receipt of advice that the Minister has accepted an undertaking, a cheque for $1,500 should be sent to the Pathology Registration Coordinator. Applicants are required to pay this fee within 14 days of the notice being given. As there is no discretion under the *Health Insurance Act 1973* to accept late payments, failure to pay the fee within the required time means that:

(i) acceptance of the undertaking will be revoked;

(ii) a new application must be completed;

(iii) acceptance of the new undertaking cannot be backdated; and

(iv) there will therefore be a period during which Medicare benefits cannot be paid.

PN.10.3 Undertakings

Consideration of Undertakings

The Minister is unable to accept undertakings from a person in respect of whom there is a determination in force that the person has breached the undertaking, or from a person who, if the undertaking were accepted, would be likely to carry on the business of a prescribed person or would enable a person to avoid the financial consequences of the disqualification (or likely disqualification) of that prescribed person. A 'prescribed person' includes, inter alia, fully or partially disqualified persons (or persons likely to be so disqualified).

Similarly an undertaking cannot be accepted unless the Minister is satisfied that the person giving such undertaking is a fit and proper person to be an Approved Pathology Authority.

When an undertaking has been given the Minister may require the person giving the undertaking to provide additional information within a specified period of time and if the person does not comply the Minister may refuse to accept the undertaking.

Refusal of Undertaking and Rights of Review

Where the Minister refuses to accept an undertaking, the Minister must notify the person of the decision. The notification must include advice of a right of internal review of the decision and a right of further appeal to the Administrative Appeals Tribunal if the internal review upholds the original decision to refuse the undertaking.

Effective Period of Undertaking

The following applies:

(i) Date of Effect the earliest day from which the Minister or delegate can accept an undertaking is the day of the decision in respect of the undertaking. The day the undertaking is signed is to be the day it is actually signed and must not be backdated;

(ii) Period of Effect in determining the period of effect of the undertaking the Minister shall, unless the Minister considers that special circumstances exist, determine that the period of effect shall be twelve months from the day on which the undertaking comes into force. There is a requirement for the Minister to notify persons giving an undertaking of the period of time for which the undertaking is to have effect, and the notice is to advise persons

whose interests are affected by the decision of their rights of appeal to the Administrative Appeals Tribunal against the Minister's decision;

(iii) Renewals when an undertaking is given and accepted by the Minister while a former undertaking is current, the new undertaking does not take effect until the former undertaking ceases to be in force. When an undertaking is given while a former undertaking is current and the date on which the former undertaking is to expire passes without the Minister giving notice to accept or reject the new undertaking, the former undertaking remains in force until the Minister gives such notification. This provision does not apply when the renewal application is not received by the Department of Human Services until after the expiry of the existing undertaking. Under these circumstances there will be a period during which Medicare benefits cannot be paid unless the new application can be backdated to the expiry of the previous undertaking. This is a limited discretion for periods up to one month and special conditions apply; and

(iv) Cessation of Undertaking the undertaking ceases to be in force if it is terminated, if the Minister revokes acceptance of the undertaking, or if the period of effect for the undertaking expires whichever event first occurs.

An Approved Pathology Authority may terminate an undertaking at any time providing that at least 30 days notice of the intention to terminate the undertaking is given.

PN.10.4 Obligations and Responsibilities of Approved Pathology Authorities

The requirements of the legislation and the undertaking impose a number of obligations and responsibilities on Approved Pathology Authorities and the Minister. The more complex of these which have not already been covered are considered in paragraphs PK and PL dealing with Breaches of Undertakings and Excessive Pathology Services.

PN.11.1 Breaches of Undertakings

Notice Required

Where the Minister has reasonable grounds for believing that an Approved Pathology Practitioner or an Approved Pathology Authority has breached the undertaking, the Minister is required to give notice in writing to the person explaining the grounds for that belief and inviting the person to put a submission to the Minister to show cause why no further action should be taken in the matter.

PN.11.2 Decisions by Minister

Where a person provides a submission, the Minister may decide to take no further action against the person. Alternatively the Minister may refer the matter to a Medicare Participation Review Committee, notifying the grounds for believing that the undertaking has been breached. If after 28 days no submission has been received from the person, the Minister must refer that matter to the Committee.

PN.11.3 Appeals

The Minister is empowered to suspend an undertaking where notice has been given to a Medicare Participation Review Committee of its possible breach, pending the outcome of the Committee's proceedings. The Minister must give notice in writing to the person who provided the undertaking of the determination to suspend it, and the notice shall inform the person of a right of appeal against the determination to the Administrative Appeals Tribunal. The Minister may also publish a notice of a determination in the Public Service Gazette. Rights of appeal to the Administrative Appeals Tribunal also exist in respect of any determination made by a Medicare Participation Review Committee.

PN.12.1 Initiation of Excessive Pathology Services

Notice Required

Where the Minister has reasonable grounds for believing that a person, of a specified class of persons, has initiated, or caused or permitted the initiation of excessive pathology services the Minister is required to give notice in writing

to the person explaining the grounds for the belief and inviting the person to put a submission to the Minister to show cause why no further action should be taken in the matter.

PN.12.2 Classes of Persons

The classes of persons are:

(i) the practitioner who initiated the services;

(ii) the employer of the practitioner who caused or permitted the practitioner to initiate the services; or

(iii) an officer of the body corporate employing the practitioner who caused or permitted the practitioner to initiate the services.

PN.12.3 Decisions by Minister for Health and Ageing

Where a person provides a submission, the Minister may decide to take no further action against the person. Alternatively, the Minister may refer the matter to a Professional Services Review (PSR) Committee, notifying the grounds for believing that excessive pathology services have been initiated. If after 28 days no submission has been received from the person, the Minister must refer the matter to the Committee. The Minister must give to the person notice in writing of the decision.

PN.12.4 Appeals

Unlike the procedures relating to breaches of undertaking there is no power given to the Minister to determine a penalty. The Minister's role is either deciding to take no further action or referring the matter to a PSR Committee. Accordingly, there are no rights of appeal to the Administrative Appeals Tribunal applicable to the above procedures. However, rights of appeal to the Administrative Appeals Tribunal exist in respect of any determination made by a Medicare Participation Review Committee.

PN.13.1 Personal Supervision

Introduction

The *Health Insurance Act 1973* provides that the form of undertaking to be given by an Approved Pathology Practitioner may make provision for pathology services carried out under the personal supervision of the Approved Pathology Practitioner.

PN.13.2 Extract from Undertaking

The following is an extract from the Approved Pathology Practitioner (APP) undertaking:

Part 2 - Personal supervision

2.1 I acknowledge that it is my obligation, subject to Parts 2.2 and 2.4, personally to supervise any person who renders any service on my behalf and I undertake to accept personal responsibility for the rendering of that service under the following conditions of personal supervision:

(i) Subject to the following conditions, I will usually be physically available in the laboratory while services are being provided at the laboratory;

(ii) I may, subject to paragraph (vi) below, be physically absent from the laboratory while services are being rendered outside its normal hours of operation but in that event I will leave with the person rendering the service particulars of the manner in which I may be contacted while the service is being rendered and I must be able to personally attend at the laboratory while the service is being rendered or formally designate another APP present while I am absent;

(iii) I may, subject to paragraph (vi) below, be absent from the laboratory for brief periods due to illness or other personal necessity, or to take part in activities which, in accordance with normal and accepted practice, relate to the provision of services by that laboratory;

(iv) I will personally keep a written log of my absences from the laboratory that extend beyond one workday in respect of that laboratory and will retain that log in the laboratory for 18 months from date of last entry;

(v) If I am to be absent from the laboratory for more than 7 consecutive workdays, I will arrange for another APP to personally supervise the rendering of services in the laboratory. That arrangement shall be recorded in writing and retained in the laboratory for 18 months from date of last entry. Until such person is appointed, and his or her appointment is recorded in writing, I will remain personally responsible to comply with this undertaking;

(vi) If a service is being rendered on my behalf by a person who is not:

(a) a medical practitioner;

(b) a scientist; or

(c) a person having special qualifications or skills relevant to the service being rendered;

and no person in the above groups is physically present in the laboratory, then I must be physically present in the laboratory and closely supervise the rendering of the service;

(vii) I accept responsibility for taking all reasonable steps to ensure that in regard to services rendered by me or on my behalf:

(a) all persons who render services are adequately trained;

(b) all services which are to be rendered in the laboratory are allocated to persons employed by the APA and, these persons shall have appropriate qualifications and experience to render the services;

(c) the methods and procedures in operation in the laboratory for the purpose of rendering services are in accordance with proper and correct practices;

(d) for services rendered, proper quality control methods are established and reviewed to ensure their reliability and effectiveness; and

(e) results of services and tests rendered are accurately recorded and sent to the treating practitioner and, where applicable, a referring practitioner;

(viii) If I perform, or there is performed on my behalf, a service which consists of the analysis of a specimen which I know, or have reason to believe, has been taken other than in accordance with the provisions of section 16A(5AA) of the Act I will endorse, or cause to be endorsed, on the assignment form or the account for that service, as the case may be, particulars of the circumstances in which I believe, or have reason to believe, the specimen was taken.

2.2 Where services are to be rendered on my behalf in a Category B laboratory as defined in the Health Insurance (Accredited Pathology Laboratories - Approval) Principles 2002, I undertake to take all reasonable measures to ensure that the service is rendered under the supervision of an appropriate person as required by those Principles as in force from time to time.

2.3 I acknowledge to the best of my ability that any act or omission by a person, when acting with my authority, whether express or implied, that would, had it been done by me, have resulted in a breach of this undertaking, constitutes a breach of this undertaking by me.

2.4 Parts 2.1(i) to 2.1(vi) and 2.2 of this undertaking do not apply where a laboratory is limited to services (and associated equipment for those services) as detailed in Schedule 3.

PN.13.3 Notes on the Above

Part 2 of the APP Undertaking outlines the requirements for the personal supervision by an Approved Pathology Practitioner where a pathology service is rendered by another person on behalf of the APP. It should be noted that "on behalf of" does not relieve an Approved Pathology Practitioner of professional responsibility for the service or from being personally involved in the supervision of services in the laboratory.

PR.5.1 Limitation of item 72860

Item 72860 does not apply if the service is performed in the accredited pathology laboratory in which the subsequent genetic test(s) is performed.

Item 72860 does not apply if the service is performed in association with:

- a service to which item 72858 or 72859 of the pathology services table applies; or
- a service to which an item in Groups P6, P10 or P11 of the pathology services table applies, as part of the subsequent patient episode.

For any particular patient, item 72860 is applicable for a maximum of one retrieval per subsequent patient episode.

PR.6.1 Episode Cone

The episode cone is an arrangement, described in Rule 18, which effectively places an upper limit on the number of items for which Medicare benefits are payable in a patient episode. This cone only applies to services requested by general practitioners for their non-hospitalised patients. Pathology services requested for hospital in-patients, or ordered by specialists, are not subject to these coning arrangements.

When more than 3 items are requested by a general practitioner in a patient episode, the benefits payable will be equivalent to the sum of the benefits for the three items with the highest Schedule fees. Rule 18 provides that for the two items with the highest Schedule fees, Medicare benefits will be payable for each item. The remaining items are regarded as one service for which the benefit payable will be equivalent to that for the item with the third highest Schedule fee. Where items have the same Schedule fee, their item numbers are used as an artificial means to rank them.

The episode cone will apply even when the pathology services in a patient episode are performed by 2 or more Approved Pathology Authorities, with the exception of the services listed below.

The following items are not included in the count of the items performed when applying the episode cone:

(i) all the items in Groups P10, P11, P12 and P13;

(ii) Cervical Screening (items 73070, 73071, 73072, 73073, 73074, 73075, 73076);

(iii) all the items detailed at Rule 18 (e) (items 65079, 65082, 65157, 65158, 65166, 65180, 65181, 66606, 66609, 66639, 66642, 66651, 66652, 66663, 66666, 66696, 66697, 66714, 66715, 66723, 66724, 66780, 66783, 66789, 66790, 66792, 66804, 66805, 66816, 66817, 66820, 66821, 66826, 66827, 69325, 69328, 69331, 69379, 69383, 69400, 69401, 69451, 69500, 69489, 69492, 69497, 69498, 71076, 71090, 71092, 71096, 71148, 71154, 71156, 71169, 71170, 73309, 73312, 73315, 73318);

(iv) supplementary test for Hepatitis B and Hepatitis C (item 69484); and

(v) the carbon-labelled urea breath test to confirm or monitor Helicobacter pylori (item 66900).

PR.9.1 Quality Assurance in Aboriginal Medical Servcies (QAAMS) Program items

Item numbers 73839, 73840 and 73844 can only be performed in the following circumstances:

a) the service is rendered by or on behalf of a medical practitioner;
b) the practitioner referred to in paragraph (a), or the organisation for which the practitioner works, is participating

in the Quality Assurance in Aboriginal Medical Services Program; and
c) the service is provided in accordance with that Program; and
d) the practitioner referred to in paragraph (a) has determined the service to be necessary for his or her patient.

P1. HAEMATOLOGY

	Group P1. Haematology
65060	Haemoglobin, erythrocyte sedimentation rate, blood viscosity - 1 or more tests (See para PN.0.33, PN.1.1 of explanatory notes to this Category) **Fee:** $7.85 **Benefit:** 75% = $5.90 85% = $6.70
65066	Examination of: (a) a blood film by special stains to demonstrate Heinz bodies, parasites or iron; or (b) a blood film by enzyme cytochemistry for neutrophil alkaline phosphatase, alpha-naphthyl acetate esterase or chloroacetate esterase; or (c) a blood film using any other special staining methods including periodic acid Schiff and Sudan Black; or (d) a urinary sediment for haemosiderin including a service described in item 65072 **Fee:** $10.40 **Benefit:** 75% = $7.80 85% = $8.85
65070	Erythrocyte count, haematocrit, haemoglobin, calculation or measurement of red cell index or indices, platelet count, leucocyte count and manual or instrument generated differential count - not being a service where haemoglobin only is requested - one or more instrument generated set of results from a single sample; and (if performed) (a) a morphological assessment of a blood film; (b) any service in item 65060 or 65072 **Fee:** $16.95 **Benefit:** 75% = $12.75 85% = $14.45
65072	Examination for reticulocytes including a reticulocyte count by any method - 1 or more tests **Fee:** $10.20 **Benefit:** 75% = $7.65 85% = $8.70
65075	Haemolysis or metabolic enzymes - assessment by: (a) erythrocyte autohaemolysis test; or (b) erythrocyte osmotic fragility test; or (c) sugar water test; or (d) G-6-P D (qualitative or quantitative) test; or (e) pyruvate kinase (qualitative or quantitative) test; or (f) acid haemolysis test; or (g) quantitation of muramidase in serum or urine; or (h) Donath Landsteiner antibody test; or

P1. HAEMATOLOGY	
	(i) other erythrocyte metabolic enzyme tests 1 or more tests **Fee:** $51.95 **Benefit:** 75% = $39.00 85% = $44.20
65078	Tests for the diagnosis of thalassaemia consisting of haemoglobin electrophoresis or chromatography and at least 2 of: (a) examination for HbH; or (b) quantitation of HbA2; or (c) quantitation of HbF; including (if performed) any service described in item 65060 or 65070 **Fee:** $90.20 **Benefit:** 75% = $67.65 85% = $76.70
65079	Tests described in item 65078 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $90.20 **Benefit:** 75% = $67.65 85% = $76.70
65081	Tests for the investigation of haemoglobinopathy consisting of haemoglobin electrophoresis or chromatography and at least 1 of: (a) heat denaturation test; or (b) isopropanol precipitation test; or (c) tests for the presence of haemoglobin S; or (d) quantitation of any haemoglobin fraction (including S, C, D, E); including (if performed) any service described in item 65060, 65070 or 65078 **Fee:** $96.60 **Benefit:** 75% = $72.45 85% = $82.15
65082	Tests described in item 65081 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $96.60 **Benefit:** 75% = $72.45 85% = $82.15
65084	Bone marrow trephine biopsy - histopathological examination of sections of bone marrow and examination of aspirated material (including clot sections where necessary), including (if performed): any test described in item 65060, 65066 or 65070 **Fee:** $165.85 **Benefit:** 75% = $124.40 85% = $141.00
65087	Bone marrow - examination of aspirated material (including clot sections where necessary), including (if performed): any test described in item 65060, 65066 or 65070 **Fee:** $83.10 **Benefit:** 75% = $62.35 85% = $70.65
65090	Blood grouping (including back-grouping if performed) - ABO and Rh (D antigen) (See para PN.0.33, PN.1.1 of explanatory notes to this Category)

P1. HAEMATOLOGY	
	Fee: $11.15 **Benefit:** 75% = $8.40 85% = $9.50
65093	Blood grouping - Rh phenotypes, Kell system, Duffy system, M and N factors or any other blood group system - 1 or more systems, including item 65090 (if performed) **Fee:** $22.00 **Benefit:** 75% = $16.50 85% = $18.70
65096	Blood grouping (including back-grouping if performed), and examination of serum for Rh and other blood group antibodies, including: (a) identification and quantitation of any antibodies detected; and (b) (if performed) any test described in item 65060 or 65070 (See para PN.1.1 of explanatory notes to this Category) **Fee:** $41.00 **Benefit:** 75% = $30.75 85% = $34.85
65099	Compatibility tests by crossmatch - all tests performed on any one day for up to 6 units, including: (a) all grouping checks of the patient and donor; and (b) examination for antibodies, and if necessary identification of any antibodies detected; and (c) (if performed) any tests described in item 65060, 65070, 65090 or 65096 (Item is subject to rule 5) **Fee:** $108.90 **Benefit:** 75% = $81.70 85% = $92.60
65102	Compatibility tests by crossmatch - all tests performed on any one day in excess of 6 units, including: (a) all grouping checks of the patient and donor; and (b) examination for antibodies, and if necessary identification of any antibodies detected; and (c) (if performed) any tests described in item 65060, 65070, 65090, 65096, 65099 or 65105 (Item is subject to rule 5) **Fee:** $164.60 **Benefit:** 75% = $123.45 85% = $139.95
65105	Compatibility testing using at least a 3 cell panel and issue of red cells for transfusion - all tests performed on any one day for up to 6 units, including: (a) all grouping checks of the patient and donor; and (b) examination for antibodies and, if necessary, identification of any antibodies detected; and (c) (if performed) any tests described in item 65060, 65070, 65090 or 65096 (Item is subject to rule 5) **Fee:** $108.90 **Benefit:** 75% = $81.70 85% = $92.60
65108	Compatibility testing using at least a 3 cell panel and issue of red cells for transfusion - all tests performed on any one day in excess of 6 units, including: (a) all grouping checks of the patient and donor; and

P1. HAEMATOLOGY	
	(b) examination for antibodies and, if necessary, identification of any antibodies detected; and (c) (if performed) any tests described in item 65060, 65070, 65090, 65096, 65099 or 65105 (Item is subject to rule 5) **Fee:** $164.60 **Benefit:** 75% = $123.45 85% = $139.95
65109	Release of fresh frozen plasma or cryoprecipitate for the use in a patient for the correction of a coagulopathy - 1 release. **Fee:** $12.90 **Benefit:** 75% = $9.70 85% = $11.00
65110	Release of compatible fresh platelets for the use in a patient for platelet support as prophylaxis to minimize bleeding or during active bleeding - 1 release. **Fee:** $12.90 **Benefit:** 75% = $9.70 85% = $11.00
65111	Examination of serum for blood group antibodies (including identification and, if necessary, quantitation of any antibodies detected) **Fee:** $23.20 **Benefit:** 75% = $17.40 85% = $19.75
65114	1 or more of the following tests: (a) direct Coombs (antiglobulin) test; (b) qualitative or quantitative test for cold agglutinins or heterophil antibodies **Fee:** $9.10 **Benefit:** 75% = $6.85 85% = $7.75
65117	1 or more of the following tests: (a) Spectroscopic examination of blood for chemically altered haemoglobins; (b) detection of methaemalbumin (Schumm's test) **Fee:** $20.25 **Benefit:** 75% = $15.20 85% = $17.25
65120	Prothrombin time (including INR where appropriate), activated partial thromboplastin time, thrombin time (including test for the presence of heparin), test for factor XIII deficiency (qualitative), Echis test, Stypven test, reptilase time, fibrinogen, or 1 of fibrinogen degradation products, fibrin monomer or D-dimer - 1 test **Fee:** $13.70 **Benefit:** 75% = $10.30 85% = $11.65
65123	2 tests described in item 65120 **Fee:** $20.35 **Benefit:** 75% = $15.30 85% = $17.30
65126	3 tests described in item 65120 **Fee:** $27.85 **Benefit:** 75% = $20.90 85% = $23.70
65129	4 or more tests described in item 65120 (See para PN.0.28 of explanatory notes to this Category) **Fee:** $35.50 **Benefit:** 75% = $26.65 85% = $30.20
65137	Test for the presence of lupus anticoagulant not being a service associated with any service to which items 65175, 65176, 65177, 65178 and 65179 apply

P1. HAEMATOLOGY	
	Fee: $25.35 **Benefit:** 75% = $19.05 85% = $21.55
65142	Confirmation or clarification of an abnormal or indeterminate result from a test described in item 65175, by testing a specimen collected on a different day - 1 or more tests **Fee:** $25.35 **Benefit:** 75% = $19.05 85% = $21.55
65144	Platelet aggregation in response to ADP, collagen, 5HT, ristocetin or other substances; or heparin, low molecular weight heparins, heparinoid or other drugs - 1 or more tests **Fee:** $56.55 **Benefit:** 75% = $42.45 85% = $48.10
65147	Quantitation of anti-Xa activity when monitoring is required for a patient receiving a low molecular weight heparin or heparinoid - 1 test **Fee:** $37.90 **Benefit:** 75% = $28.45 85% = $32.25
65150	Quantitation of von Willebrand factor antigen, von Willebrand factor activity (ristocetin cofactor assay), von Willebrand factor collagen binding activity, factor II, factor V, factor VII, factor VIII, factor IX, factor X, factor XI, factor XII, factor XIII, Fletcher factor, Fitzgerald factor, circulating coagulation factor inhibitors other than by Bethesda assay - 1 test (Item is subject to rule 6) **Fee:** $70.90 **Benefit:** 75% = $53.20 85% = $60.30
65153	2 tests described in item 65150 (Item is subject to rule 6) **Fee:** $141.85 **Benefit:** 75% = $106.40 85% = $120.60
65156	3 or more tests described in item 65150 (Item is subject to rule 6) **Fee:** $212.75 **Benefit:** 75% = $159.60 85% = $180.85
65157	A test described in item 65150, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18) **Fee:** $70.90 **Benefit:** 75% = $53.20 85% = $60.30
65158	Tests described in item 65150, other than that described in 65157, if rendered by a receiving APP - each test to a maximum of 2 tests (Item is subject to rule 6 and 18) **Fee:** $70.90 **Benefit:** 75% = $53.20 85% = $60.30
65159	Quantitation of circulating coagulation factor inhibitors by Bethesda assay - 1 test **Fee:** $70.90 **Benefit:** 75% = $53.20 85% = $60.30
65162	Examination of a maternal blood film for the presence of fetal red blood cells (Kleihauer test) **Fee:** $10.45 **Benefit:** 75% = $7.85 85% = $8.90
65165	Detection and quantitation of fetal red blood cells in the maternal circulation by detection of red cell antigens using flow cytometric methods including (if performed) any test described in item 65070 or 65162 **Fee:** $34.45 **Benefit:** 75% = $25.85 85% = $29.30

P1. HAEMATOLOGY	
65166	A test described in item 65165 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $34.45 **Benefit:** 75% = $25.85 85% = $29.30
65171	Test for the presence of antithrombin III deficiency, protein C deficiency, protein S deficiency or activated protein C resistance in a first degree relative of a person who has a proven defect of any of the above - 1 or more tests **Fee:** $25.35 **Benefit:** 75% = $19.05 85% = $21.55
65175	Test for the presence of antithrombin III deficiency, protein C deficiency, protein S deficiency, lupus anticoagulant, activated protein C resistance - where the request for the test(s) specifically identifies that the patient has a history of venous thromboembolism - quantitation by 1 or more techniques - 1 test (Item is subject to Rule 6) **Fee:** $25.35 **Benefit:** 75% = $19.05 85% = $21.55
65176	2 tests described in item 65175 (Item is subject to rule 6) **Fee:** $48.65 **Benefit:** 75% = $36.50 85% = $41.40
65177	3 tests described in item 65175 (Item is subject to rule 6) **Fee:** $71.95 **Benefit:** 75% = $54.00 85% = $61.20
65178	4 tests described in item 65175 (Item is subject to rule 6) **Fee:** $95.20 **Benefit:** 75% = $71.40 85% = $80.95
65179	5 tests described in item 65175 (Item is subject to rule 6) **Fee:** $118.50 **Benefit:** 75% = $88.90 85% = $100.75
65180	A test described in item 65175, if rendered by a receiving APA, where no tests in the item have been rendered by the referring APA - 1 test (Item is subject to rule 6 and 18) **Fee:** $25.35 **Benefit:** 75% = $19.05 85% = $21.55
65181	Tests described in item 65175, other than that described in 65180, if rendered by a receiving APA - each test to a maximum of 4 tests (Item is subject to rule 6 and 18) **Fee:** $23.30 **Benefit:** 75% = $17.50 85% = $19.85
P2. CHEMICAL	
	Group P2. Chemical
66500	Quantitation in serum, plasma, urine or other body fluid (except amniotic fluid), by any method except reagent tablet or reagent strip (with or without reflectance meter) of: acid phosphatase, alanine

P2. CHEMICAL	
	aminotransferase, albumin, alkaline phosphatase, ammonia, amylase, aspartate aminotransferase, bicarbonate, bilirubin (total), bilirubin (any fractions), C-reactive protein, calcium (total or corrected for albumin), chloride, creatine kinase, creatinine, gamma glutamyl transferase, globulin, glucose, lactate dehydrogenase, lipase, magnesium, phosphate, potassium, sodium, total protein, total cholesterol, triglycerides, urate or urea - 1 test **Fee:** $9.70 **Benefit:** 75% = $7.30 85% = $8.25
66503	2 tests described in item 66500 **Fee:** $11.65 **Benefit:** 75% = $8.75 85% = $9.95
66506	3 tests described in item 66500 **Fee:** $13.65 **Benefit:** 75% = $10.25 85% = $11.65
66509	4 tests described in item 66500 **Fee:** $15.65 **Benefit:** 75% = $11.75 85% = $13.35
66512	5 or more tests described in item 66500 **Fee:** $17.70 **Benefit:** 75% = $13.30 85% = $15.05
66517	Quantitation of bile acids in blood in pregnancy. To a maximum of 3 tests in a pregnancy. **Fee:** $19.65 **Benefit:** 75% = $14.75 85% = $16.75
66518	Investigation of cardiac or skeletal muscle damage by quantitative measurement of creatine kinase isoenzymes, troponin or myoglobin in blood - testing on 1 specimen in a 24 hour period **Fee:** $20.05 **Benefit:** 75% = $15.05 85% = $17.05
66519	Investigation of cardiac or skeletal muscle damage by quantitative measurement of creatine kinase isoenzymes, troponin or myoglobin in blood - testing on 2 or more specimens in a 24 hour period **Fee:** $40.15 **Benefit:** 75% = $30.15 85% = $34.15
66536	Quantitation of HDL cholesterol **Fee:** $11.05 **Benefit:** 75% = $8.30 85% = $9.40
66539	Electrophoresis of serum for demonstration of lipoprotein subclasses, if the cholesterol is >6.5 mmol/L and triglyceride >4.0 mmol/L or in the diagnosis of types III and IV hyperlipidaemia - (Item is subject to rule 25) **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05
66542	Oral glucose tolerance test for the diagnosis of diabetes mellitus that includes: (a) administration of glucose; and (b) at least 2 measurements of blood glucose; and (c) (if performed) any test described in item 66695 **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
66545	Oral glucose challenge test in pregnancy for the detection of gestational diabetes that includes: (a) administration of glucose; and

P2. CHEMICAL	
	(b) 1 or 2 measurements of blood glucose; and (c) (if performed) any test in item 66695 **Fee:** $15.80 **Benefit:** 75% = $11.85 85% = $13.45
66548	Oral glucose tolerance test in pregnancy for the diagnosis of gestational diabetes that includes: (a) administration of glucose; and (b) at least 3 measurements of blood glucose; and (c) any test in item 66695 (if performed) **Fee:** $19.90 **Benefit:** 75% = $14.95 85% = $16.95
66551	Quantitation of glycated haemoglobin performed in the management of established diabetes - (Item is subject to rule 25) **Fee:** $16.80 **Benefit:** 75% = $12.60 85% = $14.30
66554	Quantitation of glycated haemoglobin performed in the management of pre-existing diabetes where the patient is pregnant - including a service in item 66551 (if performed) - (Item is subject to rule 25) **Fee:** $16.80 **Benefit:** 75% = $12.60 85% = $14.30
66557	Quantitation of fructosamine performed in the management of established diabetes - each test to a maximum of 4 tests in a 12 month period **Fee:** $9.70 **Benefit:** 75% = $7.30 85% = $8.25
66560	Microalbumin - quantitation in urine **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10
66563	Osmolality, estimation by osmometer, in serum or in urine - 1 or more tests **Fee:** $24.70 **Benefit:** 75% = $18.55 85% = $21.00
66566	Quantitation of: (a) blood gases (including pO_2, oxygen saturation and pCO_2) ; and (b) bicarbonate and pH; including any other measurement (eg. haemoglobin, lactate, potassium or ionised calcium) or calculation performed on the same specimen - 1 or more tests on 1 specimen **Fee:** $33.70 **Benefit:** 75% = $25.30 85% = $28.65
66569	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 2 specimens performed within any 1 day **Fee:** $42.60 **Benefit:** 75% = $31.95 85% = $36.25
66572	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 3 specimens performed within any 1 day **Fee:** $51.55 **Benefit:** 75% = $38.70 85% = $43.85
66575	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 4 specimens performed

P2. CHEMICAL	
	within any 1 day **Fee:** $60.45 **Benefit:** 75% = $45.35 85% = $51.40
66578	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 5 specimens performed within any 1 day **Fee:** $69.35 **Benefit:** 75% = $52.05 85% = $58.95
66581	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 6 or more specimens performed within any 1 day **Fee:** $78.25 **Benefit:** 75% = $58.70 85% = $66.55
66584	Quantitation of ionised calcium (except if performed as part of item 66566) - 1 test **Fee:** $9.70 **Benefit:** 75% = $7.30 85% = $8.25
66587	Urine acidification test for the diagnosis of renal tubular acidosis including the administration of an acid load, and pH measurements on 4 or more urine specimens and at least 1 blood specimen **Fee:** $47.55 **Benefit:** 75% = $35.70 85% = $40.45
66590	Calculus, analysis of 1 or more **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05
66593	Ferritin - quantitation, except if requested as part of iron studies **Fee:** $18.00 **Benefit:** 75% = $13.50 85% = $15.30
66596	Iron studies, consisting of quantitation of: (a) serum iron; and (b) transferrin or iron binding capacity; and (c) ferritin **Fee:** $32.55 **Benefit:** 75% = $24.45 85% = $27.70
66605	Vitamins - quantitation of vitamins B1, B2, B3, B6 or C in blood, urine or other body fluid - 1 or more tests **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05
66606	A test described in item 66605 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18 and 25) **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05
66607	Vitamins - quantitation of vitamins A or E in blood, urine or other body fluid - 1 or more tests within a 6 month period **Fee:** $75.75 **Benefit:** 75% = $56.85 85% = $64.40
66610	A test described in item 66607 if rendered by a receiving APP - 1 or more tests **Fee:** $75.75 **Benefit:** 75% = $56.85 85% = $64.40
66623	All qualitative and quantitative tests on blood, urine or other body fluid for:

P2. CHEMICAL	
	(a) a drug or drugs of abuse (including illegal drugs and legally available drugs taken other than in appropriate dosage); or (b) ingested or absorbed toxic chemicals; including a service described in item 66800, 66803, 66806, 66812 or 66815 (if performed), but excluding: (c) the surveillance of sports people and athletes for performance improving substances; and (d) the monitoring of patients participating in a drug abuse treatment program **Fee:** $41.50 **Benefit:** 75% = $31.15 85% = $35.30
66626	Detection or quantitation or both (not including the detection of nicotine and metabolites in smoking withdrawal programs) of a drug, or drugs, of abuse or a therapeutic drug, on a sample collected from a patient participating in a drug abuse treatment program; but excluding the surveillance of sports people and athletes for performance improving substances; including all tests on blood, urine or other body fluid (Item is subject to rule 25) **Fee:** $24.10 **Benefit:** 75% = $18.10 85% = $20.50
66629	Beta-2-microglobulin - quantitation in serum, urine or other body fluids - 1 or more tests **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10
66632	Caeruloplasmin, haptoglobins, or prealbumin - quantitation in serum, urine or other body fluids - 1 or more tests **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10
66635	Alpha-1-antitrypsin - quantitation in serum, urine or other body fluid - 1 or more tests **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10
66638	Isoelectric focussing or similar methods for determination of alpha-1-antitrypsin phenotype in serum - 1 or more tests **Fee:** $49.05 **Benefit:** 75% = $36.80 85% = $41.70
66639	A test described in item 66638 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $29.20 **Benefit:** 75% = $21.90 85% = $24.85
66641	Electrophoresis of serum or other body fluid to demonstrate: (a) the isoenzymes of lactate dehydrogenase; or (b) the isoenzymes of alkaline phosphatase; including the preliminary quantitation of total relevant enzyme activity - 1 or more tests **Fee:** $29.20 **Benefit:** 75% = $21.90 85% = $24.85
66642	A test described in item 66641 if rendered by a receiving APP - 1 or more tests

P2. CHEMICAL	
	(Item is subject to rule 18) **Fee:** $29.20 **Benefit:** 75% = $21.90 85% = $24.85
66644	C-1 esterase inhibitor - quantitation **Fee:** $20.15 **Benefit:** 75% = $15.15 85% = $17.15
66647	C-1 esterase inhibitor - functional assay **Fee:** $45.10 **Benefit:** 75% = $33.85 85% = $38.35
66650	Alpha-fetoprotein, CA-15.3 antigen (CA15.3), CA-125 antigen (CA125), CA-19.9 antigen (CA19.9), cancer associated serum antigen (CASA), carcinoembryonic antigen (CEA), human chorionic gonadotrophin (HCG), neuron specific enolase (NSE), thyroglobulin in serum or other body fluid, in the monitoring of malignancy or in the detection or monitoring of hepatic tumours, gestational trophoblastic disease or germ cell tumour - quantitation - 1 test (Item is subject to rule 6) **Fee:** $24.35 **Benefit:** 75% = $18.30 85% = $20.70
66651	A test described in item 66650 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18) **Fee:** $24.35 **Benefit:** 75% = $18.30 85% = $20.70
66652	A test described in item 66650 if rendered by a receiving APP - other than that described in 66651, if rendered by a receiving APP, 1 test (Item is subject to rule 6 and 18) **Fee:** $20.30 **Benefit:** 75% = $15.25 85% = $17.30
66653	2 or more tests described in item 66650 (Item is subject to rule 6) **Fee:** $44.60 **Benefit:** 75% = $33.45 85% = $37.95
66655	Prostate specific antigen - quantitation - 1 of this item in a 12 month period (Item is subject to rule 25) **Fee:** $20.15 **Benefit:** 75% = $15.15 85% = $17.15
66656	Prostate specific antigen - quantitation in the monitoring of previously diagnosed prostatic disease (including a test described in item 66655) **Fee:** $20.15 **Benefit:** 75% = $15.15 85% = $17.15
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 follow up of a PSA result that lies at or above the age related median but below the age related, method specific 97.5% reference limit - 1 of this item in a 12 month period (Item is subject to rule 25) **Fee:** $37.30 **Benefit:** 75% = $28.00 85% = $31.75

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66660	Prostate specific antigen - quantitation of 2 or more fractions of PSA and any derived index including (if performed) a test described in item 66656, in the follow up of a PSA result that lies at or above the age related, method specific 97.5% reference limit, but below a value of 10 ug/L - 4 of this item in a 12 month period. (Item is subject to rule 25) **Fee:** $37.30 **Benefit:** 75% = $28.00 85% = $31.75
66662	Quantitation of hormone receptors on proven primary breast or ovarian carcinoma or a metastasis from a breast or ovarian carcinoma or a subsequent lesion in the breast - 1 or more tests **Fee:** $79.95 **Benefit:** 75% = $60.00 85% = $68.00
66663	A test described in item 66662 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $79.95 **Benefit:** 75% = $60.00 85% = $68.00
66665	Lead quantitation in blood or urine (other than for occupational health screening purposes) to a maximum of 3 tests in a 6 month period - each test **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05
66666	A test described in item 66665 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05
66667	Quantitation of serum zinc in a patient receiving intravenous alimentation - each test **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05
66671	Quantitation of serum aluminium in a patient in a renal dialysis program - each test **Fee:** $36.90 **Benefit:** 75% = $27.70 85% = $31.40
66674	Quantitation of: (a) faecal fat; or (b) breath hydrogen in response to loading with disaccharides; 1 or more tests within a 28 day period **Fee:** $39.95 **Benefit:** 75% = $30.00 85% = $34.00
66677	Test for tryptic activity in faeces in the investigation of diarrhoea of longer than 4 weeks duration in children under 6 years old **Fee:** $11.15 **Benefit:** 75% = $8.40 85% = $9.50
66680	Quantitation of disaccharidases and other enzymes in intestinal tissue - 1 or more tests **Fee:** $74.45 **Benefit:** 75% = $55.85 85% = $63.30
66683	Enzymes - quantitation in solid tissue or tissues other than blood elements or intestinal tissue - 1 or more tests **Fee:** $74.45 **Benefit:** 75% = $55.85 85% = $63.30

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66686	Performance of 1 or more of the following procedures: (a) growth hormone suppression by glucose loading; (b) growth hormone stimulation by exercise; (c) dexamethasone suppression test; (d) sweat collection by iontophoresis for chloride analysis; (e) pharmacological stimulation of growth hormone **Fee:** $50.65 **Benefit:** 75% = $38.00 85% = $43.10
66695	Quantitation in blood or urine of hormones and hormone binding proteins - ACTH, aldosterone, androstenedione, C-peptide, calcitonin, cortisol, DHEAS, 11-deoxycortisol, dihydrotestosterone, FSH, gastrin, glucagon, growth hormone, hydroxyprogesterone, insulin, LH, oestradiol, oestrone, progesterone, prolactin, PTH, renin, sex hormone binding globulin, somatomedin C(IGF-1), free or total testosterone, urine steroid fraction or fractions, vasoactive intestinal peptide, - 1 test (Item is subject to rule 6) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $30.50 **Benefit:** 75% = $22.90 85% = $25.95
66696	A test described in item 66695, if rendered by a receiving APP - where no tests in the item have been rendered by the referring APP (Item is subject to rule 6 and 18) **Fee:** $30.50 **Benefit:** 75% = $22.90 85% = $25.95
66697	Tests described in item 66695, other than that described in 66696, if rendered by a receiving APP - each test to a maximum of 4 tests (Item is subject to rule 6 and 18) **Fee:** $13.20 **Benefit:** 75% = $9.90 85% = $11.25
66698	2 tests described in item 66695 (Item is subject to rule 6) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $43.70 **Benefit:** 75% = $32.80 85% = $37.15
66701	3 tests described in item 66695 (Item is subject to rule 6) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $56.90 **Benefit:** 75% = $42.70 85% = $48.40
66704	4 tests described in item 66695

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	(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) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $70.15 **Benefit:** 75% = $52.65 85% = $59.65
66707	5 or more tests described in item 66695 (Item is subject to rule 6) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $83.35 **Benefit:** 75% = $62.55 85% = $70.85
66711	Quantitation in saliva of cortisol in: (a) the investigation of Cushing's syndrome; or (b) the management of children with congenital adrenal hyperplasia (Item is subject to rule 6) **Fee:** $30.15 **Benefit:** 75% = $22.65 85% = $25.65
66712	Two tests described in item 66711 (Item is subject to rule 6) **Fee:** $43.05 **Benefit:** 75% = $32.30 85% = $36.60
66714	A test described in item 66711, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP (Item is subject to rule 6 and 18) **Fee:** $30.15 **Benefit:** 75% = $22.65 85% = $25.65
66715	Tests described in item 66711, other than that described in 66714, if rendered by a receiving APP, each test to a maximum of 1 test (Item is subject to rule 6 and 18) **Fee:** $12.85 **Benefit:** 75% = $9.65 85% = $10.95
66716	TSH quantitation **Fee:** $25.05 **Benefit:** 75% = $18.80 85% = $21.30
66719	Thyroid function tests (comprising the service described in item 66716 and 1 or more of the following tests - free thyroxine, free T3, for a patient, if at least 1 of the following conditions is satisfied: (a) the patient has an abnormal level of TSH; (b) the tests are performed:

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	(i) for the purpose of monitoring thyroid disease in the patient; or (ii) to investigate the sick euthyroid syndrome if the patient is an admitted patient; or (iii) to investigate dementia or psychiatric illness of the patient; or (iv) to investigate amenorrhoea or infertility of the patient; (c) the medical practitioner who requested the tests suspects the patient has a pituitary dysfunction; (d) the patient is on drugs that interfere with thyroid hormone metabolism or function (Item is subject to rule 9) **Fee:** $34.80 **Benefit:** 75% = $26.10 85% = $29.60
66722	TSH quantitation described in item 66716 and 1 test described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $37.90 **Benefit:** 75% = $28.45 85% = $32.25
66723	Tests described in item 66722, that is, TSH quantitation and 1 test described in 66695, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18) **Fee:** $37.90 **Benefit:** 75% = $28.45 85% = $32.25
66724	Tests described in item 66722, if rendered by a receiving APP, other than that described in 66723. It is to include a quantitation of TSH - each test to a maximum of 4 tests described in item 66695 (Item is subject to rule 6 and 18) **Fee:** $13.15 **Benefit:** 75% = $9.90 85% = $11.20
66725	TSH quantitation described in item 66716 and 2 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 tests specified on the request form or performs 3 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $51.05 **Benefit:** 75% = $38.30 85% = $43.40
66728	TSH quantitation described in item 66716 and 3 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the

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	only 4 tests specified on the request form or performs 4 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $64.20 **Benefit:** 75% = $48.15 85% = $54.60
66731	TSH quantitation described in item 66716 and 4 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 5 tests specified on the request form or performs 5 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $77.40 **Benefit:** 75% = $58.05 85% = $65.80
66734	TSH quantitation described in item 66716 and 5 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 6 or more tests specified on the request form) (Item is subject to rule 6) **Fee:** $90.55 **Benefit:** 75% = $67.95 85% = $77.00
66743	Quantitation of alpha-fetoprotein in serum or other body fluids during pregnancy except if requested as part of items 66750 or 66751 **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10
66749	Amniotic fluid, spectrophotometric examination of, and quantitation of: (a) lecithin/sphingomyelin ratio; or (b) palmitic acid, phosphatidylglycerol or lamellar body phospholipid; or (c) bilirubin, including correction for haemoglobin 1 or more tests **Fee:** $32.95 **Benefit:** 75% = $24.75 85% = $28.05
66750	Quantitation, in pregnancy, of any two of the following - total human chorionic gonadotrophin (total HCG), free alpha human chorionic gonadotrophin (free alpha HCG), free beta human chorionic gonadotrophin (free beta HCG), pregnancy associated plasma protein A (PAPP-A), unconjugated oestriol (uE_3), alpha-fetoprotein (AFP) - to detect foetal abnormality, including a service described in 1 or more of items 73527 and 73529 (if performed) - (Item is subject to rule 25) **Fee:** $39.75 **Benefit:** 75% = $29.85 85% = $33.80
66751	Quantitation, in pregnancy, of any three or more tests described in 66750 (Item is subject to rule 25)

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	Fee: $55.25 **Benefit:** 75% = $41.45 85% = $47.00
66752	Quantitation of acetoacetate, beta-hydroxybutyrate, citrate, oxalate, total free fatty acids, cysteine, homocysteine, cystine, lactate, pyruvate or other amino acids and hydroxyproline (except if performed as part of item 66773 or 66776) - 1 test **Fee:** $24.70 **Benefit:** 75% = $18.55 85% = $21.00
66755	2 or more tests described in item 66752 **Fee:** $38.85 **Benefit:** 75% = $29.15 85% = $33.05
66756	Quantitation of 10 or more amino acids for the diagnosis of inborn errors of metabolism - up to 4 tests in a 12 month period on specimens of plasma, CSF and urine. **Fee:** $98.30 **Benefit:** 75% = $73.75 85% = $83.60
66757	Quantitation of 10 or more amino acids for monitoring of previously diagnosed inborn errors of metabolism in 1 tissue type. **Fee:** $98.30 **Benefit:** 75% = $73.75 85% = $83.60
66758	Quantitation of angiotensin converting enzyme, or cholinesterase - 1 or more tests **Fee:** $24.70 **Benefit:** 75% = $18.55 85% = $21.00
66761	Test for reducing substances in faeces by any method (except reagent strip or dipstick) **Fee:** $13.15 **Benefit:** 75% = $9.90 85% = $11.20
66764	Examination for faecal occult blood (including tests for haemoglobin and its derivatives in the faeces except by reagent strip or dip stick methods) with a maximum of 3 examinations on specimens collected on separate days in a 28 day period **Fee:** $8.90 **Benefit:** 75% = $6.70 85% = $7.60
66767	2 examinations described in item 66764 performed on separately collected and identified specimens **Fee:** $17.85 **Benefit:** 75% = $13.40 85% = $15.20
66770	3 examinations described in item 66764 performed on separately collected and identified specimens **Fee:** $26.70 **Benefit:** 75% = $20.05 85% = $22.70
66773	Quantitation of products of collagen breakdown or formation for the monitoring of patients with proven low bone mineral density, and if performed, a service described in item 66752 - 1 or more tests *(Low bone densitometry is defined in the explanatory notes to Category 2 - Diagnostic Procedures and Investigations of the Medicare Benefits Schedule)* **Fee:** $24.65 **Benefit:** 75% = $18.50 85% = $21.00
66776	Quantitation of products of collagen breakdown or formation for the monitoring of patients with metabolic bone disease or Paget's disease of bone, and if performed, a service described in item 66752 - 1 or more tests **Fee:** $24.65 **Benefit:** 75% = $18.50 85% = $21.00
66779	Adrenaline, noradrenaline, dopamine, histamine, hydroxyindoleacetic acid (5HIAA), hydroxymethoxymandelic acid (HMMA), homovanillic acid (HVA), metanephrines,

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	methoxyhydroxyphenylethylene glycol (MHPG), phenylacetic acid (PAA) or serotonin quantitation - 1 or more tests **Fee:** $39.95 **Benefit:** 75% = $30.00 85% = $34.00
66780	A test described in item 66779 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $39.95 **Benefit:** 75% = $30.00 85% = $34.00
66782	Porphyrins or porphyrins precursors - detection in plasma, red cells, urine or faeces - 1 or more tests **Fee:** $13.15 **Benefit:** 75% = $9.90 85% = $11.20
66783	A test described in item 66782 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $13.15 **Benefit:** 75% = $9.90 85% = $11.20
66785	Porphyrins or porphyrins precursors - quantitation in plasma, red cells, urine or faeces - 1 test (Item is subject to rule 6) **Fee:** $39.95 **Benefit:** 75% = $30.00 85% = $34.00
66788	Porphyrins or porphyrins precursors - quantitation in plasma, red cells, urine or faeces - 2 or more tests (Item is subject to rule 6) **Fee:** $65.85 **Benefit:** 75% = $49.40 85% = $56.00
66789	A test described in item 66785 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18) **Fee:** $39.95 **Benefit:** 75% = $30.00 85% = $34.00
66790	A test described in item 66785 other than that described in 66789, if rendered by a receiving APP - to a maximum of 1 test (Item is subject to rule 6 and 18) **Fee:** $25.90 **Benefit:** 75% = $19.45 85% = $22.05
66791	Porphyrin biosynthetic enzymes - measurement of activity in blood cells or other tissues - 1 or more tests **Fee:** $74.45 **Benefit:** 75% = $55.85 85% = $63.30
66792	A test described in item 66791 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $74.45 **Benefit:** 75% = $55.85 85% = $63.30
66800	Quantitation in blood, urine or other body fluid by any method (except reagent tablet or reagent strip) of any of the following being used therapeutically by the patient from whom the specimen was taken: amikacin, carbamazepine, digoxin, disopyramide, ethanol, ethosuximide, gentamicin, lithium, lignocaine, netilmicin, paracetamol, phenobarbitone, primidone, phenytoin, procainamide, quinidine,

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	salicylate, theophylline, tobramycin, valproate or vancomycin - 1 test (Item to be subject to rule 6) (See para PN.0.17 of explanatory notes to this Category) **Fee:** $18.15 **Benefit:** 75% = $13.65 85% = $15.45
66803	2 tests described in item 66800 (Item is subject to rule 6) **Fee:** $30.50 **Benefit:** 75% = $22.90 85% = $25.95
66804	A test described in item 66800 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18) **Fee:** $18.15 **Benefit:** 75% = $13.65 85% = $15.45
66805	A test described in item 66800 other than that described in 66804, if rendered by a receiving APP - each test to a maximum of 2 tests (Item is subject to rule 6 and 18) **Fee:** $12.35 **Benefit:** 75% = $9.30 85% = $10.50
66806	3 tests described in item 66800 (Item is subject to rule 6) **Fee:** $41.85 **Benefit:** 75% = $31.40 85% = $35.60
66812	Quantitation, not elsewhere described in this Table by any method or methods, in blood, urine or other body fluid, of a drug being used therapeutically by the patient from whom the specimen was taken - 1 test (This fee applies where 1 laboratory performs the only test specified on the request form or performs 1 test and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) (See para PN.0.17 of explanatory notes to this Category) **Fee:** $34.80 **Benefit:** 75% = $26.10 85% = $29.60
66815	2 tests described in item 66812 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $59.55 **Benefit:** 75% = $44.70 85% = $50.65
66816	A test described in item 66812 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18)

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	Fee: $34.80 **Benefit:** 75% = $26.10 85% = $29.60
66817	A test described in item 66812, other than that described in 66816, if rendered by a receiving APP - to a maximum of 1 test (Item is subject to rule 6 and 18) **Fee:** $24.75 **Benefit:** 75% = $18.60 85% = $21.05
66819	Quantitation of copper, manganese, selenium, or zinc (except if item 66667 applies), in blood, urine or other body fluid - 1 test. (Item is subject to rule 6, 22 and 25) **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05
66820	A test described in item 66819 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6, 18, 22 and 25) **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05
66821	A test described in item 66819 other than that described in 66820 if rendered by a receiving APP to a maximum of 1 test (Item is subject to rule 6, 18, 22 and 25) **Fee:** $21.80 **Benefit:** 75% = $16.35 85% = $18.55
66822	Quantitation of copper, manganese, selenium, or zinc (except if item 66667 applies), in blood, urine or other body fluid - 2 or more tests. (Item is subject to rule 6, 22 and 25) **Fee:** $52.45 **Benefit:** 75% = $39.35 85% = $44.60
66825	Quantitation of aluminium (except if item 66671 applies), arsenic, beryllium, cadmium, chromium, gold, mercury, nickel, or strontium, in blood, urine or other body fluid or tissue - 1 test. To a maximum of 3 of this item in a 6 month period (Item is subject to rule 6, 22 and 25) **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05
66826	A test described in item 66825 if rendered by a receiving APP where no tests have been rendered by the referring APP - 1 test (Item is subject to rules 6, 18, 22 and 25) **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05
66827	A test described in item 66825, other than that described in 66826, if rendered by a receiving APP to a maximum of 1 test (Item is subject to rules 6, 18, 22 and 25) **Fee:** $21.80 **Benefit:** 75% = $16.35 85% = $18.55
66828	Quantitation of aluminium (except if item 66671 applies), arsenic, beryllium, cadmium, chromium, gold, mercury, nickel, or strontium, in blood, urine or other body fluid or tissue - 2 or more tests. To a

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	maximum of 3 of this item in a 6 month period (Item is subject to rule 6, 22 and 25) **Fee:** $52.45 **Benefit:** 75% = $39.35 85% = $44.60
66830	Quantitation of BNP or NT-proBNP for the diagnosis of heart failure in patients presenting with dyspnoea to a hospital Emergency Department (Item is subject to rule 25) **Fee:** $58.50 **Benefit:** 75% = $43.90 85% = $49.75
66831	Quantitation of copper or iron in liver tissue biopsy **Fee:** $30.95 **Benefit:** 75% = $23.25 85% = $26.35
66832	A test described in item 66831 if rendered by a receiving APP (Item is subject to rule 18A and 22) **Fee:** $30.95 **Benefit:** 75% = $23.25 85% = $26.35
66833	25-hydroxyvitamin D, quantification in serum, for the investigation of a patient who: (a) has signs or symptoms of osteoporosis or osteomalacia; or (b) has increased alkaline phosphatase and otherwise normal liver function tests; or (c) has hyperparathyroidism, hypo- or hypercalcaemia, or hypophosphataemia; or (d) is suffering from malabsorption (for example, because the patient has cystic fibrosis, short bowel syndrome, inflammatory bowel disease or untreated coeliac disease, or has had bariatric surgery); or (e) has deeply pigmented skin, or chronic and severe lack of sun exposure for cultural, medical, occupational or residential reasons; or (f) is taking medication known to decrease 25OH-D levels (for example, anticonvulsants); or (g) has chronic renal failure or is a renal transplant recipient; or (h) is less than 16 years of age and has signs or symptoms of rickets; or (i) is an infant whose mother has established vitamin D deficiency; or (j) is a exclusively breastfed baby and has at least one other risk factor mentioned in a paragraph in this item; or (k) has a sibling who is less than 16 years of age and has vitamin D deficiency **Fee:** $30.05 **Benefit:** 75% = $22.55 85% = $25.55
66834	A test described in item 66833 if rendered by a receiving APP (Item is subject to Rule 18) **Fee:** $30.05 **Benefit:** 75% = $22.55 85% = $25.55
66835	1, 25-dihydroxyvitamin D - quantification in serum, if the request for the test is made by, or on advice

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	of, the specialist or consultant physician managing the treatment of the patient **Fee:** $39.05 **Benefit:** 75% = $29.30 85% = $33.20
66836	1, 25-dihydroxyvitamin D-quantification in serum, if: (a) the patient has hypercalcaemia; and (b) the request for the test is made by a general practitioner managing the treatment of the patient **Fee:** $39.05 **Benefit:** 75% = $29.30 85% = $33.20
66837	A test described in item 66835 or 66836 if rendered by a receiving APP (Item is subject to Rule 18) **Fee:** $39.05 **Benefit:** 75% = $29.30 85% = $33.20
66838	Serum vitamin B12 test (Item is subject to Rule 25) **Fee:** $23.60 **Benefit:** 75% = $17.70 85% = $20.10
66839	Quantification of vitamin B12 markers such as holoTranscobalamin or methylmalonic acid, where initial serum vitamin B12 result is low or equivocal **Fee:** $42.95 **Benefit:** 75% = $32.25 85% = $36.55
66840	Serum folate test and, if required, red cell folate test for a patient at risk of folate deficiency, including patients with malabsorption conditions, macrocytic anaemia or coeliac disease **Fee:** $23.60 **Benefit:** 75% = $17.70 85% = $20.10
66841	Quantitation of HbA1c (glycated haemoglobin) performed for the diagnosis of diabetes in asymptomatic patients at high risk. (Item is subject to rule 25) **Fee:** $16.80 **Benefit:** 75% = $12.60 85% = $14.30
66900	CARBON-LABELLED UREA BREATH TEST using oral C-13 or C-14 urea, including the measurement of exhaled 13CO2 or 14CO2 (except if item 12533 applies) for either:- (a) the confirmation of *Helicobacter pylori* colonisation OR (b) the monitoring of the success of eradication of *Helicobacter pylori.* **Fee:** $77.65 **Benefit:** 75% = $58.25 85% = $66.05
P3. MICROBIOLOGY	
	Group P3. Microbiology
69300	Microscopy of wet film material other than blood, from 1 or more sites, obtained directly from a patient (not cultures) including: (a) differential cell count (if performed); or (b) examination for dermatophytes; or (c) dark ground illumination; or (d) stained preparation or preparations using any relevant stain or stains;

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	1 or more tests **Fee:** $12.50 **Benefit:** 75% = $9.40 85% = $10.65
69303	Culture and (if performed) microscopy to detect pathogenic micro-organisms from nasal swabs, throat swabs, eye swabs and ear swabs (excluding swabs taken for epidemiological surveillance), including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in item 69300; specimens from 1 or more sites **Fee:** $22.00 **Benefit:** 75% = $16.50 85% = $18.70
69306	Microscopy and culture to detect pathogenic micro-organisms from skin or other superficial sites, including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in items 69300, 69303, 69312, 69318; 1 or more tests on 1 or more specimens **Fee:** $33.75 **Benefit:** 75% = $25.35 85% = $28.70
69309	Microscopy and culture to detect dermatophytes and other fungi causing cutaneous disease from skin scrapings, skin biopsies, hair and nails (excluding swab specimens) and including (if performed): (a) the detection of antigens not elsewhere specified in this Table; or (b) a service described in items 69300, 69303, 69306, 69312, 69318; 1 or more tests on 1 or more specimens **Fee:** $48.15 **Benefit:** 75% = $36.15 85% = $40.95
69312	Microscopy and culture to detect pathogenic micro-organisms from urethra, vagina, cervix or rectum (except for faecal pathogens), including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in items 69300, 69303, 69306 and 69318; 1 or more tests on 1 or more specimens **Fee:** $33.75 **Benefit:** 75% = $25.35 85% = $28.70
69316	Detection of Chlamydia trachomatis by any method - 1 test (Item is subject to rule 26) **Fee:** $28.65 **Benefit:** 75% = $21.50 85% = $24.40
69317	1 test described in item 69494 and a test described in 69316. (Item is subject to rule 26) **Fee:** $35.85 **Benefit:** 75% = $26.90 85% = $30.50
69318	Microscopy and culture to detect pathogenic micro-organisms from specimens of sputum (except when part of items 69324, 69327 and 69330), including (if performed):

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	(a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in items 69300, 69303, 69306 and 69312; 1 or more tests on 1 or more specimens **Fee:** $33.75 **Benefit:** 75% = $25.35 85% = $28.70
69319	2 tests described in item 69494 and a test described in 69316. (Item is subject to rule 26) **Fee:** $42.95 **Benefit:** 75% = $32.25 85% = $36.55
69321	Microscopy and culture of post-operative wounds, aspirates of body cavities, synovial fluid, CSF or operative or biopsy specimens, for the presence of pathogenic micro-organisms involving aerobic and anaerobic cultures and the use of different culture media, and including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in item 69300, 69303, 69306, 69312 or 69318; specimens from 1 or more sites **Fee:** $48.15 **Benefit:** 75% = $36.15 85% = $40.95
69324	Microscopy (with appropriate stains) and culture for mycobacteria - 1 specimen of sputum, urine, or other body fluid or 1 operative or biopsy specimen, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b) pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300 **Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55
69325	A test described in item 69324 if rendered by a receiving APP (Item is subject to rule 18) **Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55
69327	Microscopy (with appropriate stains) and culture for mycobacteria - 2 specimens of sputum, urine, or other body fluid or 2 operative or biopsy specimens, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b) pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300 **Fee:** $85.00 **Benefit:** 75% = $63.75 85% = $72.25
69328	A test described in item 69327 if rendered by a receiving APP (Item is subject to rule 18) **Fee:** $85.00 **Benefit:** 75% = $63.75 85% = $72.25
69330	Microscopy (with appropriate stains) and culture for mycobacteria - 3 specimens of sputum, urine, or other body fluid or 3 operative or biopsy specimens, including (if performed):

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	(a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b) pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300 **Fee:** $128.00 **Benefit:** 75% = $96.00 85% = $108.80
69331	A test described in item 69330 if rendered by a receiving APP (Item is subject to rule 18) **Fee:** $128.00 **Benefit:** 75% = $96.00 85% = $108.80
69333	Urine examination (including serial examination) by any means other than simple culture by dip slide, including: (a) cell count; and (b) culture; and (c) colony count; and (d) (if performed) stained preparations; and (e) (if performed) identification of cultured pathogens; and (f) (if performed) antibiotic susceptibility testing; and (g) (if performed) examination for pH, specific gravity, blood, protein, urobilinogen, sugar, acetone or bile salts **Fee:** $20.55 **Benefit:** 75% = $15.45 85% = $17.50
69336	Microscopy of faeces for ova, cysts and parasites that must include a concentration technique, and the use of fixed stains or antigen detection for cryptosporidia and giardia - including (if performed) a service mentioned in item 69300 - 1 of this item in any 7 day period **Fee:** $33.45 **Benefit:** 75% = $25.10 85% = $28.45
69339	Microscopy of faeces for ova, cysts and parasites using concentration techniques examined subsequent to item 69336 on a separately collected and identified specimen collected within 7 days of the examination described in 69336 - 1 examination in any 7 day period **Fee:** $19.10 **Benefit:** 75% = $14.35 85% = $16.25
69345	Culture and (if performed) microscopy without concentration techniques of faeces for faecal pathogens, using at least 2 selective or enrichment media and culture in at least 2 different atmospheres including (if performed): (a) pathogen identification and antibiotic susceptibility testing; and (b) the detection of clostridial toxins; and (c) a service described in item 69300; - 1 examination in any 7 day period **Fee:** $52.90 **Benefit:** 75% = $39.70 85% = $45.00

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69354	Blood culture for pathogenic micro-organisms (other than viruses), including sub-cultures and (if performed): (a) identification of any cultured pathogen; and (b) necessary antibiotic susceptibility testing; to a maximum of 3 sets of cultures - 1 set of cultures **Fee:** $30.75 **Benefit:** 75% = $23.10 85% = $26.15
69357	2 sets of cultures described in item 69354 **Fee:** $61.45 **Benefit:** 75% = $46.10 85% = $52.25
69360	3 sets of cultures described in item 69354 **Fee:** $92.20 **Benefit:** 75% = $69.15 85% = $78.40
69363	Detection of *Clostridium difficile* or *Clostridium difficile* toxin (except if a service described in item 69345 has been performed) - one or more tests **Fee:** $28.65 **Benefit:** 75% = $21.50 85% = $24.40
69378	Quantitation of HIV viral RNA load in plasma or serum in the monitoring of a HIV sero-positive patient not on antiretroviral therapy - 1 or more tests **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25
69379	A test described in item 69378 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25
69380	Genotypic testing for HIV antiretroviral resistance in a patient with confirmed HIV infection if the patient's viral load is greater than 1,000 copies per ml at any of the following times: (a) at presentation; or (b) before antiretroviral therapy: or (c) when treatment with combination antiretroviral agents fails; maximum of 2 tests in a 12 month period **Fee:** $770.30 **Benefit:** 75% = $577.75 85% = $685.60
69381	Quantitation of HIV viral RNA load in plasma or serum in the monitoring of antiretroviral therapy in a HIV sero-positive patient - 1 or more tests on 1 or more specimens **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25
69382	Quantitation of HIV viral RNA load in cerebrospinal fluid in a HIV sero-positive patient - 1 or more tests on 1 or more specimens **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25
69383	A test described in item 69381 if rendered by a receiving APP - 1 or more tests on 1 or more specimens (Item is subject to rule 18) **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25

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69384	Quantitation of 1 antibody to microbial antigens not elsewhere described in the Schedule - 1 test (This fee applies where a laboratory performs the only antibody test specified on the request form or performs 1 test and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) (See para PN.0.18 of explanatory notes to this Category) **Fee:** $15.65 **Benefit:** 75% = $11.75 85% = $13.35
69387	2 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 estimations specified on the request form or performs 2 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) (See para PN.0.18 of explanatory notes to this Category) **Fee:** $29.00 **Benefit:** 75% = $21.75 85% = $24.65
69390	3 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 estimations specified on the request form or performs 3 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) (See para PN.0.18 of explanatory notes to this Category) **Fee:** $42.35 **Benefit:** 75% = $31.80 85% = $36.00
69393	4 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 estimations specified on the request form or performs 4 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) (See para PN.0.18 of explanatory notes to this Category) **Fee:** $55.70 **Benefit:** 75% = $41.80 85% = $47.35
69396	5 or more tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 5 estimations specified on the request form or performs 5 of the antibody tests specified on the

	request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) (See para PN.0.18 of explanatory notes to this Category) **Fee:** $69.10 **Benefit:** 75% = $51.85 85% = $58.75
69400	A test described in item 69384, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rules 6 and 18) **Fee:** $15.65 **Benefit:** 75% = $11.75 85% = $13.35
69401	A test described in item 69384, other than that described in 69400, if rendered by a receiving APP - each test to a maximum of 4 tests (Item is subject to rule 6, 18 and 18A) **Fee:** $13.35 **Benefit:** 75% = $10.05 85% = $11.35
69405	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of 1 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 (See para PN.0.18 of explanatory notes to this Category) **Fee:** $15.65 **Benefit:** 75% = $11.75 85% = $13.35
69408	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of 2 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 (See para PN.0.18 of explanatory notes to this Category) **Fee:** $29.00 **Benefit:** 75% = $21.75 85% = $24.65
69411	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of 3 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 (See para PN.0.18 of explanatory notes to this Category) **Fee:** $42.35 **Benefit:** 75% = $31.80 85% = $36.00
69413	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or

	varicella during that pregnancy) including: (a) the determination of 4 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 (See para PN.0.18 of explanatory notes to this Category) **Fee:** $55.70 **Benefit:** 75% = $41.80 85% = $47.35
69415	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of all 5 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 (See para PN.0.18 of explanatory notes to this Category) **Fee:** $69.10 **Benefit:** 75% = $51.85 85% = $58.75
69445	Detection of Hepatitis C viral RNA in a patient undertaking antiviral therapy for chronic HCV hepatitis (including a service described in item 69499) - 1 test. To a maximum of 4 of this item in a 12 month period (Item is subject to rule 25) **Fee:** $92.20 **Benefit:** 75% = $69.15 85% = $78.40
69451	A test described in item 69445 if rendered by a receiving APP - 1 test. (Item is subject to rule 18 and 25) **Fee:** $92.20 **Benefit:** 75% = $69.15 85% = $78.40
69471	Test of cell-mediated immune response in blood for the detection of latent tuberculosis by interferon gamma release assay (IGRA) in the following people: (a) a person who has been exposed to a confirmed case of active tuberculosis; (b) a person who is infected with human immunodeficiency virus; (c) a person who is to commence, or has commenced, tumour necrosis factor (TNF) inhibitor therapy; (d) a person who is to commence, or has commenced, renal dialysis; (e) a person with silicosis; (f) a person who is, or is about to become, immunosuppressed because of a disease, or a medical treatment, not mentioned in paragraphs (a) to (e) (See para PN.3.4 of explanatory notes to this Category) **Fee:** $34.90 **Benefit:** 75% = $26.20 85% = $29.70
69472	Detection of antibodies to Epstein Barr Virus using specific serology - 1 test **Fee:** $15.65 **Benefit:** 75% = $11.75 85% = $13.35

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69474	Detection of antibodies to Epstein Barr Virus using specific serology - 2 or more tests **Fee:** $28.65 **Benefit:** 75% = $21.50 85% = $24.40
69475	One test for hepatitis antigen or antibodies to determine immune status or viral carriage following exposure or vaccination to Hepatitis A, Hepatitis B, Hepatitis C or Hepatitis D (Item subject to rule 11) **Fee:** $15.65 **Benefit:** 75% = $11.75 85% = $13.35
69478	2 tests described in 69475 (Item subject to rule 11) **Fee:** $29.25 **Benefit:** 75% = $21.95 85% = $24.90
69481	Investigation of infectious causes of acute or chronic hepatitis - 3 tests for hepatitis antibodies or antigens, (Item subject to rule 11) (See para PN.0.19 of explanatory notes to this Category) **Fee:** $40.55 **Benefit:** 75% = $30.45 85% = $34.50
69482	Quantitation of Hepatitis B viral DNA in patients who are Hepatitis B surface antigen positive and have chronic hepatitis B, but are not receiving antiviral therapy - 1 test (Item is subject to rule 25) **Fee:** $152.10 **Benefit:** 75% = $114.10 85% = $129.30
69483	Quantitation of Hepatitis B viral DNA in patients who are Hepatitis B surface antigen positive and who have chronic hepatitis B and are receiving antiviral therapy - 1 test (Item is subject to rule 25) **Fee:** $152.10 **Benefit:** 75% = $114.10 85% = $129.30
69484	Supplementary testing for Hepatitis B surface antigen or Hepatitis C antibody using a different assay on the specimen which yielded a reactive result on initial testing (Item is subject to rule 18) **Fee:** $17.10 **Benefit:** 75% = $12.85 85% = $14.55
69488	Quantitation of HCV RNA load in plasma or serum in: (a) the pre-treatment evaluation, of a patient with chronic HCV hepatitis, for antiviral therapy; or (b) the assessment of efficacy of antiviral therapy for such a patient (including a service in item 69499 or 69445) (Item is subject to rule 18 and 25) **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25
69489	A test described in item 69488 if rendered by a receiving APP

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	(Item is subject to rule 18 and 25) **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25
69491	Nucleic acid amplification and determination of Hepatitis C virus (HCV) genotype if the patient is HCV RNA positive and is being evaluated for antiviral therapy of chronic HCV hepatitis. To a maximum of 1 of this item in a 12 month period **Fee:** $204.80 **Benefit:** 75% = $153.60 85% = $174.10
69492	A test described in item 69491 if rendered by a receiving APP - 1 test (Item is subject to rule 18 and 25) **Fee:** $204.80 **Benefit:** 75% = $153.60 85% = $174.10
69494	Detection of a virus or microbial antigen or microbial nucleic acid (not elsewhere specified) 1 test (Item is subject to rule 6 and 26) **Fee:** $28.65 **Benefit:** 75% = $21.50 85% = $24.40
69495	2 tests described in 69494 (Item is subject to rule 6 and 26) **Fee:** $35.85 **Benefit:** 75% = $26.90 85% = $30.50
69496	3 or more tests described in 69494 (Item is subject to rule 6 and 26) **Fee:** $43.05 **Benefit:** 75% = $32.30 85% = $36.60
69497	A test described in item 69494, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6, 18 and 26) **Fee:** $28.65 **Benefit:** 75% = $21.50 85% = $24.40
69498	A test described in item 69494, other than that described in 69497, if rendered by a receiving APP - each test to a maximum of 2 tests (Item is subject to rule 6, 18 and 26) **Fee:** $7.20 **Benefit:** 75% = $5.40 85% = $6.15
69499	Detection of Hepatitis C viral RNA if at least 1 of the following criteria is satisfied: (a) the patient is Hepatitis C seropositive; (b) the patient's serological status is uncertain after testing; (c) the test is performed for the purpose of: (i) determining the Hepatitis C status of an immunosuppressed or immunocompromised patient; or (ii) the detection of acute Hepatitis C prior to seroconversion where considered necessary for the

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	clinical management of the patient; To a maximum of 1 of this item in a 12 month period (Item is subject to rule 19 and 25) **Fee:** $92.20 **Benefit:** 75% = $69.15 85% = $78.40
69500	A test described in item 69499 if rendered by a receiving APP - 1 test (Item is subject to rule 18,19 and 25) **Fee:** $92.20 **Benefit:** 75% = $69.15 85% = $78.40

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71057	Electrophoresis, quantitative and qualitative, of serum, urine or other body fluid all collected within a 28 day period, to demonstrate: (a) protein classes; or (b) presence and amount of paraprotein; including the preliminary quantitation of total protein, albumin and globulin - 1 specimen type **Fee:** $32.90 **Benefit:** 75% = $24.70 85% = $28.00
71058	Examination as described in item 71057 of 2 or more specimen types **Fee:** $50.50 **Benefit:** 75% = $37.90 85% = $42.95
71059	Immunofixation or immunoelectrophoresis or isoelectric focusing of: (a) urine for detection of Bence Jones proteins; or (b) serum, plasma or other body fluid; and characterisation of a paraprotein or cryoglobulin - examination of 1 specimen type (eg. serum, urine or CSF) **Fee:** $35.65 **Benefit:** 75% = $26.75 85% = $30.35
71060	Examination as described in item 71059 of 2 or more specimen types **Fee:** $44.05 **Benefit:** 75% = $33.05 85% = $37.45
71062	Electrophoresis and immunofixation or immunoelectrophoresis or isoelectric focussing of CSF for the detection of oligoclonal bands and including if required electrophoresis of the patient's serum for comparison purposes - 1 or more tests **Fee:** $44.05 **Benefit:** 75% = $33.05 85% = $37.45
71064	Detection and quantitation of cryoglobulins or cryofibrinogen - 1 or more tests **Fee:** $20.75 **Benefit:** 75% = $15.60 85% = $17.65

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71066	Quantitation of total immunoglobulin A by any method in serum, urine or other body fluid - 1 test **Fee:** $14.55 **Benefit:** 75% = $10.95 85% = $12.40
71068	Quantitation of total immunoglobulin G by any method in serum, urine or other body fluid - 1 test **Fee:** $14.55 **Benefit:** 75% = $10.95 85% = $12.40
71069	2 tests described in items 71066, 71068, 71072 or 71074 **Fee:** $22.75 **Benefit:** 75% = $17.10 85% = $19.35
71071	3 or more tests described in items 71066, 71068, 71072 or 71074 **Fee:** $30.95 **Benefit:** 75% = $23.25 85% = $26.35
71072	Quantitation of total immunoglobulin M by any method in serum, urine or other body fluid - 1 test **Fee:** $14.55 **Benefit:** 75% = $10.95 85% = $12.40
71073	Quantitation of all 4 immunoglobulin G subclasses **Fee:** $106.15 **Benefit:** 75% = $79.65 85% = $90.25
71074	Quantitation of total immunoglobulin D by any method in serum, urine or other body fluid - 1 test **Fee:** $14.55 **Benefit:** 75% = $10.95 85% = $12.40
71075	Quantitation of immunoglobulin E (total), 1 test. (Item is subject to rule 25) **Fee:** $23.00 **Benefit:** 75% = $17.25 85% = $19.55
71076	A test described in item 71073 if rendered by a receiving APP - 1 test (Item is subject to rule 18) **Fee:** $106.15 **Benefit:** 75% = $79.65 85% = $90.25
71077	Quantitation of immunoglobulin E (total) in the follow up of a patient with proven immunoglobulin-E-secreting myeloma, proven congenital immunodeficiency or proven allergic bronchopulmonary aspergillosis, 1 test. (Item is subject to rule 25) **Fee:** $27.05 **Benefit:** 75% = $20.30 85% = $23.00
71079	Detection of specific immunoglobulin E antibodies to single or multiple potential allergens, 1 test (Item is subject to rule 25) **Fee:** $26.80 **Benefit:** 75% = $20.10 85% = $22.80
71081	Quantitation of total haemolytic complement **Fee:** $40.55 **Benefit:** 75% = $30.45 85% = $34.50
71083	Quantitation of complement components C3 and C4 or properdin factor B - 1 test **Fee:** $20.15 **Benefit:** 75% = $15.15 85% = $17.15
71085	2 tests described in item 71083

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	Fee: $28.95 **Benefit:** 75% = $21.75 85% = $24.65
71087	3 or more tests described in item 71083 **Fee:** $37.70 **Benefit:** 75% = $28.30 85% = $32.05
71089	Quantitation of complement components or breakdown products of complement proteins not elsewhere described in an item in this Schedule - 1 test (Item is subject to rule 6) **Fee:** $29.15 **Benefit:** 75% = $21.90 85% = $24.80
71090	A test described in item 71089, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18) **Fee:** $29.15 **Benefit:** 75% = $21.90 85% = $24.80
71091	2 tests described in item 71089 (Item is subject to rule 6) **Fee:** $52.85 **Benefit:** 75% = $39.65 85% = $44.95
71092	Tests described in item 71089, other than that described in 71090, if rendered by a receiving APP - each test to a maximum of 2 tests (Item is subject to rule 6 and 18) **Fee:** $23.70 **Benefit:** 75% = $17.80 85% = $20.15
71093	3 or more tests described in item 71089 (Item is subject to rule 6) **Fee:** $76.45 **Benefit:** 75% = $57.35 85% = $65.00
71095	Quantitation of serum or plasma eosinophil cationic protein, or both, to a maximum of 3 assays in 1 year, for monitoring the response to therapy in corticosteroid treated asthma, in a child aged less than 12 years (See para PN.0.20 of explanatory notes to this Category) **Fee:** $40.55 **Benefit:** 75% = $30.45 85% = $34.50
71096	A test described in item 71095 if rendered by a receiving APP. (Item is subject to rule 18) **Fee:** $40.55 **Benefit:** 75% = $30.45 85% = $34.50
71097	Antinuclear antibodies - detection in serum or other body fluids, including quantitation if required **Fee:** $24.45 **Benefit:** 75% = $18.35 85% = $20.80
71099	Double-stranded DNA antibodies - quantitation by 1 or more methods other than the Crithidia method **Fee:** $26.50 **Benefit:** 75% = $19.90 85% = $22.55
71101	Antibodies to 1 or more extractable nuclear antigens - detection in serum or other body fluids **Fee:** $17.40 **Benefit:** 75% = $13.05 85% = $14.80

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71103	Characterisation of an antibody detected in a service described in item 71101 (including that service) **Fee:** $52.05 **Benefit:** 75% = $39.05 85% = $44.25
71106	Rheumatoid factor - detection by any technique in serum or other body fluids, including quantitation if required **Fee:** $11.30 **Benefit:** 75% = $8.50 85% = $9.65
71119	Antibodies to tissue antigens not elsewhere specified in this Table - detection, including quantitation if required, of 1 antibody (See para PN.0.33 of explanatory notes to this Category) **Fee:** $17.35 **Benefit:** 75% = $13.05 85% = $14.75
71121	Detection of 2 antibodies specified in item 71119 (See para PN.0.33 of explanatory notes to this Category) **Fee:** $20.80 **Benefit:** 75% = $15.60 85% = $17.70
71123	Detection of 3 antibodies specified in item 71119 (See para PN.0.33 of explanatory notes to this Category) **Fee:** $24.25 **Benefit:** 75% = $18.20 85% = $20.65
71125	Detection of 4 or more antibodies specified in item 71119 (See para PN.0.33 of explanatory notes to this Category) **Fee:** $27.65 **Benefit:** 75% = $20.75 85% = $23.55
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), 1 of this item to a maximum of 2 in a 12 month period **Fee:** $176.35 **Benefit:** 75% = $132.30 85% = $149.90
71129	2 tests described in item 71127 **Fee:** $217.85 **Benefit:** 75% = $163.40 85% = $185.20
71131	3 or more tests described in item 71127 **Fee:** $259.35 **Benefit:** 75% = $194.55 85% = $220.45
71133	Investigation of recurrent infection by qualitative assessment for the presence of defects in oxidative pathways in neutrophils by the nitroblue tetrazolium (NBT) reduction test **Fee:** $10.40 **Benefit:** 75% = $7.80 85% = $8.85
71134	Investigation of recurrent infection by quantitative assessment of oxidative pathways by flow cytometric techniques, including a test described in 71133 (if performed) **Fee:** $104.05 **Benefit:** 75% = $78.05 85% = $88.45
71135	Quantitation of neutrophil function, comprising at least 2 of the following:

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	(a) chemotaxis; (b) phagocytosis; (c) oxidative metabolism; (d) bactericidal activity; including any test described in items 65066, 65070, 71133 or 71134 (if performed), 1 of this item to a maximum of 2 in a 12 month period **Fee:** $207.95 **Benefit:** 75% = $156.00 85% = $176.80
71137	Quantitation of cell-mediated immunity by multiple antigen delayed type hypersensitivity intradermal skin testing using a minimum of 7 antigens, 1 of this item to a maximum of 2 in a 12 month period **Fee:** $30.25 **Benefit:** 75% = $22.70 85% = $25.75
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 or total leucocyte count by any method, on 1 or more specimens of blood, CSF or serous fluid **Fee:** $104.05 **Benefit:** 75% = $78.05 85% = $88.45
71141	Characterisation of 3 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations on 1 or more disaggregated tissue specimens **Fee:** $197.35 **Benefit:** 75% = $148.05 85% = $167.75
71143	Characterisation of 6 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations for the diagnosis (but not monitoring) of an immunological or haematological malignancy, including a service described in 1 or both of items 71139 and 71141 (if performed), on a specimen of blood, CSF, serous fluid or disaggregated tissue **Fee:** $260.00 **Benefit:** 75% = $195.00 85% = $221.00
71145	Characterisation of 6 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations for the diagnosis (but not monitoring) of an immunological or haematological malignancy, including a service described in 1 or more of items 71139, 71141 and 71143 (if performed), on 2 or more specimens of disaggregated tissues or 1 specimen of disaggregated tissue and 1 or more specimens of blood, CSF or serous fluid **Fee:** $424.50 **Benefit:** 75% = $318.40 85% = $360.85
71146	Enumeration of CD34+ cells, only for the purposes of autologous or directed allogeneic haemopoietic stem cell transplantation, including a total white cell count on the pherisis collection **Fee:** $104.05 **Benefit:** 75% = $78.05 85% = $88.45
71147	HLA-B27 typing (Item is subject to rule 27) **Fee:** $40.55 **Benefit:** 75% = $30.45 85% = $34.50
71148	A test described in item 71147 if rendered by a receiving APP. (Item is subject to rule 18 and 27) **Fee:** $40.55 **Benefit:** 75% = $30.45 85% = $34.50

P4. IMMUNOLOGY	
71149	Complete tissue typing for 4 HLA-A and HLA-B Class I antigens (including any separation of leucocytes), including (if performed) a service described in item 71147 **Fee:** $108.25 **Benefit:** 75% = $81.20 85% = $92.05
71151	Tissue typing for HLA-DR, HLA-DP and HLA-DQ Class II antigens (including any separation of leucocytes) - phenotyping or genotyping of 2 or more antigens **Fee:** $118.85 **Benefit:** 75% = $89.15 85% = $101.05
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 6 and 23) **Fee:** $34.55 **Benefit:** 75% = $25.95 85% = $29.40
71154	A test described in item 71153, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test. (Item is subject to rule 6, 18 and 23) **Fee:** $34.55 **Benefit:** 75% = $25.95 85% = $29.40
71155	Detection of 2 antibodies described in item 71153 (Item is subject to rule 6 and 23) **Fee:** $47.45 **Benefit:** 75% = $35.60 85% = $40.35
71156	Tests described in item 71153, other than that described in 71154, if rendered by a receiving APP - each test to a maximum of 3 tests (Item is subject to rule 6, 18 and 23) **Fee:** $12.85 **Benefit:** 75% = $9.65 85% = $10.95
71157	Detection of 3 antibodies described in item 71153 (Item is subject to rule 6 and 23) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
71159	Detection of 4 or more antibodies described in item 71153 (Item is subject to rule 6 and 23) **Fee:** $73.15 **Benefit:** 75% = $54.90 85% = $62.20
71163	Detection of one of the following antibodies (of 1 or more class or isotype) in the assessment or diagnosis of coeliac disease or other gluten hypersensitivity syndromes and including a service described in item 71066 (if performed): a) Antibodies to gliadin; or b) Antibodies to endomysium; or c) Antibodies to tissue transglutaminase;

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	- 1 test **Fee:** $24.75 **Benefit:** 75% = $18.60 85% = $21.05
71164	Two or more tests described in 71163 and including a service described in 71066 (if performed) **Fee:** $39.90 **Benefit:** 75% = $29.95 85% = $33.95
71165	Antibodies to tissue antigens (acetylcholine receptor, adrenal cortex, heart, histone, insulin, insulin receptor, intrinsic factor, islet cell, lymphocyte, neuron, ovary, parathyroid, platelet, salivary gland, skeletal muscle, skin basement membrane and intercellular substance, thyroglobulin, thyroid microsome or thyroid stimulating hormone receptor) - detection, including quantitation if required, of 1 antibody (Item is subject to rule 6) **Fee:** $34.55 **Benefit:** 75% = $25.95 85% = $29.40
71166	Detection of 2 antibodies described in item 71165 (Item is subject to rule 6) **Fee:** $47.45 **Benefit:** 75% = $35.60 85% = $40.35
71167	Detection of 3 antibodies described in item 71165 (Item is subject to rule 6) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30
71168	Detection of 4 or more antibodies described in item 71165 (Item is subject to rule 6) **Fee:** $73.15 **Benefit:** 75% = $54.90 85% = $62.20
71169	A test described in item 71165, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18) **Fee:** $34.55 **Benefit:** 75% = $25.95 85% = $29.40
71170	Tests described in item 71165, other than that described in 71169, if rendered by a receiving APP - each test to a maximum of 3 tests (Item is subject to rule 6 and 18) **Fee:** $12.85 **Benefit:** 75% = $9.65 85% = $10.95
71180	Antibody to cardiolipin or beta-2 glycoprotein I - detection, including quantitation if required; one antibody specificity (IgG or IgM) **Fee:** $34.55 **Benefit:** 75% = $25.95 85% = $29.40
71183	Detection of two antibodies described in item 71180 **Fee:** $47.45 **Benefit:** 75% = $35.60 85% = $40.35
71186	Detection of three or more antibodies described in item 71180 **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30

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71189	Detection of specific IgG antibodies to 1 or more respiratory disease allergens not elsewhere specified. **Fee:** $15.50 **Benefit:** 75% = $11.65 85% = $13.20
71192	2 items described in item 71189. **Fee:** $28.35 **Benefit:** 75% = $21.30 85% = $24.10
71195	3 or more items described in item 71189. **Fee:** $40.05 **Benefit:** 75% = $30.05 85% = $34.05
71198	Estimation of serum tryptase for the evaluation of unexplained acute hypotension or suspected anaphylactic event, assessment of risk in stinging insect anaphylaxis, exclusion of mastocytosis, monitoring of known mastocytosis. **Fee:** $40.55 **Benefit:** 75% = $30.45 85% = $34.50
71200	Detection and quantitation, if present, of free kappa and lambda light chains in serum for the diagnosis or monitoring of amyloidosis, myeloma or plasma cell dyscrasias. **Fee:** $59.60 **Benefit:** 75% = $44.70 85% = $50.70
71203	Determination of HLAB5701 status by flow cytometry or cytotoxity assay prior to the initiation of Abacavir therapy including item 73323 if performed. **Fee:** $40.55 **Benefit:** 75% = $30.45 85% = $34.50
P5. TISSUE PATHOLOGY	
	Group P5. Tissue Pathology
72813	Examination of complexity level 2 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 13) **Fee:** $71.50 **Benefit:** 75% = $53.65 85% = $60.80
72814	Immunohistochemical examination by immunoperoxidase or other labelled antibody techniques using the programmed cell death ligand 1 (PD-L1) antibody of tumour material from a patient diagnosed with non-small cell lung cancer, to determine if the requirements relating to PD-L1 status for access to pembrolizumab under the Pharmaceutical Benefits Scheme are fulfilled. **Fee:** $74.50 **Benefit:** 75% = $55.90 85% = $63.35
72816	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 separately identified specimen (Item is subject to rule 13) **Fee:** $86.35 **Benefit:** 75% = $64.80 85% = $73.40
72817	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 2 to 4

	separately identified specimens (Item is subject to rule 13) **Fee:** $96.80 **Benefit:** 75% = $72.60 85% = $82.30
72818	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 5 or more separately identified specimens (Item is subject to rule 13) **Fee:** $107.05 **Benefit:** 75% = $80.30 85% = $91.00
72823	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 separately identified specimen (Item is subject to rule 13) **Fee:** $97.15 **Benefit:** 75% = $72.90 85% = $82.60
72824	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 2 to 4 separately identified specimens (Item is subject to rule 13) **Fee:** $141.35 **Benefit:** 75% = $106.05 85% = $120.15
72825	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 5 to 7 separately identified specimens (Item is subject to rule 13) **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25
72826	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 8 to 11 separately identified specimens (Item is subject to rule 13) **Fee:** $194.60 **Benefit:** 75% = $145.95 85% = $165.45
72827	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen

P5. TISSUE PATHOLOGY	
	dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 12 to 17 separately identified specimens (Item is subject to Rule 13) **Fee:** $208.95 **Benefit:** 75% = $156.75 85% = $177.65
72828	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 18 or more separately identified specimens (Item is subject to Rule 13) **Fee:** $223.30 **Benefit:** 75% = $167.50 85% = $189.85
72830	Examination of complexity level 5 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 13) **Fee:** $274.15 **Benefit:** 75% = $205.65 85% = $233.05
72836	Examination of complexity level 6 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 13) **Fee:** $417.20 **Benefit:** 75% = $312.90 85% = $354.65
72838	Examination of complexicity level 7 biopsy material with multiple tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens. (Item is subject to rule 13) **Fee:** $466.85 **Benefit:** 75% = $350.15 85% = $396.85
72844	Enzyme histochemistry of skeletal muscle for investigation of primary degenerative or metabolic muscle diseases or of muscle abnormalities secondary to disease of the central or peripheral nervous system - 1 or more tests **Fee:** $30.75 **Benefit:** 75% = $23.10 85% = $26.15
72846	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 antibodies except those listed in 72848 (Item is subject to rule 13) **Fee:** $59.60 **Benefit:** 75% = $44.70 85% = $50.70
72847	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 4-6 antibodies

P5. TISSUE PATHOLOGY	
	(Item is subject to rule 13) **Fee:** $89.40 **Benefit:** 75% = $67.05 85% = $76.00
72848	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 of the following antibodies - oestrogen, progesterone and c-erb-B2 (HER2) (Item is subject to rule 13) **Fee:** $74.50 **Benefit:** 75% = $55.90 85% = $63.35
72849	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 7-10 antibodies (Item is subject to rule 13) **Fee:** $104.30 **Benefit:** 75% = $78.25 85% = $88.70
72850	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 11 or more antibodies (Item is subject to rule 13) **Fee:** $119.20 **Benefit:** 75% = $89.40 85% = $101.35
72851	Electron microscopic examination of biopsy material - 1 separately identified specimen (Item is subject to rule 13) **Fee:** $565.00 **Benefit:** 75% = $423.75 85% = $480.30
72852	Electron microscopic examination of biopsy material - 2 or more separately identified specimens (Item is subject to rule 13) **Fee:** $753.00 **Benefit:** 75% = $564.75 85% = $668.30
72855	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) **Fee:** $184.35 **Benefit:** 75% = $138.30 85% = $156.70
72856	Intraoperative consultation and examination of biopsy material by frozen section or tissue imprint or smear - 2 to 4 separately identified specimens (Item is subject to rule 13) **Fee:** $245.80 **Benefit:** 75% = $184.35 85% = $208.95

P5. TISSUE PATHOLOGY	
72857	Intraoperative consultation and examination of biopsy material by frozen section or tissue imprint or smear - 5 or more separately identified specimens (Item is subject to rule 13) **Fee:** $286.75 **Benefit:** 75% = $215.10 85% = $243.75
72858	A second opinion, provided in a written report, where the opinion and report together require no more than 30 minutes to complete, on a patient specimen, requested by a treating practitioner, where further information is needed for accurate diagnosis and appropriate patient management. (See para PN.0.33 of explanatory notes to this Category) **Fee:** $180.00 **Benefit:** 75% = $135.00 85% = $153.00
72859	A second opinion, provided in a written report, where the opinion and report together require more than 30 minutes to complete, on a patient specimen, requested by a treating practitioner, where further information is needed for accurate diagnosis and appropriate patient management. (See para PN.0.33 of explanatory notes to this Category) **Fee:** $370.00 **Benefit:** 75% = $277.50 85% = $314.50
72860	Retrieval and review of archived formalin fixed paraffin embedded block(s) to determine the appropriate sample(s) for the purpose of conducting further genetic testing. For any particular patient, this item is applicable for a maximum of one retrieval per subsequent patient episode. (See para PR.5.1 of explanatory notes to this Category) **Fee:** $85.00 **Benefit:** 75% = $63.75 85% = $72.25

P6. CYTOLOGY	
	Group P6. Cytology
73043	Cytology (including serial examinations) of nipple discharge or smears from skin, lip, mouth, nose or anus for detection of precancerous or cancerous changes 1 or more tests **Fee:** $22.85 **Benefit:** 75% = $17.15 85% = $19.45
73045	Cytology (including serial examinations) for malignancy (other than an examination mentioned in item 73076); and including any Group P5 service, if performed on: (a) specimens resulting from washings or brushings from sites not specified in item 73043; or (b) a single specimen of sputum or urine; or (c) 1 or more specimens of other body fluids; 1 or more tests **Fee:** $48.60 **Benefit:** 75% = $36.45 85% = $41.35
73047	Cytology of a series of 3 sputum or urine specimens for malignant cells **Fee:** $94.70 **Benefit:** 75% = $71.05 85% = $80.50
73049	Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues -

P6. CYTOLOGY	
	1 identified site **Fee:** $68.15 **Benefit:** 75% = $51.15 85% = $57.95
73051	Cytology of material obtained directly from a patient at one identified site by fine needle aspiration of solid tissue or tissues if a recognized pathologist: (a) performs the aspiration; or (b) attends the aspiration and performs cytological examination during the attendance **Fee:** $170.35 **Benefit:** 75% = $127.80 85% = $144.80
73059	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 antibodies except those listed in 73061 (Item is subject to rule 13) **Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55
73060	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 4 to 6 antibodies (Item is subject to rule 13) **Fee:** $57.35 **Benefit:** 75% = $43.05 85% = $48.75
73061	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 of the following antibodies - oestrogen, progesterone and c-erb-B2 (HER2) (Item is subject to rule 13) **Fee:** $51.20 **Benefit:** 75% = $38.40 85% = $43.55
73062	Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues - 2 or more separately identified sites. **Fee:** $89.00 **Benefit:** 75% = $66.75 85% = $75.65
73063	Cytology of material obtained directly from a patient at one identified site by fine needle aspiration of solid tissue or tissues if an employee of an approved pathology authority attends the aspiration for confirmation of sample adequacy **Fee:** $99.35 **Benefit:** 75% = $74.55 85% = $84.45
73064	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 7 to 10 antibodies

P6. CYTOLOGY	
	(Item is subject to rule 13) **Fee:** $71.70 **Benefit:** 75% = $53.80 85% = $60.95
73065	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 11 or more antibodies (Item is subject to rule 13) **Fee:** $86.00 **Benefit:** 75% = $64.50 85% = $73.10
73066	Cytology of material obtained directly from a patient at 2 or more separately identified sites by fine needle aspiration of solid tissue or tissues if a recognized pathologist: (a) performs the aspiration; or (b) attends the aspiration and performs cytological examination during the attendance **Fee:** $221.45 **Benefit:** 75% = $166.10 85% = $188.25
73067	Cytology of material obtained directly from a patient at 2 or more separately identified sites by fine needle aspiration of solid tissue or tissues if an employee of an approved pathology authority attends the aspiration for confirmation of sample adequacy **Fee:** $129.15 **Benefit:** 75% = $96.90 85% = $109.80
73070	73070 A test, including partial genotyping, for oncogenic human papillomavirus that may be associated with cervical pre-cancer or cancer: (a) performed on a liquid based cervical specimen; and (b) for an asymptomatic patient who is at least 24 years and 9 months of age For any particular patient, once only in a 57 month period (See para PN.0.22 of explanatory notes to this Category) **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75
73071	73071 A test, including partial genotyping, for oncogenic human papillomavirus that may be associated with cervical pre-cancer or cancer: (a) performed on a self-collected vaginal specimen; and (b) for an asymptomatic patient who is at least 30 years of age For any particular patient, once only in a 7 year period (See para PN.0.22 of explanatory notes to this Category)

P6. CYTOLOGY	
	Fee: $35.00 **Benefit:** 75% = $26.25 85% = $29.75
73072	A test, including partial genotyping, for oncogenic human papillomavirus, performed on a liquid based cervical specimen: (a) for the investigation of a patient in a specific population that appears to have a higher risk of cervical pre-cancer or cancer; or (b) for the follow-up management of a patient with a previously detected oncogenic human papillomavirus infection or cervical pre-cancer or cancer; or (c) for the investigation of a patient with symptoms suggestive of cervical cancer; or (d) for the follow-up management of a patient after treatment of high grade squamous intraepithelial lesions or adenocarcinoma in situ of the cervix; or (e) for the follow-up management of a patient with glandular abnormalities; or (f) for the follow-up management of a patient exposed to diethylstilboestrol in utero (See para PN.0.22 of explanatory notes to this Category) **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75
73073	A test, including partial genotyping, for oncogenic human papillomavirus: (a) performed on a self-collected vaginal specimen; and (b) for the follow-up management of a patient with oncogenic human papillomavirus infection or cervical pre-cancer or cancer that was detected by a test to which item 73071 applies For any particular patient, once only in a 21 month period (See para PN.0.22 of explanatory notes to this Category) **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75
73074	A test, including partial genotyping, for oncogenic human papillomavirus: (a) performed on a liquid based vaginal vault specimen; and (b) for the investigation of a patient following a total hysterectomy (See para PN.0.22 of explanatory notes to this Category) **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75
73075	A test, including partial genotyping, for oncogenic human papillomavirus, if: (a) the test is a repeat of a test to which item 73070, 73071, 73072, 73073, 73074 or this item applies; and (b) the specimen collected for the previous test is unsatisfactory (See para PN.0.22 of explanatory notes to this Category) **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75
73076	Cytology of a liquid-based cervical or vaginal vault specimen, where the stained cells are examined microscopically or by automated image analysis by or on behalf of a pathologist, if: (a) the cytology is associated with the detection of oncogenic human papillomavirus infection by:

P6. CYTOLOGY	
	(i) a test to which item 73070, 73071, 73073, 73074 or 73075 applies; or (ii) a test to which item 73072 applies for a patient mentioned in paragraph (a) or (b) of that item; or (b) the cytology is associated with a test to which item 73072 applies for a patient mentioned in paragraph (c), (d), (e) or (f) of that item; or (c) the cytology is associated with a test to which item 73074 applies; or (d) the test is a repeat of a test to which this item applies, if the specimen collected for the previous test is unsatisfactory; or (e) the cytology is for the follow-up management of a patient treated for endometrial adenocarcinoma (See para PN.0.22 of explanatory notes to this Category) **Fee:** $46.00 **Benefit:** 75% = $34.50 85% = $39.10
P7. GENETICS	
	Group P7. Genetics
73287	The study of the whole of every chromosome by cytogenetic or other techniques, performed on 1 or more of any tissue or fluid except blood (including a service mentioned in item 73293, if performed) - 1 or more tests **Fee:** $394.55 **Benefit:** 75% = $295.95 85% = $335.40
73289	The study of the whole of every chromosome by cytogenetic or other techniques, performed on blood (including a service mentioned in item 73293, if performed) - 1 or more tests **Fee:** $358.95 **Benefit:** 75% = $269.25 85% = $305.15
73290	The study of the whole of each chromosome by cytogenetic or other techniques, performed on blood or bone marrow, in the diagnosis and monitoringof haematological malignancy (including a service in items 73287 or 73289, if performed). - 1 or more tests. **Fee:** $394.55 **Benefit:** 75% = $295.95 85% = $335.40
73291	Analysis of one or more chromosome regions for specific constitutional genetic abnormalities of blood or fresh tissue in a) diagnostic studies of a person with developmental delay, intellectual disability, autism, or at least two congenital abnormalities, in whom cytogenetic studies (item 73287 or 73289) are either normal or have not been performed; or b) studies of a relative for an abnormality previously identified in such an affected person. - 1 or more tests. **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35
73292	Analysis of chromosomes by genome-wide micro-array including targeted assessment of specific regions for constitutional genetic abnormalities in diagnostic studies of a person with developmental delay, intellectual disability, autism, or at least two congenital abnormalities (including a service in items 73287, 73289 or 73291, if performed) - 1 or more tests. **Fee:** $589.90 **Benefit:** 75% = $442.45 85% = $505.20

P7. GENETICS	
73293	Analysis of one or more regions on all chromosomes for specific constitutional genetic abnormalities of fresh tissue in diagnostic studies of the products of conception, including exclusion of maternal cell contamination. - 1 or more tests. **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35
73294	Analysis of the PMP22 gene for constitutional genetic abnormalities causing peripheral neuropathy, either as: a) diagnostic studies of an affected person; or b) studies of a relative for an abnormality previously identified in an affected person - 1 or more tests. **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35
73295	Detection of germline *BRCA1* or *BRCA2* gene mutations, in a patient with platinum-sensitive relapsed ovarian, fallopian tube or primary peritoneal cancer with high grade serous features or a high grade serous component, and who has responded to subsequent platinum-based chemotherapy, requested by a specialist or consultant physician, to determine whether the eligibility criteria for olaparib under the Pharmaceutical Benefits Scheme (PBS) are fulfilled. Maximum one test per lifetime (See para PN.0.27 of explanatory notes to this Category) **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1115.30
73296	Characterisation of germline gene mutations, requested by a specialist or consultant physician, including copy number variation in BRCA1 and BRCA2 genes and one or more of the following genes STK11, PTEN, CDH1, PALB2, or TP53 in a patient with breast or ovarian cancer for whom clinical and family history criteria, as assessed by the specialist or consultant physician who requests the service using a quantitative algorithm, place the patient at >10% risk of having a pathogenic mutation identified in one or more of the genes specified above. (See para PN.0.27 of explanatory notes to this Category) **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1115.30
73297	Characterisation of germline gene mutations, requested by a specialist or consultant physician, including copy number variation in BRCA1 and BRCA2 genes and one or more of the following genes STK11, PTEN, CDH1, PALB2, or TP53 in a patient who is a biological relative of a patient who has had a pathogenic mutation identified in one or more of the genes specified above, and has not previously received a service under item 73296. (See para PN.0.23 of explanatory notes to this Category) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00
73298	Characterisation of germline gene variants in the following genes: (a) COL4A3; and (b) COL4A4; and (c) COL4A5; in a patient for whom clinical and relevant family history criteria have been assessed by a specialist or

	consultant physician, who requests the service to be strongly suggestive of Alport syndrome. **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1115.30
73299	Characterisation of germline gene variants: (a) in the following genes: (i) COL4A3; and (ii) COL4A4; and (iii) COL4A5; (b) in a patient who: (i) is a first degree biological relative of a patient who has had a pathogenic mutation identified in one or more of the genes mentioned in subparagraphs (a)(i), (ii) and (iii); and (ii) has not previously received a service which item 73298 applies; requested by a specialist or consultant physician. **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00
73300	Detection of mutation of the FMR1 gene where: (a) the patient exhibits intellectual disability, ataxia, neurodegeneration, or premature ovarian failure consistent with an FMRI mutation; or (b) the patient has a relative with a FMR1 mutation 1 or more tests (See para PN.0.23 of explanatory notes to this Category) **Fee:** $101.30 **Benefit:** 75% = $76.00 85% = $86.15
73305	Detection of mutation of the FMR1 gene by Southern Blot analysis where the results in item 73300 are inconclusive (See para PN.0.23 of explanatory notes to this Category) **Fee:** $202.65 **Benefit:** 75% = $152.00 85% = $172.30
73308	Characterisation of the genotype of a patient for Factor V Leiden gene mutation, or detection of the other relevant mutations in the investigation of proven venous thrombosis or pulmonary embolism - 1 or more tests **Fee:** $36.45 **Benefit:** 75% = $27.35 85% = $31.00
73309	A test described in item 73308, if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $36.45 **Benefit:** 75% = $27.35 85% = $31.00
73311	Characterisation of the genotype of a person who is a first degree relative of a person who has proven to have 1 or more abnormal genotypes under item 73308 - 1 or more tests **Fee:** $36.45 **Benefit:** 75% = $27.35 85% = $31.00
73312	A test described in item 73311, if rendered by a receiving APP - 1 or more tests

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	(Item is subject to rule 18) **Fee:** $36.45 **Benefit:** 75% = $27.35 85% = $31.00
73314	Characterisation of gene rearrangement or the identification of mutations within a known gene rearrangement, in the diagnosis and monitoring of patients with laboratory evidence of: (a) acute myeloid leukaemia; or (b) acute promyelocytic leukaemia; or (c) acute lymphoid leukaemia; or (d) chronic myeloid leukaemia; **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35
73315	A test described in item 73314, if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35
73317	Detection of the C282Y genetic mutation of the HFE gene and, if performed, detection of other mutations for haemochromatosis where: (a) the patient has an elevated transferrin saturation or elevated serum ferritin on testing of repeated specimens; or (b) the patient has a first degree relative with haemochromatosis; or (c) the patient has a first degree relative with homozygosity for the C282Y genetic mutation, or with compound heterozygosity for recognised genetic mutations for haemochromatosis (Item is subject to rule 20) **Fee:** $36.45 **Benefit:** 75% = $27.35 85% = $31.00
73318	A test described in item 73317, if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18 and 20) **Fee:** $36.45 **Benefit:** 75% = $27.35 85% = $31.00
73320	Detection of HLA-B27 by nucleic acid amplification includes a service described in 71147 unless the service in item 73320 is rendered as a pathologist determinable service. (Item is subject to rule 27) **Fee:** $40.55 **Benefit:** 75% = $30.45 85% = $34.50
73321	A test described in item 73320, if rendered by a receiving APP - 1 or more tests. (Item is subject to rule 18 and 27) **Fee:** $40.55 **Benefit:** 75% = $30.45 85% = $34.50

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73323	Determination of HLAB5701 status by molecular techniques prior to the initiation of Abacavir therapy including item 71203 if performed. **Fee:** $40.55 **Benefit:** 75% = $30.45 85% = $34.50
73324	A test described in item 73323 if rendered by a receiving APP 1 or more tests (Item is subject to Rule 18) **Fee:** $40.95 **Benefit:** 75% = $30.75 85% = $34.85
73325	Characterisation of mutations in: (a) the JAK2 gene; or (b) the MPL gene; or (c) both genes; in the diagnostic work-up, by, or on behalf of, the specialist or consultant physician, of a patient with clinical and laboratory evidence of: a) polycythaemia vera; or b) essential thrombocythaemia; 1 or more tests **Fee:** $74.50 **Benefit:** 75% = $55.90 85% = $63.35
73326	Characterisation of the gene rearrangement FIP1L1-PDGFRA in the diagnostic work-up and management of a patient with laboratory evidence of: a) mast cell disease; or b) idiopathic hypereosinophilic syndrome; or c) chronic eosinophilic leukaemia;. 1 or more tests **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35
73327	Detection of genetic polymorphisms in the Thiopurine S-methyltransferase gene for the prevention of dose-related toxicity during treatment with thiopurine drugs; including (if performed) any service described in item 65075. 1 or more tests **Fee:** $51.95 **Benefit:** 75% = $39.00 85% = $44.20

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73332	An in situ hybridization (ISH) test of tumour tissue from a patient with breast cancer requested by, or on the advice of, a specialist or consultant physician who manages the treatment of the patient to determine if the requirements relating to human epidermal growth factor receptor 2 (HER2) gene amplification for access to trastuzumab under the Pharmaceutical Benefits Scheme (PBS) or the Herceptin Program are fulfilled. **Fee:** $315.40 **Benefit:** 75% = $236.55 85% = $268.10
73333	Detection of germline mutations of the von Hippel-Lindau (VHL) gene: (a) in a patient who has a clinical diagnosis of VHL syndrome and: (i) a family history of VHL syndrome and one of the following: (A) haemangioblastoma (retinal or central nervous system); (B) phaeochromocytoma; (C) renal cell carcinoma; or (i) 2 or more haemangioblastomas; or (ii) one haemangioblastoma and a tumour or a cyst of: (A) the adrenal gland; or (B) the kidney; or (C) the pancreas; or (D) the epididymis; or (E) a broad ligament (other than epididymal and single renal cysts, which are common in the general population); or (a) in a patient presenting with one or more of the following clinical features suggestive of VHL syndrome: (i) haemangioblastomas of the brain, spinal cord, or retina; (ii) phaeochromocytoma; (iii) functional extra-adrenal paraganglioma (See para PN.0.27 of explanatory notes to this Category) **Fee:** $600.00 **Benefit:** 75% = $450.00 85% = $515.30
73334	Detection of germline mutations of the von Hippel-Lindau (VHL) gene in biological relatives of a patient with a known mutation in the VHL gene (See para PN.0.23 of explanatory notes to this Category) **Fee:** $340.00 **Benefit:** 75% = $255.00 85% = $289.00
73335	Detection of somatic mutations of the von Hippel-Lindau (VHL) gene in a patient with: (a) 2 or more tumours comprising: (i) 2 or more haemangioblastomas, or

	(ii) one haemangioblastoma and a tumour of: (A) the adrenal gland; or (B) the kidney; or (C) the pancreas; or (D) the epididymis; and (b) no germline mutations of the VHL gene identified by genetic testing **Fee:** $470.00 **Benefit:** 75% = $352.50 85% = $399.50
73336	A test of tumour tissue from a patient with unresectable stage III or stage IV metastatic cutaneous melanoma, requested by, or on behalf of, a specialist or consultant physician, to determine if the requirements relating to BRAF V600 mutation status for access to dabrafenib or vemurafenib under the Pharmaceutical Benefits Scheme are fulfilled. **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35
73337	A test of tumour tissue from a patient diagnosed with non-small cell lung cancer, shown to have non-squamous histology or histology not otherwise specified, requested by, or on behalf of, a specialist or consultant physician, to determine if the requirements relating to epidermal growth factor receptor (EGFR) gene status for access to erlotinib, gefitinib or afatinib under the Pharmaceutical Benefits Scheme (PBS) are fulfilled. **Fee:** $397.35 **Benefit:** 75% = $298.05 85% = $337.75
73338	A test of tumour tissue from a patient with metastatic colorectal cancer (stage IV), requested by a specialist or consultant physician, to determine if the requirements relating to rat sarcoma oncogene (RAS) gene mutation status for access to cetuximab or panitumumab under the Pharmaceutical Benefits Scheme (PBS) are fulfilled, if: (a) the test is conducted for all clinically relevant mutations on KRAS exons 2, 3 and 4 and NRAS exons 2, 3, and 4; or (b) a RAS mutation is found. (See para PN.0.26 of explanatory notes to this Category) **Fee:** $362.60 **Benefit:** 75% = $271.95 85% = $308.25
73339	Detection of germline mutations in the RET gene in patients with a suspected clinical diagnosis of multiple endocrine neoplasia type 2 (MEN2) requested by a specialist or consultant physician who manages the treatment of the patient. One test. (Item is subject to rule 25) (See para PN.0.23 of explanatory notes to this Category) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00
73340	Detection of a known mutation in the RET gene in an asymptomatic relative of a patient with a documented pathogenic germline RET mutation requested by a specialist or consultant physician who manages the treatment of the patient.

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	One test. (Item is subject to rule 25) (See para PN.0.23 of explanatory notes to this Category) **Fee:** $200.00 **Benefit:** 75% = $150.00 85% = $170.00
73341	Fluorescence in situ hybridisation (FISH) test of tumour tissue from a patient with locally advanced or metastatic non-small cell lung cancer, which is of non-squamous histology or histology not otherwise specified, with documented evidence of anaplastic lymphoma kinase (ALK) immunoreactivity by immunohistochemical (IHC) examination giving a staining intensity score > 0, and with documented absence of activating mutations of the epidermal growth factor receptor (EGFR) gene, requested by a specialist or consultant physician to determine if requirements relating to ALK gene rearrangement status for access to crizotinib, ceritinib or alectinib under the Pharmaceutical Benefits Scheme (PBS) are fulfilled (See para PN.1.2 of explanatory notes to this Category) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00
73342	An in situ hybridisation (ISH) test of tumour tissue from a patient with metastatic adenocarcinoma of the stomach or gastro-oesophageal junction, with documented evidence of human epidermal growth factor receptor 2 (*HER2*) overexpression by immunohistochemical (IHC) examination giving a staining intensity score of 2+ or 3+ on the same tumour tissue sample, requested by, or on the advice of, a specialist or consultant physician who manages the treatment of the patient to determine if the requirements relating to *HER2* gene amplification for access to trastuzumab under the Pharmaceutical Benefits Scheme are fulfilled. (See para PN.1.2 of explanatory notes to this Category) **Fee:** $315.40 **Benefit:** 75% = $236.55 85% = $268.10
73343	Detection of 17p chromosomal deletions by fluorescence *in situ* hybridisation, in a patient with relapsed or refractory chronic lymphocytic leukaemia or small lymphocytic lymphoma, on a peripheral blood or bone marrow sample, requested by a specialist or consultant physician, to determine if the requirements for access to idelalisib, ibrutinib or venetoclax on the Pharmaceutical Benefits Scheme are fulfilled. **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35
73344	Fluorescence in situ hybridization (FISH) test of tumour tissue from a patient with locally advanced or metastatic non-small-cell lung cancer (NSCLC), which is of non-squamous histology or histology not otherwise specified, with documented evidence of ROS proto-oncogene 1 (ROS1) immunoreactivity by immunohistochemical (IHC) examination giving a staining intensity score of 2+ or 3+; and with documented absence of both activating mutations of the epidermal growth factor receptor (EGFR) gene and anaplastic lymphoma kinase (ALK) immunoreactivity by IHC, requested by a specialist or consultant physician to determine if requirements relating to ROS1 gene rearrangement status for access to crizotinib under the Pharmaceutical Benefits Scheme are fulfilled. (See para PN.1.2 of explanatory notes to this Category) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00
73345	Testing of a patient for pathogenic cystic fibrosis transmembrane conductance regulator variants for the purpose of investigating, making or excluding a diagnosis of cystic fibrosis or a cystic fibrosis transmembrane conductance regulator related disorder when requested by a specialist or consultant physician who manages the treatment of the patient, not being a service associated with a service to which item 73347, 73348, or 73349 applies. The patient must have clinical or laboratory findings suggesting there is a high probability suggestive of

	cystic fibrosis or a cystic fibrosis transmembrane conductance regulator related disorder. (See para PN.7.3 of explanatory notes to this Category) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00
73346	Testing of a pregnant patient whose carrier status for pathogenic cystic fibrosis transmembrane conductance regulator variants, as well as their reproductive partner carrier status is unknown, for the purpose of determining whether pathogenic cystic fibrosis transmembrane conductance regulator variants are present in the fetus, in order to make or exclude a diagnosis of cystic fibrosis or a cystic fibrosis transmembrane conductance regulator related disorder in the fetus when requested by a specialist or consultant physician who manages the treatment of the patient, not being a service associated with a service to which item 73350 applies. The fetus must have ultrasonic findings of echogenic gut, with unknown familial cystic fibrosis transmembrane conductance regulator variants. (See para PN.7.3 of explanatory notes to this Category) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00
73347	Testing of a prospective parent for pathogenic cystic fibrosis transmembrane conductance regulator variants for the purpose of determining the risk of their fetus having pathogenic cystic fibrosis transmembrane conductance regulator variants. This is indicated when the fetus has ultrasonic evidence of echogenic gut when requested by a specialist or consultant physician who manages the treatment of the patient, not being a service associated with a service to which item 73345, 73348, or 73349 applies. (See para PN.7.3 of explanatory notes to this Category) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00
73348	Testing of a patient with a laboratory-established family history of pathogenic cystic fibrosis transmembrane conductance regulator variants, for the purpose of determining whether the patient is an asymptomatic genetic carrier of the pathogenic cystic fibrosis transmembrane conductance regulator variants that have been laboratory established in the family history when requested by a specialist or consultant physician who manages the treatment of the patient, not being a service associated with a service to which item 73345, 73347, or 73349 applies. The patient must have a positive family history, confirmed by laboratory findings of pathogenic cystic fibrosis transmembrane conductance regulator variants, with a personal risk of being a heterozygous genetic carrier of at least 6%. (This includes family relatedness of: parents, children, full-siblings, half-siblings, grand-parents, grandchildren, aunts, uncles, first cousins, and first cousins once-removed, but excludes relatedness of second cousins or more distant relationships). (See para PN.7.3 of explanatory notes to this Category) **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50
73349	Testing of a patient for pathogenic cystic fibrosis transmembrane conductance regulator variants for the purpose of determining the reproductive risk of the patient with their reproductive partner because their reproductive partner is already known to have pathogenic cystic fibrosis transmembrane conductance regulator variants requested by a specialist or consultant physician who manages the treatment of the patient, not being a service associated with a service to which item 73345, 73347, or 73348 applies. (See para PN.7.3 of explanatory notes to this Category) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00
73350	Testing of a pregnant patient, where one or both prospective parents are known to be a genetic carrier of pathogenic cystic fibrosis transmembrane conductance regulator variants for the purpose of determining whether pathogenic cystic fibrosis transmembrane conductance regulator variants are present in the fetus in order to make or exclude a diagnosis of cystic fibrosis or a cystic fibrosis transmembrane conductance regulator related disorder in the fetus, when requested by a specialist or consultant physician who

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	manages the treatment of the patient, not being a service associated with a service to which item 73346 applies. The fetus must be at 25% or more risk of cystic fibrosis or a cystic fibrosis transmembrane conductance regulator related disorder because of known familial cystic fibrosis transmembrane conductance regulator variants. (See para PN.7.3 of explanatory notes to this Category) **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50
73351	A test of tumour tissue that is derived from a new sample from a patient with locally advanced (Stage IIIb) or metastatic (Stage IV) non-small cell lung cancer (NSCLC), who has progressed on or after treatment with an epidermal growth factor receptor tyrosine kinase inhibitor (EGFR TKI). The test is to be requested by a specialist or consultant physician, to determine if the requirements relating to EGFR T790M gene status for access to osimertinib under the Pharmaceutical Benefits Scheme are fulfilled. **Fee:** $397.35 **Benefit:** 75% = $298.05 85% = $337.75

P8. INFERTILITY AND PREGNANCY TESTS	
	Group P8. Infertility And Pregnancy Tests
73521	Semen examination for presence of spermatozoa or examination of cervical mucus for spermatozoa (Huhner's test) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $9.70 **Benefit:** 75% = $7.30 85% = $8.25
73523	Semen examination (other than post-vasectomy semen examination), including: (a) measurement of volume, sperm count and motility; and (b) examination of stained preparations; and (c) morphology; and (if performed) (d) differential count and 1 or more chemical tests; (Item is subject to rule 25) **Fee:** $41.75 **Benefit:** 75% = $31.35 85% = $35.50
73525	Sperm antibodies - sperm-penetrating ability - 1 or more tests (See para TN.1.4 of explanatory notes to this Category) **Fee:** $28.35 **Benefit:** 75% = $21.30 85% = $24.10
73527	Human chorionic gonadotrophin (HCG) - detection in serum or urine by 1 or more methods for diagnosis of pregnancy - 1 or more tests **Fee:** $10.00 **Benefit:** 75% = $7.50 85% = $8.50
73529	Human chorionic gonadotrophin (HCG), quantitation in serum by 1 or more methods (except by latex, membrane, strip or other pregnancy test kit) for diagnosis of threatened abortion, or follow up of abortion or diagnosis of ectopic pregnancy, including any services performed in item 73527 - 1 test (See para PN.0.33 of explanatory notes to this Category) **Fee:** $28.65 **Benefit:** 75% = $21.50 85% = $24.40

P9. SIMPLE BASIC PATHOLOGY TESTS	
	Group P9. Simple Basic Pathology Tests
73801	Semen examination for presence of spermatozoa **Fee:** $6.90 **Benefit:** 75% = $5.20 85% = $5.90
73802	Leucocyte count, erythrocyte sedimentation rate, examination of blood film (including differential leucocyte count), haemoglobin, haematocrit or erythrocyte count - 1 test **Fee:** $4.55 **Benefit:** 75% = $3.45 85% = $3.90
73803	2 tests described in item 73802 **Fee:** $6.35 **Benefit:** 75% = $4.80 85% = $5.40
73804	3 or more tests described in item 73802 **Fee:** $8.15 **Benefit:** 75% = $6.15 85% = $6.95
73805	Microscopy of urine, excluding dipstick testing. **Fee:** $4.55 **Benefit:** 75% = $3.45 85% = $3.90
73806	Pregnancy test by 1 or more immunochemical methods **Fee:** $10.15 **Benefit:** 75% = $7.65 85% = $8.65
73807	Microscopy for wet film other than urine, including any relevant stain **Fee:** $6.90 **Benefit:** 75% = $5.20 85% = $5.90
73808	Microscopy of Gram-stained film, including (if performed) a service described in item 73805 or 73807 **Fee:** $8.65 **Benefit:** 75% = $6.50 85% = $7.40
73809	Chemical tests for occult blood in faeces by reagent stick, strip, tablet or similar method **Fee:** $2.35 **Benefit:** 75% = $1.80 85% = $2.00
73810	Microscopy for fungi in skin, hair or nails - 1 or more sites **Fee:** $6.90 **Benefit:** 75% = $5.20 85% = $5.90
73811	Mantoux test **Fee:** $11.20 **Benefit:** 75% = $8.40 85% = $9.55
73828	Semen examination for presence of spermatozoa by a participating nurse practitioner **Fee:** $6.90 **Benefit:** 85% = $5.90
73829	Leucocyte count, erythrocyte sedimentation rate, examination of blood film (including differential leucocyte count), haemoglobin, haematocrit or erythrocyte count by a participating nurse practitioner - 1 test **Fee:** $4.55 **Benefit:** 85% = $3.90
73830	2 tests described in item 73829 by a participating nurse practitioner **Fee:** $6.35 **Benefit:** 85% = $5.40
73831	3 or more tests described in item 73829 by a participating nurse practitioner **Fee:** $8.15 **Benefit:** 85% = $6.95

P9. SIMPLE BASIC PATHOLOGY TESTS	
Amend 73832	Microscopy of urine, excluding dipstick testing by a participating nurse practitioner. **Fee:** $4.55 **Benefit:** 85% = $3.90
73833	Pregnancy test by 1 or more immunochemical methods by a participating nurse practitioner **Fee:** $10.15 **Benefit:** 85% = $8.65
73834	Microscopy for wet film other than urine, including any relevant stain by a participating nurse practitioner **Fee:** $6.90 **Benefit:** 85% = $5.90
73835	Microscopy of Gram-stained film, including (if performed) a service described in item 73832 or 73834 by a participating nurse practitioner **Fee:** $8.65 **Benefit:** 85% = $7.40
73836	Chemical tests for occult blood in faeces by reagent stick, strip, tablet or similar method by a participating nurse practitioner **Fee:** $2.35 **Benefit:** 85% = $2.00
73837	Microscopy for fungi in skin, hair or nails by a participating nurse practitioner - 1 or more sites **Fee:** $6.90 **Benefit:** 85% = $5.90
73839	Quantitation of HbA1c (glycated haemoglobin) performed for the diagnosis of diabetes in asymptomatic patients at high risk - not more than once in a 12 month period. (Item is subject to restrictions in rule PR.9.1 of explanatory notes to this category) (See para PR.9.1 of explanatory notes to this Category) **Fee:** $16.80 **Benefit:** 75% = $12.60 85% = $14.30
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. (Item is subject to restrictions in rule PR.9.1 of explanatory notes to this category) (See para PR.9.1 of explanatory notes to this Category) **Fee:** $17.00 **Benefit:** 75% = $12.75 85% = $14.45
73844	Quantitation of urinary microalbumin as determined by urine albumin excretion on a timed overnight urine sample or urine albumin/creatinine ratio as determined on a first morning urine sample in the management of established diabetes. (Item is subject to restrictions in rule PR.9.1 of explanatory notes to this category) (See para PR.9.1 of explanatory notes to this Category) **Fee:** $20.35 **Benefit:** 75% = $15.30 85% = $17.30
P10. PATIENT EPISODE INITIATION	
	Group P10. Patient Episode Initiation
73899	Initiation of a patient episode that consists of a service described in item 72858 or 72859 in circumstances other than those mentioned in item 73900 **Fee:** $5.95 **Benefit:** 75% = $4.50 85% = $5.10
73900	Initiation of a patient episode that consists of a service described in item 72858 or 72859 if the service is

P10. PATIENT EPISODE INITIATION	
	rendered in a prescribed laboratory. **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05
73920	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected in an approved collection centre that the APA operates in the same premises as it operates a category GX or GY pathology laboratory **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05
73922	Initiation of a patient episode that consists of a service described in item 73070, 73071, 73072, 73073, 73074, 73075 or 73076 (in circumstances other than those described in item 73923). **Fee:** $8.20 **Benefit:** 75% = $6.15 85% = $7.00
73923	Initiation of a patient episode that consists of a service described in items 73070, 73071, 73072, 73073, 73074, 73075 or 73076 if: (a) the person is a private patient in a recognised hospital; or (b) the person receives the service from a prescribed laboratory **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05
73924	Initiation of a patient episode that consists of 1 or more services described in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 (in circumstances other than those described in item 73925) from a person who is an in-patient of a hospital. **Fee:** $14.65 **Benefit:** 75% = $11.00 85% = $12.50
73925	Initiation of a patient episode that consists of 1 or more services described in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 if the person is: (a) a private patient of a recognised hospital; or (b) a private patient of a hospital who receives the service or services from a prescribed laboratory. **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05
73926	Initiation of a patient episode that consists of 1 or more services described in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 (in circumstances other than those described in item 73927) from a person who is not a patient of a hospital. **Fee:** $8.20 **Benefit:** 75% = $6.15 85% = $7.00
73927	Initiation of a patient episode by a prescribed laboratory that consists of 1 or more services described in items, 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 from a person who is not a patient of a hospital. **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05
73928	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected in an approved collection centre. Unless item 73920 or 73929 applies **Fee:** $5.95 **Benefit:** 75% = $4.50 85% = $5.10
73929	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner for a prescribed laboratory or by an employee of an approved pathology authority, who conducts a prescribed laboratory, if the specimen is collected in an approved pathology collection centre

P10. PATIENT EPISODE INITIATION	
	Fee: $2.40 **Benefit:** 75% = $1.80 85% = $2.05
73930	Initiation of a patient episode by collection of a specimen for a service for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person who is an in-patient of a hospital other than a recognised hospital. Unless item 73931 applies **Fee:** $5.95 **Benefit:** 75% = $4.50 85% = $5.10
73931	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if: () the specimen is collected by an approved pathology practitioner for a prescribed laboratory or by an employee of an approved pathology authority, who conducts a prescribed laboratory, from a person who is a private patient in a hospital or () the person is a private patient in a recognised hospital and the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05
73932	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person in the place where the person was residing. Unless item 73933 applies **Fee:** $10.25 **Benefit:** 75% = $7.70 85% = $8.75
73933	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner for a prescribed laboratory or by an employee of an approved pathology authority, who conducts a prescribed laboratory, from a person in the place where the person is residing **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05
73934	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 and 73926) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person in a residential aged care home or institution. Unless 73935 applies **Fee:** $17.60 **Benefit:** 75% = $13.20 85% = $15.00
73935	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner or by an employee of an approved pathology authority, who conducts a prescribed laboratory, from a person in a residential aged care home or institution **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05
73936	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected from the person by the person. **Fee:** $5.95 **Benefit:** 75% = $4.50 85% = $5.10
73937	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926), if the specimen is collected from the person by the person and if:

P10. PATIENT EPISODE INITIATION	
	() the service is performed in a prescribed laboratory or () the person is a private patient in a recognised hospital **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05
73938	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by or on behalf of the treating practitioner. Unless item 73939 applies **Fee:** $7.95 **Benefit:** 75% = $6.00 85% = $6.80
73939	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926), if the specimen is collected by or on behalf of the treating practitioner and if: () the service is performed in a prescribed laboratory or () the person is a private patient in a recognised hospital **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05

P11. SPECIMEN REFERRED	
	Group P11. Specimen Referred
73940	Receipt of a specimen by an approved pathology practitioner of an approved pathology authority from another approved pathology practitioner of a different approved pathology authority or another approved pathology authority (Item is subject to rules 14, 15 and 16) **Fee:** $10.25 **Benefit:** 75% = $7.70 85% = $8.75

P12. MANAGEMENT OF BULK-BILLED SERVICES	
	Group P12. Management Of Bulk-Billed Services
74990	A pathology service to which an item in this table (other than this item or item 74991) applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in respect of the fees for: (i) this item; and (ii) the other item in this table applying to the service (See para PN.0.24 of explanatory notes to this Category) **Fee:** $7.05 **Benefit:** 85% = $6.00

P12. MANAGEMENT OF BULK-BILLED SERVICES	
74991	A pathology service to which an item in this table (other than this item or item 74990) applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in respect of the fees for: (i) this item; and (ii) the other item in this table applying to the service; and (e) the service is provided at, or from, a practice location in: (i) a regional, rural or remote area; or (ii) Tasmania; or (iii) A geographical area included in any of the following SSD spatial units: (A) Beaudesert Shire Part A (B) Belconnen (C) Darwin City (D) Eastern Outer Melbourne (E) East Metropolitan, Perth (F) Frankston City (G) Gosford-Wyong (H) Greater Geelong City Part A (I) Gungahlin-Hall (J) Ipswich City (part in BSD) (K) Litchfield Shire (L) Melton-Wyndham (M) Mornington Peninsula Shire (N) Newcastle (O) North Canberra (P) Palmerston-East Arm

P12. MANAGEMENT OF BULK-BILLED SERVICES	
	(Q) Pine Rivers Shire (R) Queanbeyan (S) South Canberra (T) South Eastern Outer Melbourne (U) Southern Adelaide (V) South West Metropolitan, Perth (W) Thuringowa City Part A (X) Townsville City Part A (Y) Tuggeranong (Z) Weston Creek-Stromlo (ZA) Woden Valley (ZB) Yarra Ranges Shire Part A; or (iv) the geographical area included in the SLA spatial unit of Palm Island (AC) (See para PN.0.24 of explanatory notes to this Category) **Fee:** $10.65 **Benefit:** 85% = $9.10

P13. BULK-BILLING INCENTIVE	
	Group P13. Bulk-Billing Incentive
74992	A payment when the episode is bulk billed and includes item 73920. **Fee:** $1.60 **Benefit:** 75% = $1.20 85% = $1.40
74993	A payment when the episode is bulk billed and includes item 73922 or 73926. **Fee:** $3.75 **Benefit:** 75% = $2.85 85% = $3.20
74994	A payment when the episode is bulk billed and includes item 73924. **Fee:** $3.25 **Benefit:** 75% = $2.45 85% = $2.80
74995	A payment when the episode is bulk billed and includes item 73899, 73900, 73928, 73930 or 73936. **Fee:** $4.00 **Benefit:** 75% = $3.00 85% = $3.40
74996	A payment when the episode is bulk billed and includes item 73932 or 73940. **Fee:** $3.70 **Benefit:** 75% = $2.80 85% = $3.15
74997	A payment when the episode is bulk billed and includes item 73934. **Fee:** $3.30 **Benefit:** 75% = $2.50 85% = $2.85
74998	A payment when the episode is bulk billed and includes item 73938. **Fee:** $2.00 **Benefit:** 75% = $1.50 85% = $1.70

P13. BULK-BILLING INCENTIVE	
	A payment when the episode is bulk billed and includes item 73923, 73925, 73927, 73929, 73931, 73933, 73935, 73937 or 73939.
74999	**Fee:** $1.60 **Benefit:** 75% = $1.20 85% = $1.40

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Listeria - microbial antibody testing LIS 69384
Lithium LI 66800
Liver/kidney microsomes - tissue antigens - antibodies LKA 71119
Lupus anticoagulant LUPA 65137, 65142
Luteinizing hormone LH 66695
Lymphocytes - functional tests - 1 test LF1 71127
Lymphocytes - functional tests - 2 test LF2 71129
Lymphocytes - functional tests - 3 tests LF3 71131

M

Magnesium MG 66500
Mammary serum antigen MSA 66650
Mantoux test MANT 73811
Mast cell disease 73326
Measles - microbial antigen testing MEA 69384
Metabolic bone disease CBMB 66776
Metanephrines MNEP 66779
Methadone MTDN 66812
Methaemalbumin detection (Schumm's test) SCHM 65117
Methotrextate MTTA 66812
Methsuximide MSUX 66812
Methylphenobarbitone MPBT 66812
Metronidazole MRDZ 66812
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Mianserin MIAS 66812
Microalbumin MALB 66560
Microbial antibody testing - Varicella zoster VCZ 69384
Microbial antibody testing - actinomyetes ACT 69384
Microbial antibody testing - adenovirus ADE 69384
Microbial antibody testing - aspergillus ASP 69384
Microbial antibody testing - avian precipitins (bird fancier's disease) APP 69384
Microbial antibody testing - Blastomyces BLM 69384
Microbial antibody testing - Bordetella pertussis BOR 69384
Microbial antibody testing - Borrelia burgdorferi BOB 69384
Microbial antibody testing - Brucella BRU 69384
Microbial antibody testing - Campylobacter jejuni CAM 69384
Microbial antibody testing - Candida CAN 69384
Microbial antibody testing - Chlamydia CHL 69384
Microbial antibody testing - Coccidiodes CCC 69384
Microbial antibody testing - Coxsackie B1-6 COX 69384
Microbial antibody testing - cryptococcus CRY 69384
Microbial antibody testing - cytomegalovirus CMV 69384
Microbial antibody testing - cytomegalovirus serology in pregnancy CMVP 69384
Microbial antibody testing - dengue DEN 69384
Microbial antibody testing - diphtheria DIP 69384
Microbial antibody testing - echinococcus ECC 69384
Microbial antibody testing - echo-coxsackie group ECH 69384
Microbial antibody testing - Entamoeba histolytica AMO 69384
Microbial antibody testing - Epstein Barr virus EBV 69474
Microbial antibody testing - Eptein Barr virus EBV 69472
Microbial antibody testing - fluorescent treponemal antibody - absorption test (69384
Microbial antibody testing - Haemophilus influenzae HUS 69384
Microbial antibody testing - herpes simplex virus HPA 69384
Microbial antibody testing - Histoplasma HIP 69384
Microbial antibody testing - Human Immunodeficiency Virus 69384
Microbial antibody testing - hydatid HYD 69384
Microbial antibody testing - infectious mononucleosis IM 69384
Microbial antibody testing - influenza A FLA 69384
Microbial antibody testing - influenza B FLB 69384
Microbial antibody testing - Legionella pneumophila - serogroup 1 LP1 69384
Microbial antibody testing - Legionella pneumophila - serogroup 2 LP2 69384
Microbial antibody testing - leishmaniasis LEI 69384
Microbial antibody testing - Leptospira LEP 69384
Microbial antibody testing - Listeria LIS 69384
Microbial antibody testing - measles MEA 69384
Microbial antibody testing - Micropolyspora faeni MIC 69384
Microbial antibody testing - mumps MUM 69384
Microbial antibody testing - Murray Valley encephalitis MVE 69384
Microbial antibody testing - Mycoplasma pneumoniae MYC 69384
Microbial antibody testing - Neisseria meningitidis MEN 69384
Microbial antibody testing - Newcastle disease NCD 69384
Microbial antibody testing - parainfluenza 1 PF1 69384
Microbial antibody testing - parainfluenza 2 PF2 69384
Microbial antibody testing - parainfluenza 3 PF3 69384
Microbial antibody testing - paratyphi PTY 69384
Microbial antibody testing - pertussis PER 69384
Microbial antibody testing - poliomyelitis PLO 69384
Microbial antibody testing - Proteus OX 19 POX 69384
Microbial antibody testing - Proteus OXK POK 69384
Microbial antibody testing - Q fever QFF 69384
Microbial antibody testing - rapid plasma reagin test RPR 69384
Microbial antibody testing - respiratory syncytial virus RSV 69384
Microbial antibody testing - Ross River virus RRV 69384
Microbial antibody testing - rubella RUB 69384
Microbial antibody testing - Salmonella typhi (H) SAH 69384
Microbial antibody testing - Salmonella typhi (O) SAO 69384
Microbial antibody testing - Schistosoma STO 69384
Microbial antibody testing - streptococcal serology - anti DNASE B titre ADNB 69384
Microbial antibody testing - streptococcal serology - anti-streptolysin O titre 69384

Microbial antibody testing - Strptococcus pneumoniae PCC 69384
Microbial antibody testing - tetanus TET 69384
Microbial antibody testing - Thermoactinomyces vulgaris THE 69384
Microbial antibody testing - thermopolyspora TPS 69384
Microbial antibody testing - Toxocara TOC 69384
Microbial antibody testing - toxoplasma TOX 69384
Microbial antibody testing - TPHA (Treponema pallidum haemagglutination test) TP 69384
Microbial antibody testing - Treponema pallidum haemagglutination test TPHA 69384
Microbial antibody testing - trichinosis TOS 69384
Microbial antibody testing - typhus, Weil-Felix TYP 69384
Microbial antibody testing - VDRL (Venereal Disease Research Laboratory) VDRL 69384
Microbial antibody testing - Yersinia entercolitica YER 69384
Microbial antigen testing - Clostridium difficile CLDT 69363
Microscopic examination of - faeces for parasites OCP 69336 69339
Microscopy & culture of - material from nose, throat, eye or ear MCSW 69303
Microscopy & culture of - material from skin MCSK 69309
Microscopy & culture of - postoperative wounds, aspirates of body cavities MCPO 69321
Microscopy & culture of - specimens of sputum MCSP 69318
Microscopy & culture of - specimens of sputum, urine or other body fluids for my 69324, 69327, 69330
Microscopy & culture of - superficial sites MCSS 69306
Microscopy & culture of - urethra, vagina, cervix or rectum MCGR 69312
Microscopy of wet film material other than blood MWFM 69300
Microscopy, culture, identification & sensitivity of urine UMCS 69333
Mitachondria - tissue antigens - antibodies MA 71119
Mouth - cytology on specimens from SMCY 73043
Mumps - microbial antibody testing MUM 69384
Murray Valley encephalitis - microbial antibody testing MVE 69384
Mycobacteria microscopy & culture of sputum - 1 specimen AFB1 69324
Mycobacteria microscopy & culture of sputum - 2 specimens AFB2 69327
Mycobacteria microscopy & culture of sputum - 3 specimens AFB3 69330
Mycoplasma pneumoniae - microbial antibody testing MYC 69384
Myoglobin MYOG 66518

N

N-acetyl procainamide NAPC 66812
Neisseria menigitidis antibody testing MEN 69384
Netilmicin 66800
Neutrophil functions NFT 71135
Newcastle disease - microbial antibody testing NCD 69384
Nipple discharge - cytology on specimens from SMCY 73043
Nitrazepam NITR 66812
Nordothiepin NDIP 66812
Norfluoxetine NFLE 66812
Nortriptyline NORT 66812
Nose - cytology on specimens from SMCY 73043
Nose - microscopy & culture of material from MCSW 69303
Nuclear antigens - detection of antibodies to ANA 71097

O

Oestradiol E2 66695
Oestrone E1 66695
Oligoclonal proteins OGP 71062
Op/biopsy specimens - microscopy & culture of material from MCPO 69321
Oral glucose challenge test - gestational diabetes OGCT 66545
Oral glucose tolerance test - gestational diabetes GTTP 66542
Osmolality, serum or urine OSML 66563
Oxalate OXAL 66752
Oxazepam OXAZ 66812

P

PAA (phenyl acetic acid) PAA 66779
Palmitic acid in amniotic fluid PALM 66749
Paracetamol PARA 66800
Parainfluenza 1 - microbial antibody testing PF1 69384
Parainfluenza 2 - microbial antibody testing PF2 69384
Parainfluenza 3 - microbial antibody testing PF3 69384
Paraprotein characterisation - by electrophoresis, and immunoelectrophoresis or 71059
Paraprotein characterisation - on concurrently collected serum or urine PPSU 71060
Paraprotein quantitation - by electrophoresis EPPI 71057
Paraquat PARQ 66812
Parasites - microscopic examination of faeces OCP 69336 69339
Parathyroid hormone (PTH) PTH 66695
Paratyphi - microbial antibody testing PTY 69384
Partial thromboplastin time PTT 65120
Patient Episode Initiation private 73899
Patient Episode Initiation public 73900
Pentobarbitone PENT 66812
Perhexiline PHEX 66812
Pertussis - microbial antibody testing PER 69384
Phenobarbitone PHBA 66800
Phensuximide PHEN 66812
Phenylacetic acid PAA 66779
Phenytoin PHEY 66800
Phosphate PHOS 66500
Phosphatidylglycerol PTGL 66749
Platelet - aggregation PLTG 65144
Platelet count PLTC 65070
PM-Sc1 - tissue antigens - antibodies PM1 71119
Poliomyelitis - microbial antibody testing PLO 69384
Polycythaemia vera 73325
Porphobilinogen in urine UPG 66782
Porphyrins - quantitative test, 1 or more fractions PR 66785
Porphyrins in urine - qualitative test UPR 66782
Potassium K 66500
Prealbumin PALB 66632
Prednisolone PRED 66812
Pregnancy serology - 1 test MSP1 69405
Pregnancy serology - 2 tests MSP2 69408
Pregnancy serology - 3 tests MSP3 69411
Pregnancy serology - 4 tests MSP4 69413
Pregnancy testing 73806
Pregnancy testing - bile acids in blood BABP 66517
Pregnancy testing - HCG detection HCGP 73527, 73529

Pregnancy testing - HCG quantitation HCG 73529
Primidone PRIM 66800
Procainamide PCAM 66800
Progesterone PROG 66695
Prolactin PROL 66695
Propranolol PPNO 66812
Prostate specific antigen PSA 66655-66656, 66659
Protein C PROC 65142, 65171
Protein S PROS 65142, 65171
Protein, quantitation of - alpha fetoprotein AFP 66650-66653 66743
Protein, quantitation of - alpha-l-antitrypsin AAT 66635
Protein, quantitation of - beta-2-microglobulin BMIC 66629
Protein, quantitation of - C-1 esterase inhibitor CEI 66644
Protein, quantitation of - caeruloplasmin CPLS 66632
Protein, quantitation of - classes or presence and amount of paraprotein by elec 71057-71058
Protein, quantitation of - ferritin (see also Iron studies) FERR 66593
Protein, quantitation of - haptoglobins HGLB 66632
Protein, quantitation of - microalbumin MALB 66560
Protein, total - quantitation of PROT 66500
Proteus OX 19 - microbial antibody testing POX 69384
Proteus OXK - microbial antibody testing POK 69384
Prothrombin time PT 65120
Pyruvate PVTE 66500

Q

Q Fever - microbial antibody testing QFF 69384
Quinalbarbitone QUIB 66812
Quinidine QUIN 66800
Quinine QNN 66812

R

Rapid plasma reagin test - microbial antibody testing RPR 69384
RAST RAST 71079
Rectum - microscopy & culture of material from MCGR 69312
Red blood cells - Kleihauer KLEI 65162
Red cell porphyrins - qualitative test RCP 66782
Renin REN 66695
Reptilase test REPT 65120
Respiratory syncytial virus - microbial antibody testing RSV 69384
Reticulin - tissue antigens - antibodies RCA 71119
Reticulocyte count RETC 65072
Rheumatoid factor - quantitation RFQ 71106
Rheumatoid factor RF 71106
Ross River virus - microbial antibody testing RRV 69384
RSV (respiratory syncytial virus) - microbial antibody testing RSV 69384
Rubella - serology RUB 69384

S

Salicylate (aspirin) SALI 66800
Salmonella typhi (H) - microbial antibody testing SAH 69384
Salmonella typhi (O) - microbial antibody testing SAO 69384
Schistosoma - microbial antibody testing STO 69384
Scl-70 - tissue antigens - antibodies SCL 71119
Second, expert, opinion morphology, complex - SEOC 72859
Second, expert, opinion morphology, non-complex - SEON 72858
Semen examination - for spermatozoa (post vasectomy) SES 73521
Semen examination SEE 73523
Serotonin 5HT 66779
Serum - B12 B12 66838
Serum Folate & Red cell folate if required 66840
Serum Folate SF 66840
Sex hormone binding globulin SHBG 66695
SF 66840
Skin - microscopy & culture of material from MCSS 69306
Skin - microscopy, culture & Chlamydia of material from MCSK 69309
Skin cytology SMCY 73043
Smooth muscle - tissue antigens - antibodies SMA 71119
Snake venom HISS 66623
Sodium NA 66500
Solid tissue or tissues - chemical assays ENZS 66683
Solid tissue or tissues - cytology of fine needle aspiration FNCY 73049
Solid tissue or tissues - cytology of fine needle aspitation by, or in presence 73051
Somatomedin SOMA 66695
Sotalol SALL 66812
Specific IgC antibodies - respiratory disease allergens RDA 71189
Specific IgG or IgE antibodies RAST 71079
Specimen dissection - level 7 SPE7 72838
Sperm antibodies - penetrating ability SPA 73525
Sperm antibodies SAB 73525
Sputum - cytology (1 specimen) BFCY 73045
Sputum - cytology (3 specimens) SPCY 73047
Sputum - for mycobacteria - 1 specimen AFB1 69324
Sputum - for mycobacteria - 2 specimens AFB2 69327
Sputum - for mycobacteria - 3 specimens AFB3 69330
Sputum - microscopy & culture of specimens MCSP 69318
Stelazine STEL 66812
Steroid fraction or fractions in urine USF 66695
Streptococcal serology - anti-DNASE B titre - microbial antibody testing ADNB 69384
Streptococcal serology - anti-streptolysin O titre - microbial antibody testing 69384
Streptococcus pneumoniae - microbial antibody testing PCC 69384
Stypven test STYP 65120
Sugar water test SWT 65075
Sulthiame (Ospolot) SUL 66812
Syphilis serology (see test groups at para PQ.4) STS 69387

T

Testosterone TES 66695
Tetanus - microbial antibody testing TET 69384
Thalassaemia studies TS 65078
Theophylline THEO 66800
Thermaactinomyces vulgaris - microbial antibody testing THE 69384
Thermopolyspora - microbial antibody testing TPS 69384
Thiopentone TOPO 66812
Thiopurine S-methyltransferase 73327
Thioridazine THIO 66812
Throat - microscopy & culture of material from MCSW 69303
Thrombin time TT 65120
Thyroglobulin TGL 66650

Thyroid function tests (including TSH) TFT 66719
Thyroid stimulating hormone 66734
Thyroid stimulating hormone (if requested on its own, or as a preliminary test 66716
Thyroid stimulating hormone (if requested with other hormones referred to in ite 66722-66725, 66728, 66731
Tissue transglutaminase antibodies TTG 71163
Tobramicin 66800
Total protein PROT 66500
Toxocara - microbial antibody testing TOC 69384
Toxoplasma - microbial antibody testing TOX 69384
TPHA (Treponema pallidum haemagglutination test) 69384
Treponema pallidum haemagglutination test 69384
Trichinosis - microbial antibody testing TOS 69384
Triglycerides TRIG 66500
Trimipramine TRIM 66812
Troponin TROP 66518
Tryptase - serum TRYP 71198
Tryptic activity in faeces TAF 66677
Tuberculosis MANT 73811
Tumour markers - CA-125 antigen C125 66650
Tumour markers - CA-15.3 anitgen CA15 66650
Tumour markers - CA-19.9 antigen CA19 66650
Tumour markers - carcinoembryonic antigen CEA 66650
Tumour markers - mammary serum antigen MSA 66650
Tumour markers - prostate specific antigen PSA 66656
Tumour markers - prostatic acid phosphatase - 1 or more fractions ACP 66656
Tumour markers - thryroglobulin TGL 66650
Typhus, Weil-Felix - microbial antibody testing TYP 69384

U

Urate URAT 66500
Urea U 66500
Urethra - microscopy & culture of material from MCGR 69312
Urine - acidification test UAT 66587
Urine - cystine (cysteine) UCYS 66782
Urine - cytology - on 1 specimen BFCY 73045
Urine - cytology - on 3 specimens SPCY 73047
Urine - haemoglobin UHB 66782
Urine - microscopy, culture, identification & sensitivity UMCS 69333
Urine - porphyrins - qualitative test UPR 66782
Urine - prophobilinogen UPG 66782
Urine - steroid fraction or fractions USF 66695
Urine - urobilinogen UUB 66782

V

Vagina - microscopy & culture of material from MCGR 69312
Valproate (Epilim) VALP 66800
Vancomycin VAN 66800
Varicella zoster - microbial antibody testing VCZ 69384
Vasoactive intestinal peptide VIP 66695
Vasopressin ADH 66695
VDRL (Venereal Disease Researce Laboratory) - microbial antibody testing VDRL 69384
Viscosity of blood or plasma VISC 65060
Vitamins - 1,25-dihydroxyvitamin D 66835-66836
Vitamins - 25-hydroxyvitamin D 66833
Vitamins - B12 B12 66838
Vitamins - B12 markers B12M 66839
Vitamins - D VITD 66833, 66835-66836
Vitamins - quantitation of A or E 66607
Vitamins - quantitation of B1, B2, B3, B6 or C 66605
Von Hippel-Lindau - Diagnostics (germline) 73333
Von Hippel-Lindau - Predictive (relatives) 73334
Von Hippel-Lindau - Somatic 73335
Von Willebrand's factor antigen VWA 65150
Von Willebrand's factor VWF 65150

W

Warfarin WFR 66812

Y

Yersinia entercolitica - microbial antibody testing YER 69384

Z

Zinc ZN 66667

COMPLEXITY LEVELS FOR HISTOPATHOLOGY ITEMS

Specimen Type	Complexity level
Adrenal resection, neoplasm	5
Adrenal resection, not neoplasm	4
Anus, all specimens not otherwise specified	3
Anus, neoplasm, biopsy	4
Anus, neoplasm, radical resection	6
Anus, submucosal resection – neoplasm	5
Appendix	3
Artery, all specimens not otherwise specified	3
Artery, biopsy	4
Bartholin's gland - cyst	3
Bile duct, resection - all specimens	6
Bone, biopsy, curettings or fragments - lesion	5
Bone, biopsy or curettings quantitation - metabolic disease	6
Bone, femoral head	4
Bone, resection, neoplasm - all sites and types	6
Bone marrow, biopsy	4
Bone - all specimens not otherwise specified	4
Brain neoplasm, resection - cerebello-pontine angle	4
Brain or meninges, biopsy - all lesions	5
Brain or meninges, not neoplasm - temporal lobe	6
Brain or meninges, resection - neoplasm (intracranial)	5
Brain or meninges, resection - not neoplasm	4
Branchial cleft, cyst	4
Breast, excision biopsy, guidewire localisation - non-palpable lesion	6
Breast, excision biopsy, or radical resection, malignant neoplasm or atypical proliferative disease - all specimen types	6
Breast, incision biopsy or needle biopsy, malignant neoplasm - all specimen types	4
Breast – microdochectomy	6
Breast, orientated wide local excision for carcinoma, with margin assessment	7
Breast tissue - all specimens not otherwise specified	4
Bronchus, biopsy	4
Carotid body - neoplasm	5
Cholesteatoma	3
Digits, amputation - not traumatic	4
Digits, amputation - traumatic	2
Ear, middle and inner - not cholesteatoma	4
Endocrine neoplasm - not otherwise specified	5
Extremity, amputation or disarticulation – neoplasm	6

Specimen Type	Complexity level
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, for confirmation or exclusion of Hirschsprung’s Disease	5
Large bowel (including rectum), polyp	4
Large bowel, segmental resection - colon, not neoplasm	5
Large bowel (including rectum), segmental resection, neoplasm	6
Large bowel (including rectum), submucosal resection – neoplasm	5
Larynx, biopsy	4
Larynx, partial or total resection	5
Larynx, resection with nodes or pharynx or both	6
Lip, biopsy - all specimens not otherwise specified	3
Lip, wedge resection or local excision with orientation	4
Liver, hydatid cyst or resection for trauma	4
Liver, total or subtotal hepatectomy - neoplasm	6
Liver - all specimens not otherwise specified	5

Specimen Type	Complexity level
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
Oesophagus, submucosal resection – neoplasm	5
Omentum, biopsy	4
Ovary with or without tube - neoplasm	5
Ovary with or without tube - not neoplasm	4
Pancreas, biopsy	5
Pancreas, cyst	4
Pancreas, subtotal or total with or without splenectomy	6
Parathyroid gland(s)	4
Penisectomy with node dissection	5
Penisectomy - simple	4
Peritoneum, biopsy	4
Pituitary neoplasm	4
Placenta - not third trimester	4
Placenta - third trimester, abnormal pregnancy or delivery	4
Pleura or pericardium, biopsy or tissue	4
Products of conception, spontaneous or missed abortion	4
Products of conception, termination of pregnancy	3
Prostate, radical prostatectomy or cystoprostatectomy for carcinoma	7
Prostate, radical resection	6
Prostate - all types of specimen not otherwise specified	4
Retroperitoneum, neoplasm	5
Salivary gland, Mucocele	3
Salivary gland, neoplasm - all sites	5

Specimen Type	Complexity level
Salivary gland - all specimens not otherwise specified	4
Sinus, paranasal, biopsy	4
Sinus, paranasal, resection - neoplasm	6
Skin, biopsy - blistering skin diseases	4
Skin biopsy - for investigation of alopecia other than for male pattern baldness, where serial horizontal sections are taken	5
Skin, biopsy - for investigation of lymphoproliferative disorder	5
Skin, biopsy - inflammatory dermatosis	4
Skin,eyelid, wedge resection	4
Skin, local resection - orientation	4
Skin, resection of malignant melanoma or melanoma in-situ	5
Skin - all specimens not otherwise specified including all neoplasms and cysts	3
Small bowel - biopsy, all sites	4
Small bowel, diverticulum	3
Small bowel, resection - neoplasm	6
Small bowel – resection, all specimens	5
Small bowel, submucosal resection – neoplasm	5
Soft tissue, infiltrative lesion, extensive resections at least 5cm in maximal dimension	6
Soft tissue, lipoma and variants	3
Soft tissue, neoplasm, not lipoma - all specimens	5
Soft tissue - not otherwise specified	4
Spleen	5
Stomach, endoscopic biopsy or endoscopic polypectomy	4
Stomach, resection, neoplasm - all specimens	6
Stomach, submucosal resection – neoplasm	5
Stomach - all specimens not otherwise specified	4
Tendon or tendon sheath, giant cell neoplasm	4
Tendon or tendon sheath - not otherwise specified	3
Testis, biopsy	5
Testis and adjacent structures, castration	2
Testis and adjacent structures, neoplasm with or without nodes	5
Testis and adjacent structures, vas deferens sterilization	2
Testis and adjacent structures - not otherwise specified	3
Thymus - not otherwise specified	5
Thyroglossal duct - all lesions	4
Thyroid - all specimens	5
Tissue or organ not otherwise specified, abscess	3
Tissue or organ not otherwise specified, haematoma	3
Tissue or organ not otherwise specified, malignant neoplasm with regional nodes	6
Tissue or organ not otherwise specified, neoplasm local	4

Specimen Type	Complexity level
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
reter, 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

CATEGORY 7: CLEFT LIP AND CLEFT PALATE SERVICES

SUMMARY OF CHANGES FROM 01/11/2019

The 01/11/2019 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

There are no changes to this Category for 01/11/2019.

CLEFT LIP AND CLEFT PALATE SERVICES NOTES

CN.0.1 Schedule Fees and Medicare Benefits

Medicare benefits are based on fees determined for each Schedule service. The fee is referred to in these notes as the "Schedule fee". The fee for any item listed in the Schedule is that which is regarded as being reasonable on average for that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered.

The Schedule fee and Medicare benefit levels for the medical services contained in the Schedule are located with the item descriptions. Where appropriate, the calculated benefit has been rounded to the nearest higher 5 cents. However, in no circumstances will the Medicare benefit payable exceed the fee actually charged.

There are presently two levels of Medicare benefit payable for cleft lip and cleft palate services:

(a) **75% of the Schedule fee:**

for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients). Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '*' or the letter 'H' directly after an item number where used; or a description of the professional service and an indication the service was rendered as an episode of hospital treatment (for example, 'in hospital', 'admitted' or 'in patient');

for professional services rendered as part of an episode of hospital-substitute treatment, and the patient who receives the treatment chooses to receive a benefit from a private health insurer. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service, preceded by the words 'hospital-substitute treatment'.

(b) **85% of the Schedule fee,** or the Schedule fee less $84.70 (indexed annually), whichever is the greater, for all other professional services.

It should be noted that the Health Insurance Act makes provision for private medical insurance to cover the "patient gap" (ie, the difference between the Medicare benefit and the Schedule fee) for services attracting benefit at the 75% level. Patients may insure with private health insurance organisations for the gap between the 75% Medicare benefit and the Schedule fee or for amounts in excess of the Schedule fee where the patient has an agreement with their health fund.

CN.0.2 Where Medicare Benefits are not Payable

Medicare benefits are not payable in respect of a professional service where the medical expenses for the service:-

(a) are paid/payable to a public hospital;

(b) are for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability. (Please note that if the medical expenses relate to a compensable injury/illness for which the insurer/compensation agency is disputing liability, then Medicare benefits are payable until the liability is accepted);

(c) are for a medical examination for the purposes of life insurance, superannuation, a provident account scheme, or admission to membership of a friendly society; or

(d) are incurred in mass immunisation.

Unless the Minister otherwise directs, Medicare benefits are not payable where:

(a) the service is rendered by or on behalf of, or under an arrangement with the Australian Government, a State or Territory, a local government body or an authority established under Commonwealth, State or Territory law;

(b) the medical expenses are incurred by the employer of the person to whom the service is rendered;

(c) the person to whom the service is rendered is employed in an industrial undertaking and that service is rendered for the purposes related to the operation of the undertaking; or

(d) the services is a health screening service.

Benefits are not payable for items 75150 to 75621 unless the patient was referred by letter of Referral by an eligible orthodontist.

CN.0.3 Limiting Rule

In no circumstances will the benefit payable for a professional service exceed the fee charged for the service.

CN.0.4 Penalties

Penalties of up to $10,000 or imprisonment for up to five years, or both, may be imposed on any person who makes a statement (oral or written) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used with a claim for benefits. In addition, any practitioner who is found guilty of such offences by a court shall be subject to examination by a Medicare Participation Review Committee and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.

A penalty of up to $1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on a direct-billing form without the obligatory details having been entered on the form before the person signs, or who fails to cause a patient to be given a copy of the completed form.

CN.0.5 Billing of the Patient

Where the practitioner bills the patient for medical services rendered, the patient needs a properly itemised account/receipt to enable a claim to be made for Medicare benefits.

Under the provisions of the Health Insurance Act and Regulations, Medicare benefits are not payable in respect of a professional service unless there is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of the service, the following particulars:-

(a) Patient's name;

(b) The date on which the professional service was rendered;

(c) A description of the professional service sufficient to identify the item that relates to that service, including an indication where the service is rendered to a person while hospital treatment is provided in a hospital or day-hospital facility (other than a Medicare hospital patient), that is, the words (ie, accommodation and nursing care) "admitted patient" immediately preceding the description of the service or an asterisk "*" directly after an item number where used;

(d) The name and practice address or name and provider number of the practitioner who actually rendered the service; (Where the practitioner has more than one practice location recorded with the Department of Human Services, the provider number used should be that which is applicable to the practice location at or from which the service was given).

A medical or dental practitioner must notate 'certified dental patient' on the patient's account or include 'certified dental patient' in the text field when submitting a Medicare claim for benefits.

Where a practitioner wishes to apportion the total fee between the appropriate professional fee for the particular service and any balance outstanding in respect of services rendered previously, the practitioner should ensure that the balance is described in such a way (eg balance of account) that it cannot be mistaken as being a separate service. In particular no item number should be shown against the balance.

Only one original itemised account should be issued in respect of any one medical service and any duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

CN.0.6 Claiming of Benefits

Claiming Benefits

The patient, upon receipt of a practitioner's account, has three courses open for paying the account and receiving benefits as outlined below.

Paid Accounts

The patient may pay the account and subsequently present the receipt at a Medicare customer service centre for assessment and payment of the Medicare benefit in cash. In these circumstances, where a claimant personally attends a customer service centre, the claimant is not required to complete a Medicare Patient Claim Form (PC1).

In circumstances where the claimant is seeking a cheque payment of the Medicare benefit or is arranging for an agent to receive the Medicare benefit on the claimant's behalf, completion of a Medicare Patient Claim Form (PC1) is still required.

Unpaid and Partially Paid Accounts

Where the patient has not paid the account, the unpaid account may be presented to Medicare with a Medicare claim form. In this case Medicare will forward to the claimant a benefit cheque made payable to the practitioner.

It will be the patient's responsibility to forward the cheque to the practitioner and make arrangements for payment of the balance of the account if any. "Pay doctor" cheques involving Medicare benefits cannot be sent direct to practitioners or to patients at a practitioner's address (even if requested by the patient to do so). "Pay doctor" cheques will be forwarded to the claimant's last known address.

When issuing a receipt to a patient in respect of an account that is being paid wholly or in part by a Medicare "pay doctor" cheque the practitioner should indicate on the receipt that a "Medicare" cheque for $.....was involved in the payment of the account.

Assignment of Benefits (Direct-Billing) Arrangements

Under the Health Insurance Act the Assignment of Benefit (direct-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need. If a practitioner direct-bills, the practitioner undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:-

· The patient's Medicare card number must be quoted on all direct-bill forms for that patient.

· The basic forms provided are loose leaf to enable the patient details to be imprinted from the Medicare card.

· The forms include information required by Regulations under Subsection 19(6) of the Health Insurance Act.

· The practitioner must cause the particulars relating to the professional service to be set out on the assignment form before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it.

Where a patient is unable to sign the assignment form:

- the signature of the patient's parent, guardian or other responsible person (other than the doctor, doctor's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff) is acceptable; or

- In the absence of a "responsible person" the patient signature section should be left blank.

Where the signature space is either left blank or another person signs on the patient's behalf, the form **must** include:

- the notation "Patient unable to sign" and
- in the section headed 'Practitioner's Use', an explanation should be given as to why the patient was unable to sign (e.g. unconscious, injured hand etc.) and this note should be signed or initialled by the doctor. If in the opinion of the practitioner the reason is of such a "sensitive" nature that revealing it would constitute an unacceptable breach of patient confidentiality or unduly embarrass or distress the recipient of the patient's copy of the assignment of benefits form, a concessional reason "due to medical condition" to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific.

The administration of the direct-billing arrangements under Medicare as well as the payment of Medicare benefits on patient claims is the responsibility of **the Department of Human Services**. Any enquiries in regard to these matters should therefore be directed to Medicare offices or enquiry points.

Under Medicare any eligible dental practitioner can accept assignment of benefit and direct-bill for any eligible person.

Use of Medicare Cards in Direct Billing

An eligible person who applies to enrol for Medicare benefits (using a Medicare Enrolment/Amendment Application) will be issued with a uniquely numbered Medicare card which shows the Medicare card number, the patient identification number (reference number), the applicant's first given name, initial of second given name, surname and an effective "valid to" date. These cards may be issued on an individual or family basis. Up to 5 persons may be listed on the one Medicare card, and up to 9 persons may be listed under the one Medicare card number.

The Medicare card plays an important part in direct billing as it can be used to imprint the patient details (including Medicare number) on the basic direct-billing forms. A special Medicare imprinter has been developed for this purpose and is available free of charge, on request, from Medicare.

The patient details can of course be entered on the direct-bill forms by hand, but the use of a card to imprint patient details assists practitioners and ensures accuracy of information. The latter is essential to ensure that the processing of a claim by Medicare is expedited.

The Medicare card number must be quoted on direct-bill forms. If the number is not available, then the assignment of benefit facility should not be used. To do so would incur a risk that the patient is not eligible and Medicare benefits not payable.

Where a patient presents without a Medicare card and indicates that he/she has been issued with a card but does not know the details, the practitioner may contact a Medicare telephone enquiry number to obtain the number.

Assignment of Benefit Forms

To meet varying requirements the following types of stationery are available from Medicare. Note that these forms are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of the Department of Human Services.

(a) *Form DB2.* This form is used to assign benefits for services other than requested pathology. It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Patient copy and a Practitioner copy.

(b) *Form DB4.* Is a continuous stationery version of Form DB2, and has been designed for use on most office accounting machines.

The Claim for Assigned Benefits (Form DB1N, DB1H)

Practitioners who accept assigned benefits must claim from Medicare using either Claim for Assigned Benefits form DB1N or DB1H. The DB1N form should be used where services are rendered to persons for treatment provided out of hospital or day hospital treatment. The DB1H form should be used where services are rendered to persons while hospital treatment is provided in a hospital or day hospital facility (other than public patients). Both forms have been designed to enable benefit for a claim to be directed to a practitioner other than the one who rendered the services. The facility is intended for use in situations such as where a short term locum is acting on behalf of the principal doctor and setting the locum up with a provider number and pay-group link for the principal doctor's practice is impractical. Practitioners should note that this facility cannot be used to generate payments to or through a person who does not have a provider number.

The DB1N and DB1H are also loose leaf to enable imprinting of practitioner details using the special Medicare imprinter. For this purpose, practitioner cards, showing the practitioner's name, practice address and provider numbers are available from Medicare on request.

Direct-Bill Stationery

Medical practitioners and eligible dental practitioners wishing to direct-bill may obtain information on direct-bill stationery by telephoning **132150**. Information on the completion of the forms and direct-bill procedures are provided with the forms. Information on direct-billing is available from any Medicare office.

Time Limits Applicable to Lodgement of Claims for Assigned Benefits

A time limit of two years applies to the lodgement of claims with Medicare under the direct-billing (assignment of benefit) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than two years earlier than the date the claim was lodged with Medicare.

Provision exists whereby in certain circumstances (eg hardship cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

CN.0.7 Interpretation of the Cleft Lip and Cleft Palate Scheme

The prescribed services in this section have been grouped according to the general nature of the services: orthodontic, oral surgical and general and prosthodontic.

Each professional service listed in the Schedule is a complete medical service in itself. Where a service is rendered partly by one practitioner and partly by another, only the one amount of benefit is payable.

CN.0.8 Multiple Operation Rule

The Schedule fee for two or more operations performed on a patient on the one occasion is calculated by the following rule:-

· 100% for the item with the greatest Schedule fee, plus 50% for the item with the next greatest Schedule fee, plus 25% for each other item.

NOTE: 1. Fees so calculated which result in a sum which is not a multiple of 5 cents are taken to the next higher multiple of 5 cents.

2. Where two or more operations performed on the one occasion have fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.

3. The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

The above rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient by different dental practitioners unless either practitioner assists the other. In this case, the fees and benefits specified in the Schedule apply. For these purposes the term "operation" includes items 75200- 75615.

If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

CN.0.9 Administration of Anaesthetics

When a medical practitioner administers an anaesthetic in connection with a dental procedure prescribed for the payment of Medicare benefits (and the procedure has been performed by an eligible dental practitioner), Medicare benefits are payable for the administration of the anaesthetic on the same basis as if the procedure had been rendered by a medical practitioner.

To ascertain the Schedule fee for the anaesthetic, medical practitioners should refer to Group T10 - Relative Value Guide for Anaesthesia - of the Medicare Benefits Schedule Book.

CN.0.10 Definitions

Orthodontic treatment planning

Orthodontic treatment planning is defined as the measurement and analysis of the face and jaws and occlusion providing a diagnosis and planned prescription of appliances and treatment required.

Study models

Study models are defined as orthodontic plaster casts of the upper and lower teeth and alveolar processes.

CN.0.11 Referral of Oral and Maxillofacial Surgical Services - (Items 75150 to 75621)

Benefits are payable for items 75150 to 75621 only where the service has been rendered to a patient who has been referred by letter of Referral by an eligible orthodontist.

Item 75621 may be claimed in association with items 45720 to 45754 where the service is performed by a practitioner holding a FRACDS (OMS) qualification with access to Category 3 of the MBS.

CN.0.12 General and Prosthodontic Services - (Item 75800)

Item number 75800 refers to a consultation by a dentist for prevention and prophylaxis and includes such services as dietary advice, oral hygiene and fluoride treatment.

CN.0.13 Over-servicing

Over-servicing must be avoided. In the case of denture services, examples of over-servicing might be:-

· Unjustifiably frequent replacement of dentures;

· Provision of new dentures when relining or re-modelling of an existing prosthesis would meet the clinical need;

· Provision of metal dentures where an acrylic denture would meet the clinical need.

The Schedule includes an item for metal dentures to allow for the provision of a precise, long-term prosthesis. The item is not intended for use during the period of growth, where prostheses must be replaced or altered frequently, unless there is some definite and extraordinary clinical requirement.

CN.0.14 Commonwealth Department of Health Addresses

Postal : GPO Box 9848 in each Capital City

NEW SOUTH WALES

Level 7

1 Oxford Street

SYDNEY 2000 Tel (02) 9263 3555

VICTORIA

Casselden Place

2 Lonsdale Street

MELBOURNE 3000 Tel (03) 9665 8888

QUEENSLAND

5th Floor

Samuel Griffith Building

340 Adelaide Street

BRISBANE 4000 Tel (07) 3360 2555

SOUTH AUSTRALIA

Commonwealth Centre

55 Currie Street

ADELAIDE 5000 Tel (08) 8237 8111

WESTERN AUSTRALIA

152-158 St George's Terrace

PERTH 6000 Tel (08) 9346 5111

TASMANIA

Montpelier Building

21 Kirksway Place

BATTERY POINT 7004 Tel (03) 6221 1411

AUSTRALIAN CAPITAL TERRITORY

Alexander Building

Furzer Street

PHILLIP 2606 Tel (02) 6289 1555

NORTHERN TERRITORY

Cascom Centre

13 Scaturchio Street

CASUARINA 0800 Tel (08) 8946 3444

CN.1.1 Introduction - Medicare Benefits

The Medicare Benefits Schedule includes certain professional services in respect of the treatment of cleft lip and cleft palate conditions for which Medicare benefits are payable. These services are normally described as dental services. However, for the purposes of these Notes the word "medical" is to be interpreted to include "dental". The definition of professional service as contained in the Health Insurance Act provides that such a service must be "clinically relevant". A clinically relevant service means a service rendered by a medical or dental practitioner or optometrist that is generally accepted in the medical, dental or optometrical profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered.

Medicare benefits are payable in respect of services listed in the Schedule, when the services are rendered by eligible dental practitioners to prescribed dental patients.

The Schedule lists three categories of professional services:

· (Group C1) Orthodontic Services

· (Group C2) Oral and Maxillofacial Surgical Services

· (Group C3) General and Prosthodontic Services

CN.2.1 Dental Practitioner Eligibility

In order to attract Medicare benefits, all treatment must be carried out by eligible dental practitioners who are resident in Australia.

All registered dental practitioners are entitled to perform simple extraction services covered by Items 75200-75206 listed in Group C2 of the Schedule and the general and prosthodontic services listed in Group C3 of the Schedule.

Dental practitioners who wish to perform those orthodontic services listed in Group C1 of the Schedule must be registered in the specialty of orthodontics.

Dental practitioners who were previously accredited to provide Cleft Lip and Cleft Palate services who do not meet the registration requirements as a dental specialist will be grandfathered under legislative arrangements that came into force on 1 November 2012.

Oral and maxillofacial services listed in Group C2 may be performed by:

- Medical practitioners who are specialists in the practice of their specialty of oral and maxillofacial surgery; and

· Dental practitioners who were approved by the Minister prior to 1 November 2004 for the purposes of Subsection 3 (1) of the Act to carry out prescribed medical services (oral and maxillofacial surgery) contained in the Medicare Benefits Schedule.

- Following a referral from an eligible orthodontist.

CN.3.1 Patient Eligibility

To be eligible to claim benefits for Schedule services performed by eligible dental practitioners, a patient must satisfy the following criteria:

- 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.
- Under the provisions of Section 3BA of the Health Insurance Act a patient must be a prescribed dental patient, ie
  - a person aged up to 22 years, in respect of whom, has been certified as a prescribed dental patient by a medical practitioner or dental practitioner approved by the Minister, that the person is suffering from a cleft lip or cleft palate condition*;
  - a person aged up to 28 years, in respect of whom, prior to turning 22 years,
    - has been certified as a prescribed dental patient by a medical practitioner or dental practitioner approved by the Minister, that the person is suffering from a cleft lip or cleft palate condition*, and
    - that person commenced treatment for a cleft lip or cleft palate condition;
  - a person aged 28 and over requiring a specific course of treatment for the repair of previous reconstructive surgery, provided that:
    - i. prior to turning 22 years, in respect of whom, has been certified as a prescribed dental patient by a medical practitioner or dental practitioner approved by the Minister, that the person is suffering from a cleft lip or cleft palate condition*, and
    - ii. the person received treatment for a cleft lip or cleft palate condition prior to turning 28 years, and
    - iii. if the Minister has declared in writing that he or she is satisfied that:
      1. because of exceptional circumstances, the person required repair of previous reconstructive surgery in connection with the condition, and
      2. the person therefore needs to undergo that course of treatment; and
  - a person aged up to 22 years who has been certified as a prescribed dental patient by a medical practitioner or dental practitioner approved by the Minister, that the person is suffering from a condition determined by the Minister to be a condition to which the definition of a prescribed dental patient under Section 3BA of the Act applies.

In consultation with the professions, the Department of Health has completed a review of the conditions described as 'other' underpinning the Cleft Lip and Cleft Palate Scheme. A Ministerial Determination is now in place for these 'other' conditions, enabling the payment of Medicare benefits for the conditions listed below:

1. Oral and/or facial clefting	
Limited to	Cleft lip, alveolus and/or palate
	Tessier facial cleft
2. Congenital or hereditary craniofacial malformation, deformation or disruption	
Limited to	Achondroplasia
	Branchial arch disorders including: Hemifacial/craniofacial microsomia, Goldenhar syndrome, DiGeorge syndrome, Velocardiofacial syndrome
	CHARGE syndrome
	Congenital hemifacial hyperplasia
	Congenital lymphatic and/or vascular malformations of the head & neck, cystic hygroma, Sturge-Weber syndrome, excluding haemangiomas, birth marks and naevi.
	Craniofacial Neurofibromatosis Type 1
	Craniometaphyseal dysplasia

	Ectodermal dysplasia
	Hemifacial atrophy (Parry Romberg syndrome)
	Mandibulofacial dysostosis (Treacher Collins syndrome)
	Maxillonasal dysplasia (Binder syndrome)
	Oral-facial digital syndrome Type 1
	Pierre Robin sequence
	Rubinstein-Taybi syndrome
	Sphrintzen-Goldberg syndrome
	Solitary median maxillary central incisor syndrome
	Stickler syndrome
	Syndromic craniosynostoses including: Apert, Crouzon, Pfeiffer, Saethre Chotzen, and Muenke syndromes
	Trichorhinophalangeal syndrome Type 1
3. Hereditary conditions presenting with the absence of 6 (six) or more permanent teeth, excluding 3rd molars	
4. Hereditary conditions where the presence of supernumerary teeth is a major feature	
5. Hereditary conditions affecting the formation of enamel and/or dentine of all teeth	
Limited to	Amelogenesis imperfecta
	Dentinogenesis imperfecta
	Regional odontodysplasia

*Note: The above conditions have been listed in the terminology that they are generally known under. Some conditions are similar to, or otherwise known as, other conditions on the list.

Please contact the Department of Human Services on 132 150 if the condition is not listed here.

Application for special consideration of a condition not listed above:

Applications for special consideration of a condition not approved by the Minister should include the following:

m. a clinical report from the treating professional, describing the nature of the condition and an outline of the treatment to be undertaken;
n. a treatment plan devised by the treating professional, including:
    i. an indicative time period for which the patient requires treatment
    ii. date/s the treatment is expected to commence and
    iii. date/s the treatment is expected to be completed.
o. Imaging reports should also be provided, where available.

This information can be forwarded to the Department of Human Services (DHS) for special consideration of a condition by the Department of Health.

CN.3.2 Application for approval for repairs to previous reconstructive work

Applicants aged 28 and over seeking approval for repairs to previous reconstructive work under the Cleft Lip and Cleft Palate Scheme will be required to provide clinical details outlining the need for the repair of previous reconstructive surgery.

NOTE: *Patients aged over 28 years of age are not eligible to receive Medicare payments for treatment until approval from the Minister's delegate has been obtained.*

Applications should include the following:

· proof that the patient has been certified as a prescribed dental patient;

· a treatment plan devised by the treating professional, for the repair of the reconstructive surgery to be performed, including:

o an indicative time period for which patient eligibility for claiming related treatments should be reinstated

o date/s the treatment is expected to commence and

o date/s the treatment is expected to be completed.

· proof of previous eligibility and treatment under the Cleft Lip and Cleft Palate Scheme. This should take the form of a letter from the treating practitioner, which lists the patient details as follows:

o full name

o date of birth

o address

o condition

o date (or approximate) of original surgery

· a clinical report from the treating professional, describing the nature of the repair, information detailing the previous reconstructive surgery provided and an outline of the work to be undertaken.

This information will be forwarded to the Department of Human Services (DHS) for confirmation of eligibility.

Further information about the Scheme is available on the DHS' website at:

http://www.humanservices.gov.au/customer/services/medicare/cleft-lip-and-cleft-palate-scheme

Assessment of Applications

Assessment will take into account the information provided by the applicant and consider the circumstances surrounding each individual application. In the assessment, "previous reconstructive surgery" means surgery undertaken to repair structural defects in connection with a cleft lip or cleft palate condition. Repairs to this surgery must be in relation to the failure or deterioration of this surgery and due to that failure or deterioration, the patient requires further surgical intervention to restore optimal function.

Repair to previous reconstructive surgery may involve items in both the main Medicare Benefits Schedule, and items in the Cleft Lip and Cleft Palate Schedule. Under Section 3BA (2A), upon gaining the Minister's approval, applicants will have full access to items in the Cleft Lip and Cleft Palate Schedule that are necessary for the restoration of optimal function (provided the items are rendered by suitably qualified / approved practitioners).

Patients are eligible for Medicare benefits for treatment under the scheme once they are certified by a medical or dental practitioner as a prescribed dental patient.

CN.3.3 Visitors to Australia

Medicare benefits for the Cleft Lip and Cleft Palate Scheme are generally not payable to visitors to Australia or temporary residents.

CN.3.4 Health Care Expenses Incurred Overseas

Medicare does not cover medical or hospital expenses incurred outside Australia.

C1. ORTHODONTIC SERVICES	
	Group C1. Orthodontic Services
	Note: In this Group, benefit is only payable where the service has been rendered to a patient by a dental practitioner who is registered in the specialty of orthodontics, except for the services covered by Items 75009-75023 which may also be rendered by a medical practitioner who is a specialist in the practice of his or her specialty of oral and maxillofacial surgery. CONSULTATIONS INITIAL PROFESSIONAL ATTENDANCE in a single course of treatment by an eligible orthodontist (AO)
75001	**Fee:** $86.90 **Benefit:** 75% = $65.20 85% = $73.90
	PROFESSIONAL ATTENDANCE by an eligible orthodontist subsequent to the first professional attendance by the orthodontist in a single course of treatment (AO)
75004	**Fee:** $43.70 **Benefit:** 75% = $32.80 85% = $37.15
	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
75006	**Fee:** $77.45 **Benefit:** 75% = $58.10 85% = $65.85
	RADIOGRAPHY ORTHODONTIC RADIOGRAPHY orthopantomography (panoramic radiography), including any consultation on the same occasion
75009	**Fee:** $69.25 **Benefit:** 75% = $51.95 85% = $58.90
	ORTHODONTIC RADIOGRAPHY ANTEROPOSTERIOR CEPHALOMETRIC RADIOGRAPHY with cephalometric tracings OR LATERAL CEPHALOMETRIC RADIOGRAPHY with cephalometric tracings including any consultation on the same occasion
75012	**Fee:** $109.80 **Benefit:** 75% = $82.35 85% = $93.35
	ORTHODONTIC RADIOGRAPHY ANTEROPOSTERIOR AND LATERAL CEPHALOMETRIC RADIOGRAPHY, with cephalometric tracings including any consultation on the same occasion
75015	**Fee:** $150.95 **Benefit:** 75% = $113.25 85% = $128.35
75018	ORTHODONTIC RADIOGRAPHY ANTEROPOSTERIOR AND LATERAL CEPHALOMETRIC RADIOGRAPHY, with cephalometric tracings and orthopantomography including any consultation on

C1. ORTHODONTIC SERVICES	
	the same occasion **Fee:** $192.30 **Benefit:** 75% = $144.25 85% = $163.50
75021	ORTHODONTIC RADIOGRAPHY hand-wrist studies (including growth prediction) including any consultation on the same occasion **Fee:** $235.75 **Benefit:** 75% = $176.85 85% = $200.40
75023	INTRAORAL RADIOGRAPHY - single area, periapical or bitewing film **Fee:** $47.20 **Benefit:** 75% = $35.40 85% = $40.15
75024	PRESURGICAL INFANT MAXILLARY ARCH REPOSITIONING PRESURGICAL INFANT MAXILLARY ARCH REPOSITIONING including supply of appliances and all adjustments of appliances and supervision - WHERE 1 APPLIANCE IS USED **Fee:** $609.70 **Benefit:** 75% = $457.30 85% = $525.00
75027	PRESURGICAL INFANT MAXILLARY ARCH REPOSITIONING including supply of appliances and all adjustments of appliances and supervision WHERE 2 APPLIANCES ARE USED **Fee:** $836.05 **Benefit:** 75% = $627.05 85% = $751.35
75030	DENTITION TREATMENT MAXILLARY ARCH EXPANSION not being a service associated with a service to which item 75039, 75042, 75045 or 75048 applies, including supply of appliances, all adjustments of the appliances, removal of the appliances and retention **Fee:** $744.40 **Benefit:** 75% = $558.30 85% = $659.70
75033	MIXED DENTITION TREATMENT - incisor alignment using fixed appliances in maxillary arch, including supply of appliances, all adjustments of appliances, removal of the appliances and retention **Fee:** $1,220.15 **Benefit:** 75% = $915.15 85% = $1135.45
75034	MIXED DENTITION TREATMENT - incisor alignment with or without lateral arch expansion using a removable appliance in the maxillary arch, including supply of appliances, associated adjustments and retention **Fee:** $621.05 **Benefit:** 75% = $465.80 85% = $536.35
75036	MIXED DENTITION TREATMENT - lateral arch expansion and incisor alignment using fixed appliances in maxillary arch, including supply of appliances, all adjustments of appliances, removal of appliances and retention **Fee:** $1,685.30 **Benefit:** 75% = $1264.00 85% = $1600.60
75037	MIXED DENTITION TREATMENT - lateral arch expansion and incisor correction - 2 arch (maxillary and mandibular) using fixed appliances in both maxillary and mandibular arches, including supply of appliances, all adjustments of appliances, removal of appliances and retention **Fee:** $2,122.60 **Benefit:** 75% = $1591.95 85% = $2037.90
75039	PERMANENT DENTITION TREATMENT SINGLE ARCH (mandibular or maxillary) TREATMENT

C1. ORTHODONTIC SERVICES	
	(correction and alignment) using fixed appliances, including supply of appliances - initial 3 months of active treatment **Fee:** $564.15 **Benefit:** 75% = $423.15 85% = $479.55
75042	PERMANENT DENTITION TREATMENT - SINGLE ARCH (mandibular or maxillary) TREATMENT (correction and alignment) using fixed appliances, including supply of appliances - each 3 months of active treatment (including all adjustments and maintenance and removal of the appliances) after the first for a maximum of a further 33 months **Fee:** $210.85 **Benefit:** 75% = $158.15 85% = $179.25
75045	PERMANENT DENTITION TREATMENT 2 ARCH (mandibular and maxillary) TREATMENT (correction and alignment) using fixed appliances, including supply of appliances - initial 3 months of active treatment **Fee:** $1,129.35 **Benefit:** 75% = $847.05 85% = $1044.65
75048	PERMANENT DENTITION TREATMENT - 2 ARCH (mandibular and maxillary) TREATMENT (correction and alignment) using fixed appliances, including supply of appliances - each subsequent 3 months of active treatment (including all adjustments and maintenance, and removal of the appliances) after the first for a maximum of a further 33 months **Fee:** $289.60 **Benefit:** 75% = $217.20 85% = $246.20
75049	RETENTION, FIXED OR REMOVABLE, single arch (mandibular or maxillary) - supply of retainer and supervision of retention **Fee:** $338.95 **Benefit:** 75% = $254.25 85% = $288.15
75050	RETENTION, FIXED OR REMOVABLE, 2-arch (mandibular and maxillary) - supply of retainers and supervision of retention **Fee:** $654.35 **Benefit:** 75% = $490.80 85% = $569.65
75051	JAW GROWTH GUIDANCE JAW GROWTH guidance using removable or functional appliances, including supply of appliances and all adjustments to appliances **Fee:** $1,004.45 **Benefit:** 75% = $753.35 85% = $919.75
C2. ORAL AND MAXILLOFACIAL SERVICES	
	Group C2. Oral And Maxillofacial Services
75150	*Note: (i) In this Group, benefit is only payable where the service has been rendered to a patient who has been referred by an eligible orthodontist.* *(ii)While benefit is payable for simple extractions performed by a registered dental practitioner, benefit is only payable for surgical extractions and other surgical procedures where the service is rendered by a medical practitioner who is a specialist in the practice of his or her speciality of oral and maxillofacial surgery.* CONSULTATIONS

C2. ORAL AND MAXILLOFACIAL SERVICES	
	INITIAL PROFESSIONAL attendance in a single course of treatment by an eligible oral and maxillofacial surgeon where the patient is referred to the surgeon by an eligible orthodontist (AOS) **Fee:** $86.90 **Benefit:** 75% = $65.20 85% = $73.90
75153	PROFESSIONAL ATTENDANCE by an eligible oral and maxillofacial surgeon subsequent to the first professional attendance by the surgeon in a single course of treatment where the patient is referred to the surgeon by an eligible orthodontist **Fee:** $43.70 **Benefit:** 75% = $32.80 85% = $37.15
75156	PRODUCTION OF DENTAL STUDY MODELS (not being a service associated with a service to which item 75153 applies) prior to provision of a service: (a) to which item 52321, 53212 or 75618 applies; or (b) to which an item in the series 52330 to 52382, 52600 to 52630, 53400 to 53409 or 53415 to 53429 applies; in a single course of treatment if the patient is referred by an eligible orthodontist (AOS) **Fee:** $77.45 **Benefit:** 75% = $58.10 85% = $65.85
75200	SIMPLE EXTRACTIONS Removal of tooth or tooth fragment (other than treatment to which item 75400, 75403, 75406, 75409, 75412 or 75415 applies), if the patient is referred by an eligible orthodontist (AD) **Fee:** $55.80 **Benefit:** 75% = $41.85 85% = $47.45
75203	REMOVAL OF TOOTH OR TOOTH FRAGMENT under general anaesthesia, if the patient is referred by an eligible orthodontist (AD) **Fee:** $83.75 **Benefit:** 75% = $62.85 85% = $71.20
75206	Removal of each additional tooth or tooth fragment at the same attendance at which a service to which item 75200 or 75203 applies is rendered, if the patient is referred by an eligible orthodontist (AD) **Fee:** $27.80 **Benefit:** 75% = $20.85 85% = $23.65
75400	SURGICAL EXTRACTIONS Surgical removal of erupted tooth, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $167.40 **Benefit:** 75% = $125.55 85% = $142.30
75403	Surgical removal of tooth with soft tissue impaction, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $192.30 **Benefit:** 75% = $144.25 85% = $163.50
75406	Surgical removal of tooth with partial bone impaction, if the patient is referred by an eligible orthodontist (AOS)

C2. ORAL AND MAXILLOFACIAL SERVICES	
	Fee: $219.10 **Benefit:** 75% = $164.35 85% = $186.25
75409	Surgical removal of tooth with complete bone impaction, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $248.15 **Benefit:** 75% = $186.15 85% = $210.95
75412	Surgical removal of tooth fragment requiring incision of soft tissue only, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85
75415	Surgical removal of tooth fragment requiring removal of bone, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $167.40 **Benefit:** 75% = $125.55 85% = $142.30
75600	OTHER SURGICAL PROCEDURES Surgical exposure, stimulation and packing of unerupted tooth, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $235.75 **Benefit:** 75% = $176.85 85% = $200.40
75603	Surgical exposure of unerupted tooth for the purpose of fitting a traction device, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $277.10 **Benefit:** 75% = $207.85 85% = $235.55
75606	Surgical repositioning of unerupted tooth, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $277.10 **Benefit:** 75% = $207.85 85% = $235.55
75609	Transplantation of tooth bud, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $413.65 **Benefit:** 75% = $310.25 85% = $351.65
75612	Surgical procedure for intra oral implantation of osseointegrated fixture (first stage), if the patient is referred by an eligible orthodontist (AOS) **Fee:** $511.90 **Benefit:** 75% = $383.95 85% = $435.15
75615	Surgical procedure for fixation of trans mucosal abutment (second stage of osseointegrated implant), if the patient is referred by an eligible orthodontist (AOS) **Fee:** $189.50 **Benefit:** 75% = $142.15 85% = $161.10
75618	Provision and fitting of a bite rising appliance or dental splint for the management of temporomandibular joint dysfunction syndrome, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $235.30 **Benefit:** 75% = $176.50 85% = $200.05
75621	The provision and fitting of surgical template in conjunction with orthognathic surgical procedures in association with: (a) an item in the series: (i) 45720 to 45754; or

C2. ORAL AND MAXILLOFACIAL SERVICES	
	(ii) 52342 to 52375; or (b) item 52380 or 52382; if the patient is referred by an eligible orthodontist (AOS) **Fee:** $235.30 **Benefit:** 75% = $176.50 85% = $200.05
C3. GENERAL AND PROSTHODONTIC SERVICES	
	Group C3. General And Prosthodontic Services
75800	*Note: Benefit is payable for services listed in this Group where they are rendered by a registered dental practitioner* CONSULTATIONS ATTENDANCE BY AN ELIGIBLE DENTAL PRACTITIONER involving consultation, preventive treatment and prophylaxis, of not less than 30 minutes' duration each attendance to a maximum of 3 attendances in any period of 12 months (See para CN.0.12 of explanatory notes to this Category) **Fee:** $83.75 **Benefit:** 75% = $62.85 85% = $71.20
75803	PROSTHODONTIC PROVISION AND FITTING OF ACRYLIC BASE PARTIAL DENTURE, including retainers 1 TOOTH **Fee:** $335.05 **Benefit:** 75% = $251.30 85% = $284.80
75806	PROVISION AND FITTING OF ACRYLIC BASE PARTIAL DENTURE, including retainers 2 TEETH **Fee:** $392.95 **Benefit:** 75% = $294.75 85% = $334.05
75809	PROVISION AND FITTING OF ACRYLIC BASE PARTIAL DENTURE. including retainers 3 TEETH **Fee:** $465.30 **Benefit:** 75% = $349.00 85% = $395.55
75812	PROVISION AND FITTING OF ACRYLIC BASE PARTIAL DENTURE, including retainers 4 TEETH **Fee:** $517.00 **Benefit:** 75% = $387.75 85% = $439.45
75815	PROVISION AND FITTING OF ACRYLIC BASE PARTIAL DENTURE, including retainers 5 TO 9 TEETH **Fee:** $630.85 **Benefit:** 75% = $473.15 85% = $546.15
75818	PROVISION AND FITTING OF ACRYLIC BASE PARTIAL DENTURE, including retainers

C3. GENERAL AND PROSTHODONTIC SERVICES	
	10 TO 12 TEETH **Fee:** $744.40 **Benefit:** 75% = $558.30 85% = $659.70
75821	PROVISION AND FITTING OF CAST METAL BASE (cobalt chromium alloy) PARTIAL DENTURE including casting and retainers 1 TOOTH **Fee:** $599.60 **Benefit:** 75% = $449.70 85% = $514.90
75824	PROVISION AND FITTING OF CAST METAL BASE (cobalt chromium alloy) PARTIAL DENTURE including casting and retainers 2 TEETH **Fee:** $692.70 **Benefit:** 75% = $519.55 85% = $608.00
75827	PROVISION AND FITTING OF CAST METAL BASE (cobalt chromium alloy) PARTIAL DENTURE including casting and retainers 3 TEETH **Fee:** $796.30 **Benefit:** 75% = $597.25 85% = $711.60
75830	PROVISION AND FITTING OF CAST METAL BASE (cobalt chromium alloy) PARTIAL DENTURE including casting and retainers 4 TEETH **Fee:** $878.95 **Benefit:** 75% = $659.25 85% = $794.25
75833	PROVISION AND FITTING OF CAST METAL BASE (cobalt chromium alloy) PARTIAL DENTURE including casting and retainers 5 TO 9 TEETH **Fee:** $1,075.30 **Benefit:** 75% = $806.50 85% = $990.60
75836	PROVISION AND FITTING OF CAST METAL BASE (cobalt chromium alloy) PARTIAL DENTURE including casting and retainers 10 TO 12 TEETH **Fee:** $1,230.45 **Benefit:** 75% = $922.85 85% = $1145.75
75839	PROVISION AND FITTING OF RETAINERS not being a service associated with a service to which item 75803, 75806, 75809, 75812, 75815, 75818, 75821, 75824, 75827, 75830, 75833 or 75836 applies each retainer **Fee:** $27.80 **Benefit:** 75% = $20.85 85% = $23.65
75842	ADJUSTMENT OF PARTIAL DENTURE not being a service associated with a service to which item 75803, 75806, 75809, 75812, 75815, 75818, 75821, 75824, 75827, 75830, 75833 or 75836 applies **Fee:** $41.40 **Benefit:** 75% = $31.05 85% = $35.20
75845	RELINING OF PARTIAL DENTURE by laboratory process and associated fitting **Fee:** $206.90 **Benefit:** 75% = $155.20 85% = $175.90
75848	REMODELLING AND FITTING OF PARTIAL DENTURE of more than 4 teeth **Fee:** $248.15 **Benefit:** 75% = $186.15 85% = $210.95
75851	REPAIR TO CAST METAL BASE OF PARTIAL DENTURE 1 or more points **Fee:** $124.10 **Benefit:** 75% = $93.10 85% = $105.50
75854	ADDITION OF A TOOTH OR TEETH to a partial denture to replace extracted tooth or teeth including taking of necessary impression

C3. GENERAL AND PROSTHODONTIC SERVICES		
	Fee: $124.10	**Benefit:** 75% = $93.10 85% = $105.50

CATEGORY 8: MISCELLANEOUS SERVICES

SUMMARY OF CHANGES FROM 01/11/2019

The 01/11/2019 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

New Items

82350	82351	82352	82353	82354	82355	82356	82357	82358	82359	82360	82361	82362
82363	82364	82365	82366	82367	82368	82369	82370	82371	82372	82373	82374	82375
82376	82377	82378	82379	82380	82381	82382	82383					

New MBS items for Eating Disorders

This change will introduce, a suite of 64 Eating Disorder items to support a model of best practice evidence based care for patients with anorexia nervosa and other eligible patients with eating disorders.

MISCELLANEOUS SERVICES NOTES

MN.1.1 Additional Bulk Billing Payment for General Medical Services - (Items 10990 and 10991)

Item 10990 can only be claimed where all of the conditions set out in paragraphs (a) to (d) of item 10990 have been met.

Item 10991 can only be claimed where all of the conditions set out in paragraphs (a) to (e) of item 10991 have been met.

- Item 10991 can only be used where the service is provided at, or from, a practice location that is listed in item 10991. This includes all regional, rural and remote areas (RRMA 3 to 7 under the Rural Remote Metropolitan Areas classification system), all of Tasmania and those areas covered by a Statistical Subdivision (SSD) or Statistical Local Areas (SLA) listed in item 10991 (SSDs and SLAs are specified in the Australian Standard Geographical Classification (ASGC) 2002). If you are not sure whether your practice location is in an eligible area, you can call the Department of Human Services on 132 150.

- Practice location is the place associated with the medical practitioner's provider number from which the service has been provided. This includes services performed either at the medical practitioner's surgery, or those services performed away from the surgery using the provider number for that surgery (eg home visits or visits to aged care facilities).

- Where a medical practitioner has a practice location in both an eligible and ineligible area, item 10991 can only be claimed in respect of those services provided at, or from, the eligible practice location.

Item 10990 and item 10991 can only be used in conjunction with items in the General Medical Services Table of the MBS. There are similar items to be used in conjunction with diagnostic imaging services (item 64990 or 64991) or pathology services (item 74990 or 74991).

Item 10990 or item 10991 can be claimed for each item of service claimable under the MBS (other than diagnostic imaging services and pathology services), provided the conditions of the relevant item, 10990 or 10991, are satisfied. For example, item 10990 or 10991 can be claimed in conjunction with attendance items, procedural items (other than diagnostic imaging or pathology items) or services provided by a practice nurse on behalf of a medical practitioner (items 10983, 10984, 10986, 10987 and 10997). In some cases, this will mean that item 10990 or 10991 can be claimed more than once in respect of a patient visit.

Item 10990 or 10991 can not be claimed in conjunction with each other.

Where a Medicare benefit is not payable for a particular service (eg because the patient has exceeded the number of allowable services in a period of time), the additional bulk billing payment will not be paid for that service.

All GPs whether vocationally registered or not are eligible to claim the additional bulk billing payment.

Commonwealth concession card holder means a person listed on a Pensioner Concession Card, Health Care Card or Commonwealth Seniors Health Card issued by either Centrelink or the Department of Veterans' Affairs. Gold or White Cards issued by the Department of Veterans' Affairs do not attract the additional bulk billing payment. However, if a Gold or White Card holder also holds a recognised Commonwealth concession card and chooses to be treated under the Medicare arrangements, then that patient is an eligible concession card holder.

Unreferred service means a medical service provided to a patient by, or on behalf of, a medical practitioner, being a service that has not been referred to that practitioner by another medical practitioner or person with referring rights.

The Department of Human Services will undertake regular post payment auditing to ensure that the additional bulk billing payment is being claimed correctly. Centrelink data will be used to verify concessional status and Medicare records will be used to confirm patient age.

MN.1.2 After-hours services provided in areas eligible for the higher bulk billing payment - (Item 10992)

After-hours services provided in areas eligible for the higher bulk billing payment - (Item 10992)

Item 10992 can only be claimed where all of the conditions set out in paragraphs (a) to (g) of item 10992 have been met:

· Item 10992 must be claimed in conjunction with one of the items 585, 588, 591, 594, 599, 600, 761, 763, 766, 769, 772, 776, 788, 789, 5003, 5010, 5023, 5028, 5043, 5049, 5063, 5067, 5220, 5223, 5227, 5228, 5260, 5263 5265, or 5267. These items are for services provided after-hours outside of consulting rooms or hospital.

· Item 10992 can only be used where the service is provided in one of the eligible areas listed in item 10992 by a medical practitioner whose practice location (i.e. the location associated with the medical practitioner's provider number) is not in one of these areas.

Medical practitioners whose practice location is inside one of these listed locations should claim item 10991 for eligible services.

Item 10992 cannot be claimed in conjunction with item 10990 or 10991.

Where a Medicare benefit is not payable for a particular service the payment for item 10992 will not be paid for that service.

All GPs, whether vocationally recognised or not, are eligible to claim the additional bulk billing payment.

Commonwealth concession card holder means a person listed on a Pensioner Concession Card, Health Care Card or Commonwealth Seniors Health Card issued by either Centrelink or the Department of Veterans' Affairs. Gold or White Cards issued by the Department of Veterans' Affairs do not attract the additional bulk billing payment. However, if a Gold or White Card holder also holds a recognised Commonwealth concession card and chooses to be treated under the Medicare arrangements, then that patient is an eligible concession card holder.

Unreferred service means a medical service provided to a patient by, or on behalf of, a medical practitioner, being a service that has not been referred to that practitioner by another medical practitioner or person with referring rights.

The Department of Human Services will undertake regular post payment auditing to ensure that the additional bulk billing payment is being claimed correctly. Centrelink data will be used to verify concessional status and Medicare records will be used to confirm patient age.

MN.3.1 Individual Allied Health Services (Items 10950 to 10970) for Chronic Disease Management - Eligible Patients

ELIGIBLE PATIENTS

Medicare benefits are available for certain services provided by eligible allied health professionals to people with chronic conditions and complex care needs who are being managed by a GP or medical practitioner using certain Chronic Disease Management (CDM) Medicare items or are enrolled in a Health Care Home. The allied health services must be recommended in the patient's plan as part of the management of their chronic condition.

Chronic medical conditions and complex care needs

A chronic medical condition is one that has been or is likely to be present for at least six months, e.g. asthma, cancer, cardiovascular illness, diabetes mellitus, musculoskeletal conditions.and stroke. A patient is considered to have complex care needs if they require ongoing care from a multidisciplinary team consisting of their GP or medical practitioner and at least two other health or care providers.

Prerequisite CDM services

Patients must have received the following MBS CDM services:

· GP Management Plan - MBS GP item 721 or medical practitioner item 229 (or GP review item 732 or medical practitioner review item 233 for a review of a GPMP); and

· Team Care Arrangements - MBS GP item 723 or medical practitioner item 230 (or GP review items 732 or medical practitioner review item 233 for a review of TCAs)

Alternatively, for patients who are permanent residents of an aged care facility, their GP or medical practitioner must have contributed to, or contributed to a review of, a multidisciplinary care plan prepared for them by the aged care facility (MBS GP item 731 or medical practitioner item 232).

Alternatively, for patients who are enrolled with a Health Care Home, a shared care plan must have been prepared by the medical practitioner who is leading the patient's care.

For more information on the CDM planning items, refer to the explanatory notes for these items.

Allied health membership of a TCAs team

The allied health professional providing the service may be a member of the TCAs team convened by the GP or medical practitioner to manage a patient's chronic condition and complex care needs. However, the service may also be provided by an allied health professional who is not a member of the TCAs team, provided that the service has been identified as necessary by the patient's GP or medical practitioner and recommended in the patient's care plan/s.

Group services

In addition to individual services, patients who have type 2 diabetes may also access MBS items 81100 to 81125 which provide group allied health services. Patients only need to have MBS GP items 721 or 723 or medical practitioner items 229 or 230 or a Health Care Home shared care plan in place to be eligible for the group services.

MN.3.2 Individual Allied Health Services (Items 10950 to 10970) for Chronic Disease Management - Referral Requirements

Referral form

For Medicare benefits to be payable, the patient must be referred to an eligible allied health professional by their GP or medical practitioner using a referral form that has been issued by the Australian Government Department of Health or a form that contains all the components of this form.

The form issued by the department is available at www.health.gov.au/mbsprimarycareitems (click on the link for allied health individual services).

GPs and medical practitioners are encouraged to attach a copy of the relevant part of the patient's care plan to the referral form.

GPs and medical practitioners may use one referral form to refer patients for single or multiple services of the same service type (e.g. five chiropractic services). If referring a patient for single or multiple services of different service types (e.g. two dietetic services and three podiatry services), a separate referral form will be needed for each service type.

The patient will need to present the referral form to the allied health professional at the first consultation, unless the GP or medical practitioner has previously provided it directly to the allied health professional.

It is required that allied health professionals retain the referral form for 2 years from the date the service was rendered (for the Department of Human Services auditing purposes).

A copy of the referral form is not required to accompany Medicare claims, and allied health professionals do not need to attach a signed copy of the form to patients' itemised accounts/receipts or assignment of benefit forms.

Completed forms do not have to be sent to the Department of Health.

Health Care Home shared care plan

A Health Care Home shared care plan means a written plan that is prepared for a patient enrolled at a Health Care Home trial site; is prepared by a medical practitioner (including a general practitioner but not including a specialist or consultant physician) who is leading the patient's care at the Health Care Home trial site; and includes: an outline of the patient's agreed current and long-term goals; the person or people responsible for each activity; arrangements to review the plan by a day mentioned in the plan; and if authorised by the patient, arrangements for the transfer of information between the medical practitioner and other health care providers supporting patient care about the patient's condition or conditions and treatment. A Health Care Home Shared care plan must be kept for 2 years after the date it was created.

Referral validity

Medicare benefits are available for up to five allied health services per patient per calendar year. Where a patient receives more than the limit of five services in a calendar year, the additional service/s will not attract a Medicare benefit and the MBS Safety Net arrangements will not apply to costs incurred by the patient for the service/s.

If a patient has not used all of their allied health services under a referral in a calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total of five services for which the patient is eligible in that calendar year.

When patients have used all of their referred services, or require a referral for a different type of allied health service recommended in their CDM plan/s or Health Care Home shared care plan, they will need to obtain a new referral from their GP or medical practitioner. GPs and medical practitioners may choose to use this visit to undertake a review of the patient's CDM plan/s or, where appropriate, to manage the process using a GP/medical practitioner consultation item.

It is not necessary to have a new CDM plan/s prepared each calendar year in order to access a new referral/s for eligible allied health services. Patients continue to be eligible for rebates for allied health services while they are being managed under the prerequisite CDM items or Health Care Home shared care plan as long as the need for eligible services continues to be recommended in their plan. However, regular reviews using MBS GP item 732 or medical practitioner item 233 are encouraged.

MN.3.3 Individual Allied Health Services - (Items 10950 to 10970) for Chronic Disease Management - Eligible Providers and Services

Eligible allied health providers

The following allied health professionals are eligible to provide services under Medicare for patients with a chronic or terminal medical condition and complex care needs when they meet the provider eligibility requirements set out the next section and are registered with the Department of Human Services.

- Aboriginal and Torres Strait Islander health practitioners
- Aboriginal health workers
- Audiologists
- Chiropractors
- Diabetes educators

l. Dietitians

p. Exercise physiologists

vi. Mental health workers

v. Occupational therapists

l. Osteopaths

vii. Physiotherapists

vii. Podiatrists

h. Psychologists

o. Speech pathologists

Number of services per year

Medicare benefits are available for up to five allied health services per eligible patient, per calendar year. The five allied health services can be made up of one type of service (e.g. five physiotherapy services) or a combination of different types of services (e.g. one dietetic and four podiatry services). Five services per calendar year are the legal maximum per patient and exemptions to this are not possible.

Checking patient eligibility for allied health services

Patients seeking Medicare rebates for allied health services will need to have a valid referral form. If there is any doubt about a patient's eligibility, the Department of Human Services will be able to confirm the number of allied health services already claimed by the patient during the calendar year. The allied health professional or the patient can call the Department of Human Services to check this information (132 150 for provider enquiries; 132 011 for public enquiries).

Service length and type

Individual allied health services under Medicare for patients with a chronic medical condition and complex care needs (items 10950 to 10970) must be of at least 20 minutes duration and provided to an individual patient, not to a group. The allied health professional must personally attend the patient.

Reporting back to the Practitioner

Where an allied health professional provides a single service to the patient under a referral, they must provide a written report back to the referring GP or medical practitioner after each service.

Where an allied health professional provides multiple services to the same patient under the one referral, they must provide a written report back to the referring GP or medical practitioner after the first and last service only, or more often if clinically necessary. Written reports should include:

j. any investigations, tests, and/or assessments carried out on the patient;

vii. any treatment provided; and

vii. future management of the patient's condition or problem.

The report to the Practitioner must be kept for 2 years from the date of service.

Out-of-pocket expenses and Medicare Safety Net

Allied health professionals can determine their own fees for the professional service. Charges in excess of the Medicare benefit are the responsibility of the patient. However, out-of-pocket costs will count toward the Medicare Safety Net for that patient. Allied health services in excess of five in a calendar year will not attract a Medicare benefit and the Safety Net arrangements will not apply to costs incurred by the patient for such services.

Publicly funded services

Items 10950 to 10970 do not apply for services that are provided by any Commonwealth or state funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or state/territory government health clinic, items 10950 to 10970 can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, the service or health clinic. All requirements of the relevant item must be met, including registration of the allied health professional with the Department of Human Services. Medicare services provided under a subsection 19(2) exemption must be bulk billed (i.e. the Medicare rebate is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

MN.3.4 Individual Allied Health Services - (Items 10950 to 10970) for Chronic Disease Management - Professional Eligibility

The individual allied health items (10950 to 10970) can only be claimed for services provided by eligible allied health professionals who are registered with the Department of Human Services. To be eligible to register with the Department of Human Services to provide these services, allied health professionals must meet the specific eligibility requirements detailed below.

Aboriginal and Torres Strait Islander health practitioners must be registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia. Aboriginal and Torres Strait Islander health practitioners may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioners; Aboriginal and Torres Strait Islander health practitioners; or Torres Strait Islander health practitioners.

Aboriginal health workers in a State or Territory other than the Northern Territory must have been awarded either:

a. a Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care (or an equivalent or higher qualification) by a registered training organisation; or

b. a Certificate III in Aboriginal and Torres Strait Islander Health (or an equivalent or higher qualification) by a registered training organisation before 1 July 2012.

Note: Where individuals consider their qualification to be equivalent to or higher than the qualifications listed above, they will need to contact a registered training organisation in their State or Territory to have the qualification assessed as such before they can register with the Department of Human Services. In the Northern Territory, a practitioner must be registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia.

Audiologists must be either a 'Full Member' of the Audiological Society of Australia Inc (ASA), who holds a 'Certificate of Clinical Practice' issued by the ASA; or an 'Ordinary Member - Audiologist' or 'Fellow Audiologist' of the Australian College of Audiology (ACAud).

Diabetes educators must be a Credentialled Diabetes Educator (CDE) as credentialled by the Australian Diabetes Educators Association (ADEA).

Chiropractors must be registered with the Chiropractic Board of Australia.

Dietitians must be an 'Accredited Practising Dietitian' as recognised by the Dietitians Association of Australia (DAA).

Exercise physiologists must be an 'Accredited Exercise Physiologist' as accredited by Exercise and Sports Science Australia (ESSA).

Mental health workers

'Mental health' can include services provided by members of five different allied health professional groups. 'Mental health workers' are drawn from the following:

- psychologists;
- mental health nurses;
- occupational therapists;
- social workers;
- Aboriginal and Torres Strait Islander health practitioners; and
- Aboriginal health workers.

Psychologists, occupational therapists, Aboriginal and Torres Strait Islander health practitioners and Aboriginal health workers are eligible in separate categories for these items.

Mental health nurses must be a credentialled mental health nurse, as certified by the Australian College of Mental Health Nurses.

Mental health nurses who were registered in the ACT or Tasmania prior to the introduction of the National Registration and Accreditation Scheme (NRAS) on 1 July 2010, will have until 31 December 2010 to be certified by the Australian College of Mental Health Nurses.

Social workers must be a 'Member' of the Australian Association of Social Workers (AASW) and be certified by AASW as meeting the standards for mental health set out in the document published by AASW titled 'Practice Standards for Mental Health Social Workers' as in force on 8 November 2008.

Occupational therapists must be registered with the Occupational Therapy Board of Australia.

Osteopaths must be registered with the Osteopathy Board of Australia.

Physiotherapists must be registered with the Physiotherapy Board of Australia.

Podiatrists must be registered with the Podiatry Board of Australia.

Psychologists must hold general registration in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided.

Speech pathologists must be a 'Practising Member' of Speech Pathology Australia.

Registering with the Department of Human Services

Provider registration forms may be obtained from the Department of Human Services on 132 150 or at the Department of Human Services website.

Chiropractors, osteopaths, physiotherapists and podiatrists who were already registered with the Department of Human Services on 1 July 2004 to order diagnostic imaging under Medicare, do not need to re-register to provide services under this initiative. Allied health professionals registering with the Department of Human Services for the first time only need to fill in one application form which will give them rights to provide services under this initiative and order diagnostic imaging tests etc., where appropriate, under Medicare.

Changes to provider details

Allied health providers must notify the Department of Human Services in writing of all changes to mailing details to ensure that they continue to receive information about Medicare rebateable allied health services.

The individual allied health items (10950 to 10970) can only be claimed for services provided by eligible allied health professionals who are registered with the Department of Human Services. To be eligible to register with the Department of Human Services to provide these services, allied health professionals must meet the specific eligibility requirements detailed below.

MN.3.5 Individual Allied Health Services (10950 to 10970) for Chronic Disease Management - Further Information

Further information about Medicare Benefits Schedule items is available on the Department of Health's website at www.health.gov.au/mbsprimarycareitems

MN.6.1 Provision of Psychological Therapy Services by Clinical Psychologists - (Items 80000 TO 80021)

OVERVIEW

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative commenced on 1 November 2006. Under the Better Access initiative MBS items provide Medicare benefits for the following allied mental health services:

x. psychological therapy (items 80000 to 80021) - provided by eligible clinical psychologists; and
xi. focussed psychological strategies - allied mental health (items 80100 to 80171) - provided by eligible psychologists, occupational therapists and social workers.

MN.6.2 Psychological Therapy Services Attracting Medicare Rebates

Eligible psychological therapy services

There are eight MBS items for the provision of psychological therapy services to eligible patients by a clinical psychologist, including five items for face-to-face consultations and three items for video conference consultations. Clinical psychologists must meet the provider eligibility requirements set out below and be registered with the Department of Human Services.

In these notes, 'GP' means a medical practitioner, including a general practitioner, but not including a specialist or consultant physician.

Referrals and Referral Validity

Services provided under the Psychological Therapy items will not attract a Medicare rebate unless:

l. a referral has been made by a GP or medical practitioner who is managing the patient under a GP Mental Health Treatment Plan (GP items 2700, 2701, 2715, 2717 or medical practitioner items 272, 276, 281, 282);
m. a referral has been made by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan (item 291);
n. a referral has been made by a psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see Referral Requirements for further details regarding psychiatrist and paediatrician referrals); or
o. a referral has been made by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a Health Care Home shared care plan.

Health Care Home shared care plan

A Health Care Home shared care plan means a written plan that is prepared for a patient enrolled at a Health Care Home trial site; is prepared by a medical practitioner (including a general practitioner but not including a specialist or consultant physician) who is leading the patient's care at the Health Care Home trial site; and includes: an outline of the patient's agreed current and long-term goals; the person or people responsible for each activity; arrangements to review the plan by a day mentioned in the plan; and if authorised by the patient, arrangements for the transfer of

information between the medical practitioner and other health care providers supporting patient care about the patient's condition or conditions and treatment.

Number of services per year

Medicare rebates are available for up to 10 individual allied mental health services in a calendar year. The 10 services may consist of: GP/medical practitioner focussed psychological strategies services (GP items 2721 to 2727 or medical practitioner items 283 to 287); and/or psychological therapy services (items 80000 to 80015); and/or focussed psychological strategies - allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165).

Referrals should be provided, as required, for an initial course of treatment (a maximum of six services but may be less depending on the referral and patient need) to a maximum of 10 services per calendar year. For the purposes of these services, a course of treatment will consist of the number of services stated in the patient's referral (up to a maximum of six in any one referral).

Patients will also be eligible to claim up to 10 separate services within a calendar year for group therapy services involving 6-10 patients to which items 80020 (psychological therapy - clinical psychologist), 80021 (psychological therapy by video conference - clinical psychologist), 80120 (focussed psychological strategies - psychologist), 80121 (focussed psychological strategies by video conference - psychologist), 80145 (focussed psychological strategies - occupational therapist) , 80146 (focussed psychological strategies by video conference - occupational therapist), 80170 (focussed psychological strategies - social worker) and 80171 (focussed psychological strategies by video conference - social worker) apply. These group services are separate from the individual services and do not count towards the 10 individual services per calendar year maximum associated with those items.

In the instance where a patient has received the 10 psychological therapy services (items 80000 to 80021), focussed psychological services -allied mental health services (items 80100 to 80171) or GP/medical practitioner focussed psychological strategies services (GP items 2721 to 2727 or medical practitioner items 283 to 287) available under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative per calendar year and is considered to clinically benefit from some additional services, the patient may be eligible for Primary Health Networks (PHNs) funded psychological therapies if they meet relevant eligibility criteria for the PHN commissioned services. It is recommended that providers refer to their PHN for further guidance.

Service length and type

Services provided by eligible clinical psychologists under these items must be within the specified time period within the item descriptor. The clinical psychologist must personally attend the patient face-to-face, or by video conference for items 80001, 80011, 80021, 80101, 80111, 80121, 80126, 80136, 80146, 80151, 80161 and 80171.

It is expected that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

In addition to psycho-education, it is recommended that cognitive-behaviour therapy be provided. However, other evidence-based therapies ─ such as interpersonal therapy ─ may be used if considered clinically relevant.

Course of treatment and reporting back to the referring medical practitioner

Patients are eligible to receive up to 10 individual services and up to 10 group sessions in a calendar year.

Within this maximum service allocation, the clinical psychologist can provide one or more courses of treatment. For the purposes of these services, a course of treatment consists of the number of services stated in the patient's referral (up to a maximum of six in any one referral). This enables the referring medical practitioner to consider a report from the clinical psychologist on the services provided to the patient, and the need for further treatment.

On completion of the initial course of treatment, the clinical psychologist must provide a written report to the referring GP or medical practitioner, which includes information on:

k. assessments carried out on the patient;

l. treatment provided; and
m. recommendations on future management of the patient's disorder.

A written report must also be provided to the referring GP or medical practitioner at the completion of any subsequent course(s) of treatment provided to the patient.

Out of pocket expenses and Medicare safety net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, if a service was provided out-of-hospital, any out-of-pocket costs will count towards the Medicare safety net for that patient. The out-of-pocket costs for mental health services which are not Medicare eligible do not count towards the Medicare safety net.

Eligible patients

Items 80000 to 80021 (inclusive) apply to people with an assessed mental disorder and where the patient is referred by a GP or medical practitioner who is managing the patient under a GP Mental Health Treatment Plan (GP items 2700, 2701, 2715, 2717 or medical practitioner items 272, 276, 281, 282), under a Health Care Home shared care plan, under a referred psychiatrist assessment and management plan (item 291), or on referral from an eligible psychiatrist or paediatrician.

The conditions classified as mental disorders for the purposes of these services are informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. For the purposes of these items, dementia, delirium, tobacco use disorder and mental retardation are not regarded as a mental disorder.

Checking patient eligibility for psychological therapy services

Patients seeking Medicare rebates for psychological therapy services will need to have a referral from a GP, medical practitioner, psychiatrist or paediatrician. If there is any doubt about a patient's eligibility, the Department of Human Services will be able to confirm whether a GP Mental Health Treatment Plan; shared care plan and/or a psychiatrist assessment and management plan is in place and claimed; or an eligible psychiatric or paediatric service has been claimed, as well as the number of allied mental health services already claimed by the patient during the calendar year.

Clinical psychologists can call the Department of Human Services on 132 150 to check this information, while unsure patients can seek clarification by calling 132 011.

The patient will not be eligible if they have not been appropriately referred and a relevant Medicare service provided to them. If the referring service has not yet been claimed, the Department of Human Services will not be aware of the patient's eligibility. In this case the clinical psychologist should, with the patient's permission, contact the referring practitioner to ensure the relevant service has been provided to the patient.

Publicly funded services

Psychological therapy items 80000 to 80021 do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or state/territory clinic, the items apply for services that are provided by eligible clinical psychologists salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with the Department of Human Services. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

MN.6.3 Referral Requirements (GPs, Medical Practitioners, Psychiatrists or Paediatricians to Clinical Psychologists for Psychological Therapy)

Referrals

Patients must be referred for psychological therapy services by a GP or medical practitioner managing the patient under a GP Mental Health Treatment Plan (GP items 2700, 2701, 2715, 2717 or medical practitioner items 272, 276, 281, 282), or a referred psychiatrist assessment and management plan (item 291); on referral from a psychiatrist or a paediatrician; or a Health Care Home shared care plan.

Referrals from psychiatrists and paediatricians must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 133.

Referring practitioners are not required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible clinical psychologist signed and dated by the referring practitioner.

The clinical psychologist must be in receipt of the referral at the first allied mental health consultation. It is recommended that the clinical psychologist retain the referral for 24 months from the date the service was rendered (for the Department of Human Services auditing purposes).

Health Care Home shared care plan

A Health Care Home shared care plan means a written plan that is prepared for a patient enrolled at a Health Care Home trial site; is prepared by a medical practitioner (including a general practitioner but not including a specialist or consultant physician) who is leading the patient's care at the Health Care Home trial site; and includes: an outline of the patient's agreed current and long-term goals; the person or people responsible for each activity; arrangements to review the plan by a day mentioned in the plan; and if authorised by the patient, arrangements for the transfer of information between the medical practitioner and other health care providers supporting patient care about the patient's condition or conditions and treatment.

The Health Care Home shared care plan should also include a record of the patient's agreement to mental health services; an outline of assessment of the patient's mental disorder, including the mental health formulation and diagnosis or provisional diagnosis; and if appropriate, a plan for one or more of crisis intervention and relapse prevention.

Referral validity

Medicare benefits are available for up to 10 individual and/or 10 group psychological therapy services and/or focussed psychological strategies services per patient per calendar year.

Referrals should be provided, as required, for an initial course of treatment (a maximum of six services but may be less depending on the referral and the patient's clinical need) to a maximum of 10 services per calendar year. For the purposes of these services, a course of treatment will consist of the number of services stated in the patient's referral (up to a maximum of six in any one referral).

If a patient has not used all of their psychological therapy services and/or focussed psychological strategies services under a referral in a calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total of 10 services for which the patient is eligible in that calendar year.

When patients have used all of their referred services they will need to obtain a new referral from the referring practitioner if they are eligible for further services. Where the patient's care is being managed by a GP or medical practitioner, the GP/medical practitioner may choose to use this visit to undertake a review of the patient's GP Mental Health Treatment Plan, Health Care Home shared care plan, and/or psychiatrist assessment and management plan.

It is not necessary to have a new GP Mental Health Treatment Plan, Health Care Home shared care plan, and/or psychiatrist assessment and management plan prepared each calendar year in order to access a new referral(s) for eligible psychological therapy services and/or focussed psychological strategies services. Patients continue to be eligible for rebates for psychological therapy services and/or focussed psychological strategies services while they are being managed under a GP Mental Health Treatment Plan, Health Care Home shared care plan, and/or a psychiatrist assessment and management plan as long as the need for eligible services continues to be recommended in their plan.

MN.6.4 Clinical Psychologist Professional Eligibility

Eligible clinical psychologists

A person is an allied health professional in relation to the provision of a psychological therapy health service if the person:

- o. holds general registration in the health profession of psychology under the applicable law in force in the state or territory in which the service is provided; and
- p. is endorsed by the Psychology Board of Australia to practice in clinical psychology.

Until 31 October 2015, a person was also an allied health professional in relation to the provision of a psychological therapy health service if the person:

- g. holds general registration in the health profession of psychology under the applicable law in force in the state or territory in which the service is provided; and
- h. on 31 October 2015 was an allied health professional in relation to the provision of a psychological therapy health service because the person:
  - i. was a member of the College of Clinical Psychologists of the Australian Psychological Society; or
  - ii. had been assessed by the College of Clinical Psychologists of the Australian Psychological Society as meeting the requirements for membership of that College.

The clinical psychologist must be registered with the Department of Human Services.

Registering with the Department of Human Services

Advice about registering with the Department of Human Services to provide psychological therapy services using items 80000-80021 inclusive is available from the Department of Human Services provider inquiry line on 132 150.

Further information

For further information about Medicare Benefits Schedule items, please go to the Department of Health's website at www.health.gov.au/mbsonline.

For providers, further information is also available for providers from the Department of Human Services provider inquiry line on 132 150.

MN.6.5 Telehealth Psychological Therapy Services

These notes provide information on the telehealth psychological therapy MBS video consultation items by clinical psychologists. A video consultation involves a single clinical psychologist attending a patient, or a group of 6 to 10 patients.

MBS item numbers 80001 and 80011 provide for attendance via videoconferencing by a clinical psychologist to an individual patient. MBS item number 80021 provide for attendance via videoconferencing by a clinical psychologist to a group of 6 to 10 patients. The items are stand-alone items and do not have a derived fee.

These therapies are time limited, being deliverable in up to 10 planned sessions in a calendar year (including services to which items 80001, 80011, 80101, 80111, 80126, 80136, 80151 and 80161 apply).

Patients will also be eligible to claim up to 10 separate services within a calendar year for group therapy services involving 6-10 patients to which items 80021 (psychological therapy via video conference – clinical psychologist), 80121 (focussed psychological strategies via video conference – psychologist), 80146 (focussed psychological strategies via video conference – occupational therapist) and 80171 (focussed psychological strategies via video conference – social worker) apply. These group services are separate from the individual services and do not count towards the 10 individual services per calendar year maximum associated with those items.

Clinical indications

The clinical psychologist must be satisfied that it is clinically appropriate to provide a video consultation to a patient, or a group of 6 to 10 patients.

Restrictions

The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes hospital in the home patients). Benefits are not payable for telephone or email consultations. In order to fulfil the item descriptor there must be a visual and audio link between the patient and the remote clinical psychologist. If the remote clinical psychologist is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Billing Requirements

All video consultations provided by clinical psychologists must be separately billed. That is, only the relevant telehealth MBS consultation item is to be itemised on the account/bill/voucher. Any other service/item billed should be itemised on a separate account/bill/voucher. This will ensure the claim is accurately assessed as being a video consultation and paid accordingly.

Clinical psychologists should not use the notation ‘telehealth’, ‘verbal consent’ or ‘Patient unable to sign’ to overcome administrative difficulties to obtaining a patient signature for bulk-billed claims (for further information see mbsonline.gov.au/telehealth).

Eligible Geographical Areas

Geographic eligibility for psychological telehealth services funded under Medicare (in Groups M6 and M7) is determined according to the Modified Monash Model (MMM) classifications. Telehealth Eligible Areas are those areas that are within MMM classifications 4 to 7. Patients and providers are able to check their eligibility using the Modified Monash Model locator on the Department of Health’s website (http://www.health.gov.au/internet/otd/publishing.nsf/Content/MMM_locator).

There is a requirement for the patient and clinical psychologist to be located a minimum of 15 kilometres apart at the time of the consultation. Minimum distance between clinical psychologist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the clinical psychologist is not permitted to travel to an area outside the minimum 15 kilometres distance in order to claim a video consultation.

Record Keeping

Participating telehealth clinical psychologists must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Extended Medicare Safety Net (EMSN)

All telehealth consultations (with the exception of the participating optometrist telehealth items) are subject to EMSN caps. The EMSN caps for telehealth consultation items in Groups M6 and M7 are equal to 300% of the schedule fee (to a maximum of $500).

Aftercare Rule

Video consultations are subject to the same aftercare rules as clinical psychologists providing face-to-face consultations.

Multiple attendances on the same day

In some situations a patient may receive a consultation via video conference and a face-to-face consultation by the same or different clinical psychologist on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same clinical psychologist, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Clinical psychologists will need to provide the times of each consultation on the patient's account or bulk-billing voucher.

Referrals

The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Technical requirements

In order to fulfil the item descriptor there must be a visual and audio link between the patient and the remote clinical psychologist. If the remote clinical psychologist is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

MN.7.1 Provision of Focussed Psychological Strategies Services by Allied Health Providers - (Items 80100 to 80170)

OVERVIEW

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative commenced on 1 November 2006. Under the Better Access initiative MBS items provide Medicare benefits for the following allied mental health services:

g. psychological therapy (items 80000 to 80021) - provided by eligible clinical psychologists; and
h. focussed psychological strategies – allied mental health (items 80100 to 80171) - provided by eligible psychologists, occupational therapists and social workers.

FOCUSSED PSYCHOLOGICAL STRATEGIES – ALLIED MENTAL HEALTH SERVICES ATTRACTING MEDICARE REBATES

Eligible focussed psychological strategies services

There are 24 MBS items for the provision of focussed psychological strategies (FPS) - allied mental health services to eligible patients by allied health professionals:

h. 80100, 80105, 80110, 80115 and 80120 for provision of FPS services by a psychologist;
i. 80101, 80111 and 80121 for provision of video conference FPS services by a psychologist;
j. 80125, 80130, 80135, 80140 and 80145 for provision of FPS services by an occupational therapist;

k. 80126, 80136 and 80146 for provision of video conference FPS services by an occupational therapist;
l. 80150, 80155, 80160, 80165 and 80170 for provision of FPS services by a social worker; and
m. 80151, 80161 and 80171 for provision of video conference FPS services by a social worker.

The allied health professional must meet the provider eligibility requirements set out below and be registered with the Department of Human Services.

In these notes, 'GP' means a medical practitioner, including a general practitioner, but not including a specialist or consultant physician.

Referrals and Referral Validity

Services provided under the focussed psychological strategies – allied mental health items will not attract a Medicare rebate unless:

h. a referral has been made by a GP or medical practitioner who is managing the patient under a GP Mental Health Treatment Plan (GP items 2700, 2701, 2715, 2717 or medical practitioner items 272, 276, 281, 282);
i. a referral has been made by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan;
j. a referral has been made by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or
k. a referral has been made by a psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see Referral Requirements for further details regarding psychiatrist and paediatrician referrals).

Number of services per year

Medicare rebates are available for up to 10 individual allied mental health services in a calendar year. The 10 services may consist of: GP or medical practitioner focussed psychological strategies services (GP items 2721 to 2727 or medical practitioner items 283 to 287); and/or psychological therapy services (items 80000 to 80015); and/or focussed psychological strategies - allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165.

Referrals should be provided, as required, for an initial course of treatment (a maximum of six services but may be less depending on the referral and patient need) to a maximum of 10 services per calendar year. For the purposes of these services, a course of treatment will consist of the number of services stated in the patient's referral (up to a maximum of six in any one referral).

Patients will also be eligible to claim up to 10 separate services within a calendar year for group therapy services involving 6-10 patients to which items 80020 (psychological therapy – clinical psychologist), 80021 (psychological therapy via video conference – clinical psychologist), 80120 (focussed psychological strategies – psychologist), 80121 (focussed psychological strategies via video conference – psychologist), 80145 (focussed psychological strategies – occupational therapist), 80146 (focussed psychological strategies via video conference – occupational therapist), 80170 (focussed psychological strategies - social worker) and 80171 (focussed psychological strategies via video conference – social worker) apply. These group services are separate from the individual services and do not count towards the 10 individual services per calendar year maximum associated with those items.

In the instance where a patient has received the 10 psychological therapy services (items 80000 to 80021), focussed psychological services-allied mental health services (items 80100 to 80171) or GP or medical practitioner focussed psychological strategies services (GP items 2721 to 2727 or medical practitioner items 283 to 287) available under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative per calendar year and is considered to clinically benefit from some additional services, the patient may be eligible for Primary Health Networks (PHNs) funded psychological therapies if they meet relevant eligibility criteria for the PHN commissioned services. It is recommended that providers refer to their PHN for further guidance.

Service length and type

Services provided by eligible allied health professionals under these items must be within the specified time period within the item descriptor. The allied mental health professional must personally attend the patient the patient face to face, or via video conference for items 80001, 80011, 80021, 80101, 80111, 80121, 80126, 80136, 80146, 80151, 80161 and 80171.

It is expected that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

A range of acceptable strategies has been approved for use by allied mental health professionals utilising the FPS items.

These are:

1. Psycho-education
(including motivational interviewing)
2. Cognitive-behavioural therapy including:
· **Behavioural interventions**
- Behaviour modification
- Exposure techniques
- Activity scheduling
· **Cognitive interventions**
- Cognitive therapy
3. Relaxation strategies
- Progressive muscle relaxation
- Controlled breathing
4. Skills training
- Problem solving skills and training
- Anger management
- Social skills training
- Communication training
- Stress management
- Parent management training
5. Interpersonal therapy (especially for depression)
6. Narrative therapy (for Aboriginal and Torres Strait Islander people).

Course of treatment and reporting back to the referring medical practitioner

Patients are eligible to receive up to 10 individual services and up to 10 group sessions in a calendar year.

Within this maximum service allocation, the allied mental health professional can provide one or more courses of treatment. For the purposes of these services, a course of treatment consists of the number of services stated in the patient’s referral (up to a maximum of six services in any one referral). This enables the referring medical practitioner to consider a report from the allied mental health professional on the services provided to the patient, and the need for further treatment.

On completion of the initial course of treatment, the allied mental health professional must provide a written report to the referring medical practitioner, which includes information on:

m. assessments carried out on the patient;
n. treatment provided; and
o. recommendations on future management of the patient's disorder.

A written report must also be provided to the referring medical practitioner at the completion of any subsequent course(s) of treatment provided to the patient.

Out-of-pocket expenses and Medicare safety net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, if a service was provided out of hospital, any out-of-pocket costs will count towards the Medicare safety net for that patient. The out-of-pocket costs for mental health services which are not Medicare eligible do not count towards the Medicare safety net.

Eligible patients

Items 80100 to 80171 (inclusive) apply to people with an assessed mental disorder and where the patient is referred by a GP or medical practitioner who is managing the patient under a GP Mental Health Treatment Plan (GP items 2700, 2701, 2715, 2717 or medical practitioner items 272, 276, 281, 282) under a referred psychiatrist assessment and management plan (item 291) or Health Care Home shared care plan; or from an eligible psychiatrist or paediatrician.

The conditions classified as mental disorders for the purposes of these services are informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. For the purposes of these items, dementia, delirium, tobacco use disorder and mental retardation are not regarded as a mental disorder.

Checking patient eligibility for focussed psychological strategies – allied mental health services

Patients seeking Medicare rebates for focussed psychological strategies – allied mental health services will need to have a referral from a GP, medical practitioner, psychiatrist or paediatrician. If there is any doubt about a patient's eligibility, the Department of Human Services will be able to confirm whether a GP Mental Health Treatment Plan, Health Care Home shared care plan and/or a psychiatrist assessment and management plan is in place and claimed; or an eligible psychiatric or paediatric service has been claimed, as well as the number of allied mental health services already claimed by the patient during the calendar year.

Allied mental health professionals can call the Department of Human Services on 132 150 to check this information, while unsure patients can seek clarification by calling 132 011.

The patient will not be eligible if they have not been appropriately referred and a relevant Medicare service provided to them. If the referring service has not yet been claimed, the Department of Human Services will not be aware of the patient's eligibility. In this case the allied mental health professional should, with the patient's permission, contact the referring practitioner to ensure the relevant service has been provided to the patient.

Publicly funded services

Focussed psychological strategies (FPS) services items 80100 to 80171 do not apply for services that are provided by any other Commonwealth or state funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or state/territory clinic, the FPS services items apply for services that are provided by eligible allied mental health professionals salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with the Department of Human Services. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

REFERRAL REQUIREMENTS (GPs, MEDICAL PRACTITIONERS, PSYCHIATRISTS OR PAEDIATRICIANS TO ALLIED MENTAL HEALTH PROFESSIONALS)

Referrals

Patients must be referred for focussed psychological strategies – allied mental health services by either a GP or medical practitioner managing the patient under a GP Mental Health Treatment Plan (GP items 2700, 2701, 2715, 2717 or medical practitioner items 272, 276, 281, 282), a Health Care Home shared care plan or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or on referral from a psychiatrist or a paediatrician.

Referrals from psychiatrists and paediatricians must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 133.

Referring practitioners are not required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible allied mental health professional signed and dated by the referring practitioner.

The allied mental health professional must be in receipt of the referral at the first allied mental health consultation. It is required that the allied health professional retain the referral for 24 months from the date the service was rendered (for the Department of Human Services auditing purposes).

Referral validity

Medicare benefits are available for up to 10 individual and/or 10 group psychological therapy services and/or focussed psychological strategies services per patient per calendar year.

Referrals should be provided, as required, for an initial course of treatment (a maximum of six services but may be less depending on the referral and the patient's clinical need) to a maximum of 10 services per calendar year. For the purposes of these services, a course of treatment will consist of the number of services stated in the patient's referral (up to a maximum of six in any one referral).

If a patient has not used all of their psychological therapy services and/or focussed psychological strategies services under a referral in a calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total of 10 services for which the patient is eligible in that calendar year.

When patients have used all of their referred services they will need to obtain a new referral from the referring practitioner if they are eligible for further services. Where the patient's care is being managed by a GP or medical practitioner, the GP/medical practitioner may choose to use this visit to undertake a review of the patient's GP Mental Health Treatment Plan, Home Health Care shared care plan and/or psychiatrist assessment and management plan.

It is not necessary to have a new GP Mental Health Treatment Plan, Home Health Care shared care plan and/or psychiatrist assessment and management plan prepared each calendar year in order to access a new referral(s) for eligible psychological therapy services and/or focussed psychological strategies services. Patients continue to be eligible for rebates for psychological therapy services and/or focussed psychological strategies services while they are being managed under a GP Mental Health Treatment Plan, Home Health Care shared care plan and/or a psychiatrist assessment and management plan as long as the need for eligible services continues to be recommended in their plan.

Health Care Home shared care plan

A Health Care Home shared care plan means a written plan that is prepared for a patient enrolled at a Health Care Home trial site; is prepared by a medical practitioner (including a general practitioner but not including a specialist

or consultant physician) who is leading the patient's care at the Health Care Home trial site; and includes: an outline of the patient's agreed current and long-term goals; the person or people responsible for each activity; arrangements to review the plan by a day mentioned in the plan; and if authorised by the patient, arrangements for the transfer of information between the medical practitioner and other health care providers supporting patient care about the patient's condition or conditions and treatment. Additionally, a Health Care Home shared care plan must include a record of the patient's agreement to mental health services; an outline of assessment of the patient's mental disorder, including the mental health formulation and diagnosis or provisional diagnosis; and if appropriate, a plan for one or more of crisis intervention and relapse prevention.

ALLIED MENTAL HEALTH PROFESSIONAL ELIGIBILITY

Eligible allied health professionals

A person is an allied health professional in relation to the provision of a FPS service if the person meets one of the following requirements:

o. the person is a psychologist who holds general registration in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided;
p. the person is a member of the Australian Association of Social Workers (AASW) and certified by AASW as the meeting the standards for mental health set out in the document published by AASW titled 'Practice Standards for Mental Health Social Workers 2014' as in force on 25 September 2014;
q. the person:
    a. is an occupational therapist who is registered as a person who may provide that kind of service under the applicable law in force in the State or Territory in which the service is provided; and
    b. is accredited by Occupational Therapy Australia as:
        i. having a minimum of two years experience in mental health; and
        ii. having undertaken to observe the standards set out in the document published by Occupational Therapy Australia's 'Australian Competency Standards for Occupational Therapists in Mental Health' as in force on 1 November 2006.

Continuing professional development (CPD) for Occupational Therapists and Social Workers providing focussed psychological strategies (FPS) services

Occupational Therapists and Social Workers providing FPS services are required to have completed 10hours FPS CPD.

A CPD year for the purposes of these items is from 1 July to 30 June annually.

Part-time allied mental health professionals are required to have 10 hours of FPS related CPD, the same as full-time allied mental health professionals.

Occupational Therapists and Social Workers who are registered during the course of the CPD year, their obligation to undertake CPD will be on a pro-rata basis. The amount of units will be calculated from the 1st of the month immediately succeeding the month they obtained initial registration. The obligation will be one-twelfth of the yearly requirement for each month.

CPD activities must be relevant to delivering FPS services. Acceptable CPD activities where the content is related to FPS can include formal postgraduate education, workshops, seminars, lectures, journal reading, writing papers, receipt of supervision and peer consultation, and online training.

There is flexibility in the CPD activities that can be undertaken to meet individual professional needs and their practice/client base and client needs. For example, activities could also include assessment and treatment of specific disorders and client types such as youth, or different modalities and delivery such as working with groups.

Registering with the Department of Human Services

Advice about registering with the Department of Human Services to provide focussed psychological strategies - allied mental health services using items 80100-80171 inclusive is available from the Department of Human Services provider inquiry line on 132 150.

Further information

For further information about Medicare Benefits Schedule items, please go to the Department of Health's website at www.health.gov.au/mbsonline

For providers, further information is also available for providers from the Department of Human Services provider inquiry line on 132 150.

The Department of Human Services (DHS) has developed a Health Practitioner Guideline to substantiate that a valid Allied Mental Health service has been provided (for allied health professionals) which is located on the DHS website.

MN.7.2 Telehealth Focussed Psychological Strategies Services

These notes provide information on the telehealth focussed psychological strategies MBS video consultation items by psychologists, occupational therapists and social workers. A video consultation involves a single psychologist, occupational therapist or social worker attending a patient, or a group of 6 to 10 patients.

MBS item numbers 80101, 80111, 80126, 80136, 80151 and 80161 provide for attendance via videoconferencing by a psychologist, occupational therapist or social worker to an individual patient. MBS item numbers 80121, 80146 and 80171 provide for attendance via videoconferencing by a psychologist, occupational therapist or social worker to a group of 6 to 10 patients. The items are stand-alone items and do not have a derived fee.

These therapies are time limited, being deliverable in up to 10 planned sessions in a calendar year (including services to which items 80001, 80011, 80101, 80111, 80126, 80136, 80151 and 80161 apply).

Patients will also be eligible to claim up to 10 separate services within a calendar year for group therapy services involving 6-10 patients to which items 80021 (psychological therapy via video conference – clinical psychologist), 80121 (focussed psychological strategies via video conference – psychologist), 80146 (focussed psychological strategies via video conference – occupational therapist) and 80171 (focussed psychological strategies via video conference – social worker) apply. These group services are separate from the individual services and do not count towards the 10 individual services per calendar year maximum associated with those items.

Clinical indications

The psychologist, occupational therapist or social worker must be satisfied that it is clinically appropriate to provide a video consultation to a patient, or a group of 6 to 10 patients.

Restrictions

The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes hospital in the home patients). Benefits are not payable for telephone or email consultations. In order to fulfil the item descriptor there must be a visual and audio link between the patient and the remote psychologist, occupational therapist or social worker. If the remote psychologist, occupational therapist or social worker is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Billing Requirements

All video consultations provided by psychologists, occupational therapists or social workers must be separately billed. That is, only the relevant telehealth MBS consultation item is to be itemised on the account/bill/voucher. Any other service/item billed should be itemised on a separate account/bill/voucher. This will ensure the claim is accurately assessed as being a video consultation and paid accordingly.

Psychologists, occupational therapists or social workers should not use the notation ‘telehealth’, ‘verbal consent’ or ‘Patient unable to sign’ to overcome administrative difficulties to obtaining a patient signature for bulk-billed claims (for further information see mbsonline.gov.au/telehealth).

Eligible Geographical Areas

Geographic eligibility for psychological telehealth services funded under Medicare (in Groups M6 and M7) is determined according to the Modified Monash Model (MMM) classifications. Telehealth Eligible Areas are those areas that are within MMM classifications 4 to 7. Patients and providers are able to check their eligibility using the Modified Monash Model locator on the Department of Health’s website (http://www.health.gov.au/internet/otd/publishing.nsf/Content/MMM_locator).

There is a requirement for the patient and psychologist, occupational therapist or social worker to be located a minimum of 15 kilometres apart at the time of the consultation. Minimum distance between psychologist, occupational therapist or social worker and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the psychologist, occupational therapist or social worker is not permitted to travel to an area outside the minimum 15 kilometres distance in order to claim a video consultation.

Record Keeping

Participating telehealth psychologists, occupational therapists and social workers must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Extended Medicare Safety Net (EMSN)

All telehealth consultations (with the exception of the participating optometrist telehealth items) are subject to EMSN caps. The EMSN caps for telehealth consultation items in Groups M6 and M7 are equal to 300% of the schedule fee (to a maximum of $500).

Aftercare Rule

Video consultations are subject to the same aftercare rules as psychologists, occupational therapists and social workers providing face-to-face consultations.

Multiple attendances on the same day

In some situations a patient may receive a consultation via video conference and a face-to-face consultation by the same or different psychologist, occupational therapist or social worker on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same psychologist, occupational therapist or social worker, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Psychologists, occupational therapists and social workers will need to provide the times of each consultation on the patient’s account or bulk-billing voucher.

Referrals

The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Technical requirements

In order to fulfil the item descriptor there must be a visual and audio link between the patient and the remote psychologist, occupational therapist or social worker. If the remote clinical psychologist is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

MN.8.1 Pregnancy Support Counselling - Eligible Patients - (Items 81000 to 81010)

Medicare benefits are available for non-directive pregnancy support counselling services provided to a person who is pregnant or who has been pregnant in the 12 months preceding the first service to which item 81000, 81005 or 81010 applies in relation to that pregnancy. Services can be provided either by an eligible GP or by an eligible psychologist, social worker or mental health nurse on referral from a GP.

The term 'GP' is used hereafter as a generic reference to medical practitioners (including a general practitioner, but not including a specialist or consultant physician).

The items may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

MN.8.2 Pregnancy Support Counselling - Eligible Services - (Items 81000 to 81010)

There are four MBS items for the provision of non-directive pregnancy support counselling services:

Item 4001 - services provided by an eligible GP;

Item 81000 - services provided by an eligible psychologist;

Item 81005 - services provided by an eligible social worker; and

Item 81010 - services provided by an eligible mental health nurse.

These notes relate to items 81000-81010. Each individual allied health professional must meet the provider eligibility requirements set out below and be registered with the Department of Human Services.

Service length and type

Non-directive pregnancy support counselling services provided by eligible psychologists, social workers and mental health nurses using items 81000-81010 inclusive must be of at least 30 minutes duration and provided to an individual patient. The allied health professional must personally attend the patient.

The service involves the psychologist, social worker or mental health nurse undertaking a safe, confidential process that helps the patient explore concerns they have about a current pregnancy or a pregnancy that occurred in the preceding 12 months. This includes providing, on request, unbiased, evidence-based information about all options and services available to the patient.

Non-directive counselling is a form of counselling that is based on the understanding that, in many situations, people can resolve their own problems without being provided with a solution by the counsellor. The counsellor's role is to encourage the person to express their feelings but not suggest what decision the person should make. By listening and reflecting back what the person reveals to them, the counsellor helps them to explore and understand their feelings. With this understanding, the person is able to make the decision that is best for them.

Number of services per year

Medicare benefits are available for up to three (3) eligible non-directive pregnancy support counselling services per patient, per pregnancy, provided using items 81000, 81005, 81010 and 4001.

Partners of eligible patients may attend each or any counselling session, however, only one fee applies to each service.

Out-of-pocket expenses and Medicare Safety Net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Non-directive pregnancy support counselling services in excess of three (3) per pregnancy will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Publicly funded services

Items 81000, 81005 and 81010 do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital.

However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory clinic, items 81000, 81005 and 81010 can be claimed for services provided by an eligible psychologist, social worker or mental health nurse salaried by or contracted to the service, where all requirements of the relevant item are met, including registration with the Department of Human Services. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

MN.8.3 Pregnancy Support Counselling - Referral Requirements - (Items 81000 to 81010)

Patients must be referred for non-directive pregnancy support counselling services by a GP or medical practitioner. GPs/medical practitioners are not required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible allied health professional signed and dated by the referring GP/medical practitioner.

Patients may be referred by a GP or medical practitioner to more than one eligible allied health professional for eligible non-directive pregnancy support counselling services (for example, where a patient does not wish to continue receiving services from the provider they were referred to in the first instance). However, Medicare benefits are only available for a maximum of three (3) non-directive pregnancy support counselling services to which items 792, 4001, 81000, 81005 and 81010 apply, per patient, per pregnancy.

Where the patient is unsure of the number of Medicare rebated non-directive pregnancy support counselling services they have already accessed, the patient may check with the Department of Human Services on 132 011. Alternatively, the psychologist, social worker or mental health nurse may check with the Department of Human Services.

The relevant allied health professional must be in receipt of the referral at the first non-directive pregnancy support counselling service and must retain the referral for 2 years from the date the service was rendered, for the Department of Human Services auditing purposes.

A copy of the referral is not required to accompany Medicare claims. However, referral details are required to be included on patients' itemised accounts/receipts or Medicare assignment of benefit forms.

Referral validity

The referral is valid for up to three (3) non-directive pregnancy support counselling services, per patient, per pregnancy.

Subsequent Referrals

A new referral is required where the patient seeks to access non-directive pregnancy support counselling in relation to a different pregnancy or where the patient wishes to be referred to a different allied health professional than the one they were referred to in the first instance.

MN.8.4 Pregnancy Support Counselling - Allied Health Professional Eligibility -(Items 81000 to 81010)

Eligible allied health professionals

Items 81000, 81005 and 81010 can only be claimed for services provided by psychologists, social workers and mental health nurses who meet the following specific eligibility requirements, and are registered with the Department of Human Services.

To be eligible to provide services using MBS Item 81000, a psychologist must hold general registration in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided and be certified by the Australian Psychological Society as appropriately trained in non-directive pregnancy counselling.

To be eligible to provide services using MBS Item 81005, a social worker must be a 'Member' of the Australian Association of Social Workers (AASW), be certified by AASW either as meeting the standards for mental health set out in the document published by AASW titled ‘Practice Standards for Mental Health Social Workers 2014’ as in force on 25 September 2014 or as an Accredited Social Worker, and have completed appropriate non-directive pregnancy counselling training;

To be eligible to provide services using MBS Item 81010, a mental health nurse must be a 'Credentialled Mental Health Nurse' as certified by the Australian College of Mental Health Nurses, and have completed appropriate non-directive pregnancy counselling training.

Registering with the Department of Human Services

Advice about registering with the Department of Human Services to provide non-directive pregnancy support counselling services using items 81000-81010 inclusive is available from the Department of Human Services provider inquiry line on 132 150.

Further information

A copy of the Medicare Allied Health Supplement can be accessed from www.health.gov.au/mbsonline. The Supplement includes more information about Medicare, including how to make a claim from Medicare.

Further information is also available for providers from the Department of Human Services provider inquiry line on 132 150.

MN.9.1 Group Allied Health Services (Items 81100 to 81125) for People with Type 2 Diabetes - Eligible Patients

MBS items (81100 to 81125) are available for group allied health services for patients with type 2 diabetes. These items apply to services provided by eligible diabetes educators, exercise physiologists and dietitians, on referral from a GP or medical practitioner.

Services available under these items are in addition to the five individual allied health services available to patients each calendar year (refer to items 10950 to 10970).

To be eligible for these services, the patient must have in place one of the following:

- a GP Management Plan (GPMP) (GP item 721 or medical practitioner item 229); OR

- for a resident of a residential aged care facility, the GP or medical practitioner must have contributed to, or contributed to a review of, a care plan prepared for them by the facility (GP item 731 or medical practitioner item 232). [Note: Generally, residents of an aged care facility rely on the facility for assistance to manage their type 2 diabetes. Therefore, the resident may not need to be referred for group allied health services under these items, as the self-management approach offered in group services may not be appropriate.]; OR

- a Health Care Home shared care plan.

Unlike the individual allied health services under items 10950 to 10970, there is no additional requirement for a Team Care Arrangement (GP item 723 or medical practitioner item 230) in order for the patient to be referred for group allied health services.

Once the patient has been referred by their GP or medical practitioner, a diabetes educator, exercise physiologist or dietitian will conduct an individual assessment (under items 81100, 81110 or 81120). A maximum of one (1) assessment service is available per calendar year. After assessment, the patient may receive up to eight (8) group services per calendar year from an eligible diabetes educator, exercise physiologist and/or dietitian (under items 81105, 81115 and 81125). A collaborative approach, where diabetes educators, exercise physiologists and dietitians work together to develop group service programs in their local area, is encouraged.

MN.9.2 Group Allied Health Services (Items 81100 to 81125) for People with Type 2 Diabetes - GP Referral Requirements

Patients must be referred by their GP to an eligible allied health professional (diabetes educator, exercise physiologist or dietitian) who will undertake an individual assessment of their suitability for a group services program (under item 81100, 81110 or 81120).

When referring patients, **GPs** must use a referral form that has been issued by the Australian Government Department of Health or a Health Care Home shared care plan or a form that contains all the components of this form. The form issued by the department is available at http://www.health.gov.au/mbsprimarycareitems (click on the link for group allied health services).

GPs are also encouraged to provide a copy of the relevant part of the patient's care plan to the allied health professional.

Health Care Home shared care plan

A Health Care Home shared care plan means a written plan that is prepared for a patient enrolled at a Health Care Home trial site; is prepared by a medical practitioner (including a general practitioner but not including a specialist or consultant physician) who is leading the patient's care at the Health Care Home trial site; and includes: an outline of the patient's agreed current and long-term goals; the person or people responsible for each activity; arrangements to review the plan by a day mentioned in the plan; and if authorised by the patient, arrangements for the transfer of information between the medical practitioner and other health care providers supporting patient care about the patient's condition or conditions and treatment.

MN.9.3 Group Allied Health Services (Items 81100 to 81125) for People with Type 2 Diabetes - Eligible Allied Health Professionals

Items 81100 to 81125 only apply to services provided by eligible diabetes educators, exercise physiologists and dietitians who are registered with the Department of Human Services. If providers are already registered with the Department of Human Services to use item 10951, 10953 or 10954, they do not need to register separately for items 81100 to 81125. Eligibility criteria are as follows:

Diabetes educator: must be a 'credentialed diabetes educator' (CDE) as credentialed by the Australian Diabetes Educators Association (ADEA).

Exercise physiologist: must be an 'accredited exercise physiologist' as accredited by Exercise and Sports Science Australia (ESSA).

Dietitian: must be an 'accredited practising dietitian' as recognised by the Dietitians Association of Australia (DAA).

The Department of Human Services registration forms may be obtained from the Department of Human Services on 132 150 or at the Department of Human Services' website.

MN.9.4 Assessment for Group Allied Health Services (Items 81100, 81110 and 81120) for People with Type 2 Diabetes

An assessment service is provided by a diabetes educator (item 81100), an exercise physiologist (item 81110) or a dietitian (item 81120), on referral from a GP.

The purpose of this service is to undertake an individual assessment and determine the patient's suitability for a group services program. It involves taking a comprehensive patient history and identification of individual goals. This may also provide an opportunity to identify any patient who is likely to be unsuitable for group services.

Number of services per year

Patients are eligible for a maximum of one assessment for group services (item 81100 **or** 81110 **or** 81120) per calendar year. If more than one assessment service is provided in a calendar year, the subsequent service/s will not attract a Medicare rebate and the MBS Safety Net arrangements will not apply to costs incurred by the patient for the service/s.

If there is any doubt about a patient's eligibility for items 81100, 81110 or 81120, the allied health professional should contact the Department of Human Services to confirm the number of assessment services already claimed by the patient in the calendar year. Allied health professionals can call the Department of Human Services on 132 150 to check this information.

Referral form

The GP must refer the patient using the *Referral form for group allied health services under Medicare for patients with type 2 diabetes* or a Health Care Home shared care plan or a form that contains all the components of this form. The form issued by the department is available at http://www.health.gov.au/mbsprimarycareitems (click on the link for group allied health services).

The allied health professional undertaking the assessment service will need to complete Part B of this form, and the patient will then need to present this form to the provider/s of group services.

Health Care Home shared care plan

A Health Care Home shared care plan means a written plan that is prepared for a patient enrolled at a Health Care Home trial site; is prepared by a medical practitioner (including a general practitioner but not including a specialist or consultant physician) who is leading the patient's care at the Health Care Home trial site; and includes: an outline of the patient's agreed current and long-term goals; the person or people responsible for each activity; arrangements to review the plan by a day mentioned in the plan; and if authorised by the patient, arrangements for the transfer of information between the medical practitioner and other health care providers supporting patient care about the patient's condition or conditions and treatment.

Length of service

This service must be of at least 45 minutes duration and provided to an individual patient. The allied health professional must personally attend the patient.

Reporting requirements

On completion of the assessment service, the allied health professional must provide a written report back to the referring GP outlining the assessment undertaken, whether the patient is suitable for group services and, if so, the nature of the group services to be delivered.

MN.9.5 Group Allied Health Services (Items 81105, 81115 and 81125) for People with Type 2 Diabetes - Service Requirements and Referral Forms

These services are provided in a group setting to assist with the management of type 2 diabetes.

Number of services per year

Patients are eligible for up to eight group allied health services in total (items 81105, 81115 and 81125 inclusive) per calendar year. Each separate group service must be provided to the patient by only one type of allied health professional (i.e. by a diabetes educator, or by an exercise physiologist or by a dietitian). However, the overall group services program provided for the patient could be comprised of one type of service only (e.g. eight diabetes education services) or a combination of services (e.g. three diabetes education services, three dietitian services and two exercise physiology services). An eligible allied health professional with more than one Medicare provider number (e.g. for the provision of diabetes education and dietetics) may provide separate services under each of these provider numbers.

Group allied health service providers are strongly encouraged to deliver multidisciplinary group services programs that allow patients to benefit from a range of interventions designed to assist in the management of their type 2 diabetes.

Where a patient receives more than the limit of eight group services in a calendar year, the additional service/s will not attract a Medicare benefit and the MBS Safety Net arrangements will not apply to costs incurred by the patient for the service/s.

If there is any doubt about a patient's eligibility for group services, the allied health professional should contact the Department of Human Services to confirm the number of group services already claimed by the patient in the calendar year. Allied health professionals can call the Department of Human Services on 132 150 to check this information.

Multiple services on the same day

Where clinically relevant, up to two group services may be provided consecutively on the same day by the same allied health professional.

Referral form

The allied health professional/s undertaking the group services will need to receive the *Referral form for group allied health services under Medicare for patients with type 2 diabetes issued by the Department of Health* or the Health Care Home shared care plan or a form that contains all the components of this form, with Part B completed by the provider who has undertaken the assessment service. The form issued by the department is available at http://www.health.gov.au/mbsprimarycareitems (click on the link for group allied health services).

Health Care Home shared care plan

A Health Care Home shared care plan means a written plan that is prepared for a patient enrolled at a Health Care Home trial site; is prepared by a medical practitioner (including a general practitioner but not including a specialist or consultant physician) who is leading the patient's care at the Health Care Home trial site; and includes: an outline of the patient's agreed current and long-term goals; the person or people responsible for each activity; arrangements to review the plan by a day mentioned in the plan; and if authorised by the patient, arrangements for the transfer of information between the medical practitioner and other health care providers supporting patient care about the patient's condition or conditions and treatment.

Group size

The service must be provided to a person who is part of a group of between two and 12 persons.

Length of service

Each group service must be of at least 60 minutes duration.

Reporting requirements

On completion of the group services program, each allied health professional must provide, or contribute to, a written report back to the referring GP in respect of each patient. The report should describe the group services provided for the patient and indicate the outcomes achieved. While each allied health professional is required to provide feedback to the GP in relation to the group services that they provide to the patient, allied health professionals involved in the provision of a multidisciplinary program are encouraged to combine feedback into a single report to the referring GP.

MN.9.6 Group Allied Health Services (Items 81100 to 81125) for People with Type 2 Diabetes - Additional Requirements

Retention of Referral Form for the Department of Human Services Audit Purposes

It is recommended that Allied health professionals retain a copy of the referral form for 24 months from the date the service was rendered (for the Department of Human Services auditing purposes).

Publicly funded services

Items 81100 - 81125 do not apply for services that are provided by any other Commonwealth or state-funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or a state/territory government health clinic, items 81100-81125 can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, service or health clinic. All requirements of the relevant item must be met, including registration of the allied health professional with the Department of Human Services. These services must also be bulk billed.

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid.

Out-of-pocket expenses and Medicare Safety Net

Allied health professionals are free to determine their own fees for the professional service. Charges in excess of the Medicare benefit for the allied health items are the responsibility of the patient. However, such out of pocket costs will count toward the Medicare Safety Net for that patient.

MN.9.7 Group Allied Health Services (Items 81100 to 81125) for People with Type 2 Diabetes - Further Information

Further information about these items is available on the Department of Health's website at www.health.gov.au/mbsprimarycareitems

MN.10.1 Provision of Autism, Pervasive Developmental Disorder or Disability Services by Allied Health Professionals - (Items 82000 to 82035)

Eligible patients

MBS items 82000 to 82035 provide Medicare-rebateable allied health services to children with autism or any other pervasive developmental disorder (PDD) through the Helping Children with Autism program, and to children with an eligible disability through the Better Start for Children with Disability program. Children with both autism/PDD and an eligible disability can access either program, but not both.

The conditions classified as PDD in 2008 for the purposes of these services were informed by the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), Washington, DC, American Psychiatric Association, 2000.

'Eligible disabilities' for the purpose of these services means any of the following conditions:

(a) sight impairment that results in vision of less than or equal to 6/18 vision or equivalent field loss in the better eye, with correction.

(b) hearing impairment that results in:

(iii) a hearing loss of 40 decibels or greater in the better ear, across 4 frequencies; or

(iv) permanent conductive hearing loss and auditory neuropathy.

(c) deafblindness

(d) cerebral palsy

(e) Down syndrome

(f) Fragile X syndrome

(g) Prader-Willi syndrome

(h) Williams syndrome

(i) Angelman syndrome

(j) Kabuki syndrome

(k) Smith-Magenis syndrome

(l) CHARGE syndrome

(m) Cri du Chat syndrome

(n) Cornelia de Lange syndrome

(o) microcephaly if a child has:

(iii) a head circumference less than the third percentile for age and sex; and

(iv) a functional level at or below 2 standard deviations below the mean for age on a standard developmental test, or an IQ score of less than 70 on a standardised test of intelligence.

(p) Rett's disorder

"standard developmental test" refers to the Bayley Scales of Infant Development or the Griffiths Mental Development Scales; "standardised test of intelligence" means the Wechsler Intelligence Scale for Children (WISC)

or the Wechsler Preschool and Primary Scale of Intelligence (WPPSI). It is up to the clinical judgement of the diagnosing practitioner if other tests are appropriate to be used.

Allied health services available under Medicare

Items are available for **assessment/diagnosis** services, the results of which can contribute to development of a treatment and management plan by the referring medical practitioner, and for **treatment** services.

The **assessment/diagnosis** items (82000, 82005, 82010, 82030) can be accessed when:

- a child with autism/PDD is aged under 13 years and referred by an eligible consultant psychiatrist or paediatrician; or

- a child with an eligible disability is aged under 13 years and referred by a specialist, consultant physician or GP.

The **treatmen**t items (82015, 82020, 82025 and 82035) can be accessed when:

- A child with autism/PDD is aged under 15 years and a treatment and management plan has been put in place for them before their 13th birthday, and they have been referred by an eligible consultant psychiatrist or paediatrician.

- A child with an eligible disability is aged under 15 years and a treatment and management plan has been put in place for them before their 13th birthday, and they have been referred by a specialist, consultant physician or GP.

The allied health assessment and treatment services can be provided by eligible audiologists, occupational therapists, optometrists, orthoptists, physiotherapists, psychologists and speech pathologists.

Number of assessment services

Medicare rebates are available for up to four services in total per eligible child, to assist with assessment and diagnosis and development of a treatment plan. The four services may consist of any combination of items 82000, 82005, 82010 and 82030. It is the responsibility of the referring practitioner to allocate these services in keeping with the child's individual needs and to refer the child to appropriate allied health professional(s) accordingly.

These services will not attract a Medicare rebate unless a referral has been made by a consultant psychiatrist (using items 296-370) or paediatrician (using items 110-131) for a child with autism/PDD, or by a specialist or consultant physician (using items 104-131 or 296-370 excluding item 359) or GP (using items 3-51) for a child with a disability.

Number of treatment services

Medicare rebates are available for up to twenty allied health treatment services in total per eligible child. The twenty services may consist of any combination of items 82015, 82020, 82025 and 82035. It is the responsibility of the referring practitioner to allocate these services in keeping with the child's individual treatment needs and to refer the child to appropriate allied health professional(s) accordingly.

These services will not attract a Medicare rebate unless referral has been made by a consultant psychiatrist (using item 289) or paediatrician (using item 135) for children with autism/PDD, or by a specialist or consultant physician (using item 137) or a GP for disability (using item 139) for children with disability.

Service length and type

Services under these items must be for the time period specified within the item descriptor. The allied health professional must personally attend the child.

A child may receive up to four Medicare eligible services from an allied health professional on the same day.

It is anticipated that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

It is also expected that participating allied health providers will deliver treatment under these items that is consistent with the autism/PDD or disability treatment plan prepared by the medical practitioner, and is in keeping with commonly established autism/PDD or disability interventions as practised by their profession and appropriate for the age and particular needs of the child being treated.

Eligible allied health professionals

Allied health professionals providing services under these items must be registered with the Department of Human Services. To register with the Department of Human Services to provide these services, an allied health professional must meet the specific eligibility requirements detailed below:

- **Audiologist** must be either a 'Full Member' of the Audiological Society of Australia Inc (ASA), who holds a 'Certificate of Clinical Practice' issued by the ASA; or an 'Ordinary Member - Audiologist' or 'Fellow Audiologist' of the Australian College of Audiology (ACAud).

- **Occupational Therapist** must be registered with the Occupational Therapy Board of Australia.

- **Optometrist** must be registered as an optometrist or optician under a law of a State or an internal Territory that provides for the registration of optometrists or opticians, and be a participating optometrist.

- **Orthoptist** must be registered with the Australian Orthoptic Board and have a Certificate of Currency; and be a member of Orthoptics Australia.

- **Physiotherapis**t must be registered with the Physiotherapy Board of Australia.

- **Psychologist** must hold General Registration with the Psychology Board of Australia.

- **Speech Pathologist** must be a 'Practising Member' of Speech Pathology Australia.

In addition to meeting the above mentioned credentialing requirements, it is expected that eligible providers will "self-select" for the autism/PDD and disability items (i.e. possess the skills and experience appropriate for provision of these services and be oriented to work with children with autism/PDD or disability).

Referral requirements

An allied health professional wanting to provide any of the items 82000-82035 must be in receipt of a current referral provided by an eligible medical practitioner. Referrals are only valid when prerequisite MBS services have been provided.

An eligible allied health professional can provide assessment items (82000, 82005, 82010 and 82030) to a child under the Helping Children with Autism program when:

- the child has previously been provided with any MBS service covering items 110 through 131 inclusive by a consultant paediatrician; or

- the child has previously been provided with any MBS service covering items 296 through 370 (excluding item 359) inclusive by a consultant psychiatrist.

An eligible allied health professional can provide assessment items (82000, 82005, 82010 and 82030) to a child under the Better Start for Children with Disability program when:

- the child has previously been provided with any MBS service covering items 104 through 131 inclusive, or items 296 through 370 (excluding item 359) inclusive by a specialist or consultant physician; or

- the child has previously been provided with any MBS service covering items 3 through 51 by a GP.

An eligible allied health professional can provide treatment items (82015-82025 and 82035) to a child under the Helping Children with Autism program when:

- the child has previously been provided with a treatment plan (item 135) by a consultant paediatrician; or

- the child has previously been provided with a treatment plan (item 289) by a consultant psychiatrist.

An eligible allied health professional can provide treatment items (82015-82025 and 82035) to a child under the Better Start for Children with Disability program when:

- the child has previously been provided with a treatment plan (MBS item 137) by a specialist or consultant physician; or

- the child has previously been provided with a treatment plan (MBS item 139) by a GP.

If the referring service has not yet been claimed, the Department of Human Services (DHS) will not be aware of the child's eligibility and Medicare benefits cannot be paid. DHS will be able to confirm whether a relevant MBS service has been claimed and/or the number of allied health services already claimed by the child. Allied health professionals can call the DHS provider line on 132 150. Parents and carers can call the patient information line on 132 011.

It is recommended that allied health professionals retain the referral for 24 months from the date the service was rendered for Medicare auditing purposes.

Referring medical practitioners are not required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible allied health professional signed and dated by the referring practitioner.

Referral validity

Medicare benefits are available for up to four allied health assessment and diagnosis services and up to twenty allied health treatment services per patient in total.

Patients will require a separate referral for each allied health professional they are referred to and they will also need new referrals for each new course of treatment.

A course of treatment for the allied health treatment services consists of the number of allied health services stated on the child's referral. This enables the referring practitioner to consider a report from the allied health professional(s) about the services provided to the child, and the need for further treatment.

Within the maximum service allocation of twenty services for the treatment items, the allied health professional(s) can provide one or more courses of treatment. Up to 4 services may be provided to the same child on the same day.

Reporting requirements

A written report must be provided to the referring medical practitioner by the allied health professional(s) after having provided the assessment and diagnosis and development of a treatment plan service(s) to the child.

On completion of a course of treatment, the eligible audiologist, occupational therapist, optometrist, orthoptist, physiotherapist, psychologist and speech pathologist must provide a written report to the referring medical practitioner which includes information on:

- treatment provided;

- recommendations on future management of the child's disorder; and

- any advice provided to third parties (e.g. parents, schools).

A written report must also be provided to the referring medical practitioner at the completion of any subsequent course(s) of treatment provided to the child.

Further information

For more information refer to the MBS online website or the MBS Primary Care Items information page. information page.

MN.11.1 Follow-up Allied Health Services for people of Aboriginal or Torres Strait Islander descent (Items 81300 to 81360)

Eligible Patients

A person who is of Aboriginal or Torres Strait Islander descent may be referred by their GP for follow-up allied health services under items 81300 to 81360 when the GP has undertaken a health assessment or a Health Care Home shared care plan and identified a need for follow-up allied health services.

These items are similar to the individual allied health items (items 10950 to 10970) available to patients who have a chronic or terminal medical condition and complex care needs and have a GP Management Plan and Team Care Arrangements or a Health Care Home shared care plan prepared by their GP. However items 81300 to 81360 provide an alternative referral pathway for Aboriginal or Torres Strait Islander people to access allied health services. If a patient meets the eligibility criteria for individual allied health services under the Chronic Disease Management items or the Health Care Home shared care plan and for follow-up allied health services, they can access both sets of services and are eligible for up to ten allied health services under Medicare per calendar year.

A practice nurse/Aboriginal and Torres Strait Islander health practitioner item (10987) is also available for Indigenous Australians who have received a health check. This item enables Aboriginal or Torres Strait Islander people to receive follow-up services from a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a GP. More detail on this item is provided at explanatory note M.12.4 of the Medicare Benefits Schedule.

Eligible Allied Health Services

The following allied health professionals are eligible to provide services under these items:

- Aboriginal and Torres Strait Islander health practitioners
- Aboriginal Health Workers
- Audiologists
- Chiropractors
- Diabetes Educators
- Dietitians
- Exercise Physiologists
- Mental Health Workers
- Occupational Therapists
- Osteopaths
- Physiotherapists
- Podiatrists

- Psychologists

- Speech Pathologists

Publicly funded services

Items 81300 to 81360 do not apply for services that are provided by any Commonwealth or state or territory government funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or state/territory government health clinic, items 81300 to 81360 can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, the service or health clinic. All requirements of the relevant item must be met, including registration of the allied health professional with the Department of Human Services. Medicare services provided under a subsection 19(2) exemption must be bulk billed (i.e. the Medicare rebate is accepted as full payment for services).

Number of services per year

Medicare benefits are available for up to five follow-up allied health services per eligible patient, per calendar year. The five allied health services can be made up of one type of service (e.g. five physiotherapy services) or a combination of different types of services (e.g. one dietetic, two podiatry and two physiotherapy services).

The annual limit of five allied health services per patient under items 81300 to 81360 is in addition to the individual allied health services for patients with a chronic or terminal medical condition and complex care needs (items 10950 to 10970).

Checking patient eligibility for items 81300 to 81360

If there is any doubt about a patient's eligibility, the Department of Human Services will be able to confirm the number of allied health services already claimed by the patient during the calendar year. Allied health professionals can call the Department of Human Services on 132 150 and patients can call the Department of Human Services on 132 011 or alternatively the Indigenous Access Line for the Department of Human Services on 1800 556 955.

Service length and type

Services provided by eligible allied health professionals under these items must meet the specific requirements set out in the item descriptors. These requirements include that:

- the service is of at least 20 minutes duration;

- the service is provided to the person individually (i.e. not as part of a group service) and in person (i.e. the allied health professional must personally attend the patient);

- the person is not an admitted patient of a hospital;

- the allied health professional must provide a written report to the GP; and

- if the patient has private health insurance, he/she cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for these services.

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

Reporting back to the GP

Where an allied health professional provides a single service to the patient under a referral, the allied health professional must provide a written report back to the referring GP after that service.

Where an allied health professional provides multiple services to the same patient under a referral, the allied health professional must provide a written report back to the referring GP after the first and last service, or more often if clinically necessary. Written reports should include:

- any investigations, tests, and/or assessments carried out on the patient;
- any treatment provided; and
- future management of the patient's condition or problem.

Allied health professionals are required to retain the referral form 24 months.

Out-of-pocket expenses and Medicare safety net

Allied health professionals can determine their own fees for the professional service, except where the service is provided under a subsection 19(2) exemption. Charges in excess of the Medicare benefit for the allied health items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Allied health services in excess of five in a calendar year will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Referral Requirements

Referral form

For Medicare benefits to be payable, the patient must be referred to an eligible allied health professional by their GP using a referral form that has been issued by the Australian Government Department of Health or a form that contains all the components of this form.

The form issued by the department is available at the MBS Primary Care Items information page (click on the link for follow-up allied health services).

GPs are encouraged to attach a copy of the relevant part of the patient's care plan to the referral form.

GPs may use one referral form to refer patients for single or multiple services of the same service type (e.g. five dietetic services). If referring a patient for single or multiple services of different service types (e.g. two dietetic services and three podiatry services), a separate referral form will be needed for each service type.

The patient will need to present the referral form to the allied health professional at the first consultation, unless the GP has previously provided it directly to the allied health professional.

Allied health professionals are required to retain the referral form for 2 years from the date the service was rendered (for the Department of Human Services auditing purposes). A copy of the referral form is not required to accompany Medicare claims, and allied health professionals do not need to attach a signed copy of the form to patients' itemised accounts/receipts or assignment of benefit forms.

Completed forms do not have to be sent to the Department of Health.

Health Care Home shared care plan

A Health Care Home shared care plan means a written plan that is prepared for a patient enrolled at a Health Care Home trial site; is prepared by a medical practitioner (including a general practitioner but not including a specialist or consultant physician) who is leading the patient's care at the Health Care Home trial site; and includes: an outline of the patient's agreed current and long-term goals; the person or people responsible for each activity; arrangements

to review the plan by a day mentioned in the plan; and if authorised by the patient, arrangements for the transfer of information between the medical practitioner and other health care providers supporting patient care about the patient's condition or conditions and treatment.

Referral validity

A referral is valid for the stated number of services. If all services are not used during the calendar year in which the patient was referred, the unused services can be used in the next calendar year. However, those services will be counted as part of the five rebates for allied health services available to the patient during that calendar year.

When patients have used all of their referred services they will need to obtain a new referral from their GP.

Allied health Professional Eligibility

Items 81300 to 81360 can only be claimed for services provided by eligible allied health professionals who are registered with the Department of Human Services. Allied health professionals already registered with Medicare (e.g. for items 10950 to 10970) do not need to register again to claim these items.

Specific eligibility requirements for allied health professionals providing services under these items are:

Aboriginal and Torres Strait Islander health practitioners must be registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia. Aboriginal and Torres Strait Islander health practitioners may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioners; Aboriginal and Torres Strait Islander health practitioners; or Torres Strait Islander health practitioners.

Aboriginal health workers in a State or Territory other than the Northern Territory must have been awarded either:

a. a Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care (or an equivalent or higher qualification) by a registered training organisation; or

b. a Certificate III in Aboriginal and Torres Strait Islander Health (or an equivalent or higher qualification) by a registered training organisation before 1 July 2012.

Note: Where individuals consider their qualification to be equivalent to or higher than the qualifications listed above, they will need to contact a registered training organisation in their State or Territory to have the qualification assessed as such before they can register with the Department of Human Services. In the Northern Territory, a practitioner must be registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia.

Audiologists must be either a 'Full Member' of the Audiological Society of Australia Inc (ASA), who holds a 'Certificate of Clinical Practice' issued by the ASA; or an 'Ordinary Member - Audiologist' or 'Fellow Audiologist' of the Australian College of Audiology (ACAud).

Chiropractors must be registered with the Chiropractic Board of Australia.

Diabetes educators must be a Credentialled Diabetes Educator (CDE) as credentialled by the Australian Diabetes Educators Association (ADEA).

Dietitians must be an 'Accredited Practising Dietitian' as recognised by the Dietitians Association of Australia (DAA).

Exercise physiologists must be an 'Accredited Exercise Physiologist' as accredited by Exercise and Sports Science Australia (ESSA).

Mental health workers can include services provided by members of five different allied health professional groups. 'Mental health workers' are drawn from the following:

- psychologists;

- mental health nurses;
- occupational therapists;
- social workers;
- Aboriginal and Torres Strait Islander health practitioners; and
- Aboriginal health workers.

Psychologists, occupational therapists, Aboriginal and Torres Strait Islander health practitioners and **Aboriginal health workers** are eligible in separate categories for these items.

Mental health nurses must be a credentialled mental health nurse, as certified by the Australian College of Mental Health Nurses.

Mental health nurses who were registered in the ACT or Tasmania prior to the introduction of the National Registration and Accreditation Scheme (NRAS) on 1 July 2010, will have until 31 December 2010 to be certified by the Australian College of Mental Health Nurses.

Social workers must be a 'Member' of the Australian Association of Social Workers (AASW); and be certified by AASW as meeting the standards for mental health set out in the document published by AASW titled 'Practice Standards for Mental Health Social Workers' as in force on 8 November 2008.

Occupational therapists must be registered with the Occupational Therapy Board of Australia.

Osteopaths must be registered with the Osteopathy Board of Australia.

Physiotherapists must be registered with the Physiotherapy Board of Australia.

Podiatrists must be registered with the Podiatry Board of Australia.

Psychologists must hold general registration in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided.

Speech pathologists must be a 'Practising Member' of Speech Pathology Australia.

Registering with the Department of Human Services

Provider registration forms may be obtained from the Department of Human Services on 132 150 or by visiting the Department of Human Services website and then searching for "allied health application".

Further information

Further information about these items, including a fact sheet and the referral form, is available on the Department of Health's MBS Primary Care Items information page. For providers, information is also available from the Department of Human Services provider inquiry line on 132 150. The Indigenous Access Line for the Department of Human Services on 1800 556 955 is also a useful source of information.

MN.12.1 Immunisation services provided by an Aboriginal and Torres Strait Islander health practitioner - (Item 10988)

Item 10988 can only be claimed by a medical practitioner where an immunisation is provided to a patient by an Aboriginal and Torres Strait Islander health practitioner on behalf of the medical practitioner.

Item 10988 can be claimed only once per patient visit, even if more than one vaccine is administered during the same patient visit.

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the Health Insurance Act 1973.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

The Aboriginal and Torres Strait Islander health practitioner must be appropriately qualified and trained to provide immunisations. This includes compliance with any territory requirements.

The medical practitioner under whose supervision the immunisation is provided retains responsibility for the health, safety and clinical outcomes of the patient.

Supervision may include distance supervision where the medical practitioner does not have to be physically present at the time that the service is provided by the Aboriginal and Torres Strait Islander health practitioner, but should be able to be contacted for advice if required.

The immunisation must be performed by the Aboriginal and Torres Strait Islander health practitioner in accordance with the current edition of the Australian Immunisation Handbook and the Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual.

Immunisation means the administration of a registered vaccine to a patient for any purpose other than as part of a mass immunisation of persons.

A registered vaccine means a vaccine that is included on the Australian Register of Therapeutic Goods. This includes all vaccines on the Australian Standard Vaccination Schedule and vaccines covered in the current edition of the Australian Immunisation Handbook. The following substances cannot be claimed under this item: vaccines used experimentally; homeopathic substances; immunotherapy for allergies (eg de-sensitisation preparations); and other substances that are not vaccines. There may also be territory limitations on the administration of some vaccines, such as those for tuberculosis, yellow fever and Q-fever.

All GPs whether vocationally registered or not are eligible to claim this item. District Medical Officers (DMOs) employed by the Northern Territory Department of Health and Community Services are also eligible to claim this item.

Where the medical practitioner provides a professional attendance to the patient (in addition to the immunisation service provided by the Aboriginal and Torres Strait Islander health practitioner), the medical practitioner may also claim for the professional attendance they provide to the patient.

Item 10991 can also be claimed in conjunction with item 10988 provided the conditions of both items are satisfied.

Related Items: 10988

MN.12.2 Wound management services provided by an Aboriginal and Torres Strait Islander health practitioner (item 10989)

Item 10989 can only be claimed by a medical practitioner where wound management (other than normal aftercare) is provided to a patient by an Aboriginal and Torres Strait Islander health practitioner on behalf of the medical practitioner.

Item 10989 can be claimed only once per patient visit, even if more than one wound is treated during the same patient visit.

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice

Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or 806 retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the Health Insurance Act 1973.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

The Aboriginal and Torres Strait Islander health practitioner must be appropriately qualified and trained to treat wounds. This includes compliance with any territory requirements.

The medical practitioner under whose supervision the treatment is provided retains responsibility for the health, safety and clinical outcomes of the patient.

Supervision may include distance supervision where the medical practitioner does not have to be physically present at the time that the service is provided by the Aboriginal and Torres Strait Islander health practitioner, but should be able to be contacted for advice if required.

The medical practitioner must conduct an initial assessment of the patient (including under a distance supervision arrangement if the medical practitioner is not physically present) in order to give instruction in relation to the treatment of the wound.

Where an Aboriginal and Torres Strait Islander health practitioner provides ongoing wound management, the medical practitioner is not required to give instruction or see the patient during each subsequent visit.

MN.12.3 Follow up service provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner, on behalf of a Medical Practitioner, for an Indigenous person who has received a health assessment (Item 10987)

Item 10987 may be claimed by a medical practitioner, where a follow up service is provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of that medical practitioner for an Indigenous person who has received a health check.

All GPs whether vocationally registered or not are eligible to claim this item. District Medical Officers (DMOs) employed by state/territory health Departments are also eligible to claim this item. The term 'GP' is used in these notes as a generic reference to medical practitioners able to claim this item.

Item 10987 does not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government Health clinic, item 10987 can be claimed for services provided by practice nurses or Aboriginal and Torres Strait Islander health practitioner salaried or contracted to, the Service or Health clinic. All requirements of the item must be met.

Item 10987 will assist Indigenous patients who have received a health check which has identified a need for follow up services which can be provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner between further consultations with the patient's GP.

Item 10987 may be used to provide:

k. Examinations/interventions as indicated by the health check;
l. Education regarding medication compliance and associated monitoring;
m. Checks on clinical progress and service access;
n. Education, monitoring and counselling activities and lifestyle advice;
o. Taking a medical history; and
p. Prevention advice for chronic conditions, and associated follow up.

Item 10987 may be claimed up to a maximum of 10 times per patient per calendar year.

Item 10987 may be accessed by an Indigenous patient who has received the Aboriginal and Torres Strait Islander Peoples Health Assessment (item 715), which is available to:

a) children between the ages of 0 and 14 years;

b) adults between the ages of 15 and 54 years; and

c) older people over the age of 55 years.

The item can also be accessed by a child who has received a health check as part of the Northern Territory Emergency Response (NTER).

Patients whose condition is unstable/deteriorating should be referred to their GP for further treatment.

A practice nurse means a registered or enrolled nurse who is employed by, or whose services are otherwise retained by a general practice or by a health service that has an exemption to claim Medicare benefits under sub-section 19(2) of the *Health Insurance Act 1973*.

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the Health Insurance Act 1973.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

In all cases, the GP under whose supervision the health check follow-up is being provided retains responsibility for the health, safety and clinical outcomes of the patient. The GP must be satisfied that the practice nurse or Aboriginal and Torres Strait Islander health practitioner is appropriately qualified and trained to provide the relevant follow up for the patient. GPs are advised to consult their insurer concerning indemnity coverage for services provided on their behalf.

General practices where nurses or Aboriginal and Torres Strait Islander health practitioners provide follow up for Indigenous people who have received a health check, should also have a written clinical risk management strategy covering issues like clinical roles, patient follow up and patient consent.

Continuing professional development is recommended for all nurses and an Aboriginal and Torres Strait Islander health practitioners providing follow up services for Indigenous people who have received a health check.

Supervision of the practice nurse/Aboriginal and Torres Strait Islander health practitioner by the GP at a distance is recognised as an acceptable form of supervision. This means that the claiming GP does not have to be physically present at the time the service is provided. However the GP should be able to be contacted if required.

Where the GP and practice nurse/Aboriginal and Torres Strait Islander health practitioner are at the same location, the GP is not required to be present while the health check follow up is undertaken. It is up to the GP to decide whether they need to see the patient. Where the GP has a consultation with the patient, then the GP is entitled to claim a Medicare item for the time and complexity of their personal attendance on the patient. The time the patient spends receiving a service from the practice nurse or Aboriginal and Torres Strait Islander health practitioner is itemised separately under item 10987 and should not be counted as part of the Medicare items claimed for time spent with the GP. Where the practice nurse or Aboriginal and Torres Strait Islander health practitioner provides another service (eg immunisation, cervical screening) on the same day, the GP is able to claim for all practice nurse/ Aboriginal and Torres Strait Islander health practitioner services provided.

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with item 10987 provided the conditions of item 10990 or 10991 are satisfied.

MN.12.4 Provision of monitoring and support for a person with a chronic disease by a practice nurse or Aboriginal and Torres Strait Islander health practitioner (item 10997)

Item 10997 may be claimed by a medical practitioner, where a monitoring and support service for a person with a chronic disease care plan is provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of that medical practitioner.

All GPs whether vocationally registered or not are eligible to claim this item. The term 'GP' is used in these notes as a generic reference to medical practitioners able to claim this item.

Item 10997 does not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, item 10997 can be claimed for services provided by practice nurses or Aboriginal and Torres Strait Islander health practitioners salaried by or contracted to, the Service or health clinic. All requirements of the item must be met.

Item 10997 will assist patients who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the care plan by the patient's usual GP.

Item 10997 may be used to provide:

k. checks on clinical progress;

xvii. monitoring medication compliance;

- self management advice, and;
- collection of information to support GP/medical practitioner reviews of Care Plans.

The services provided by the practice nurse or Aboriginal and Torres Strait Islander health practitioner should be consistent with the scope of the GP Management Plan, Team Care Arrangements, or Multidisciplinary Care Plan.

Item 10997 may be claimed up to a maximum of 5 times per patient per calendar year.

Item 10997 may only be accessed by a patient with a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan (GP items 721, 723, 729, 731, 732 or medical practitioner items 229, 230, 231, 232, 233).

Patients whose condition is unstable/deteriorating should be referred to their GP or medical practitioner for further treatment.

A practice nurse means a registered or enrolled nurse or Nurse Practitioner who is employed by, or whose services are otherwise retained by a general practice.

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the Health Insurance Act 1973.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

In all cases, the GP or medical practitioner under whose supervision the chronic disease monitoring and support is being provided retains responsibility for the health, safety and clinical outcomes of the patient. The GP or medical practitioner must be satisfied that the practice nurse is appropriately qualified and trained to provide chronic disease support and monitoring. GPs and medical practitioners are advised to consult their insurer concerning indemnity coverage for services performed on their behalf.

General practices where nurses or Aboriginal and Torres Strait Islander health practitioner provide chronic disease support and monitoring, should also have a written clinical risk management strategy covering issues like clinical roles, patient follow up and patient consent.

Continuing professional development is recommended for all nurses and Aboriginal and Torres Strait Islander health practitioners providing chronic disease monitoring and support.

Supervision by the GP or medical practitioner at a distance is recognised as an acceptable form of supervision. This means that the claiming GP or medical practitioner does not have to be physically present at the time the service is provided. However, the GP/medical practitioner should be able to be contacted if required.

Where the GP/medical practitioner and the practice nurse/ Aboriginal and Torres Strait Islander health practitioner are at the same location, the GP/medical practitioner is not required to be present while the chronic disease monitoring and support is undertaken. It is up to the GP/medical practitioner to decide whether they need to see the patient. Where the GP/medical practitioner has a consultation with the patient, then the GP/medical practitioner is entitled to claim a Medicare item for the time and complexity of their personal attendance on the patient. The time the patient spends receiving a service from the practice nurse or Aboriginal and Torres Strait Islander health practitioner is itemised separately under item 10997 and should not be counted as part of the Medicare item claimed for time spent with the GP/medical practitioner. Where the practice nurse or Aboriginal and Torres Strait Islander health practitioner provides another service (eg immunisation) on the same day, the GP/medical practitioner is able to claim for both practice nurse/ Aboriginal and Torres Strait Islander health practitioner items.

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with item 10997 provided the conditions of item 10990 or 10991 are satisfied (see explanatory note M.1).

MN.12.5 Telehealth Support Services by Health Professionals

These notes provide information on the telehealth MBS attendance items for health professionals to provide clinical support to their patients during video consultations with a specialist, consultant physicians and psychiatrists under items 10945 to 10948 in Group A10 which are available for participating optometrists, items 82150, 82151 and 82152 in Group M13 which are available for participating midwives, items 82220 to 82225 in Group M14 for participating nurse practitioners and items 10983 and 10984 in Group M12 for practice nurses, Aboriginal and Torres Strait Islander health practitioners or Aboriginal health workers for services provided for and on behalf of a medical practitioner.

Telehealth patient-end support services can only be claimed where:

- a Medicare eligible specialist service is claimed;
- the service is rendered in Australia; and
- where this is necessary for the provision of the specialist service.

The above patient-end support services provide for attendances in various settings including eligible residential aged care services, eligible Aboriginal Medical Service or Aboriginal Community Controlled Health Service to which a 19(2) direction under the Health Insurance Act 1973 applies.

Clinical indications

The specialist, consultant physician or psychiatrist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the specialist, consultant physician or psychiatrist.

Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

Collaborative Consultation

The practitioner, who provides assistance to the patient where this is necessary for the provision of the specialist service, may seek assistance from a health professional (e.g. a practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker) but only one item is billable for the patient-end support service. The practitioner must be present during part or all of the consultation in order to bill an appropriate time-tiered MBS item. Any time spent by another health professional called to assist with the consultation may not be counted against the overall time taken to complete the video consultation.

Restrictions

The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes hospital in the home patients). Benefits are not payable for telephone or email consultations. In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Eligible Geographical Areas

Geographic eligibility for telehealth services funded under Medicare are determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are areas that are outside a Major City (RA1) according to ASGC-RA (RA2-5). Patients and providers are able to check their eligibility by following the links on the MBS Online website.

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

This rule will not apply to specialist video consultation with patients who are a care recipient in a residential care service; or at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service for which a direction, made under subsection 19(2) of the Health Insurance Act 1973, as these patients are to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at the MBS Online website.

Record Keeping

Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Multiple attendances on the same day

In some situations a patient may receive a telehealth consultation and a face to face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Aftercare Rule

Video consultations are subject to the same aftercare rules as face to face consultations.

Referrals

The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Technical requirements

In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a video conference meets the applicable laws for security and privacy.

Bulk billing

Bulk bill incentive items 10990 or 10991 may be billed in conjunction with the MBS medical practitioner telehealth items 812, 827, 829, 867, 868, 869, 873, 876, 881, 885, 892 or GP items 2100, 2122, 2125, 2126, 2137, 2138, 2143, 2147, 2179, 2195, 2199 and 2220.

Duration of attendance

The practitioner attending at the patient end of the video consultation does not need to be present for the entire consultation, only as long as is clinically relevant - this can be established in consultation with the specialist. The MBS fee payable for the supporting practitioner will be determined by the total time spent assisting the patient. This time does not need to be continuous.

Aboriginal health workers

For the purpose of items 10983 and 10984 an Aboriginal health worker means a person who:

a) holds a Certificate III in Aboriginal or Torres Strait Islander Health Worker Primary Health Care (Clinical) or other appropriate qualifications; or

b) is registered, and holds a current registration issued by a State or Territory regulatory authority, as an Aboriginal health worker; and

c) is employed by, or whose services are otherwise retained by a medical practitioner or their practice. This includes health service in relation to which a direction made under subsection 19(2) of the Act applies.

Aboriginal and Torres Strait Islander health practitioners

For the purpose of items 10983 and 10984 an Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the Health Insurance Act 1973.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

Practice Nurse

For the purpose of items 10983 and 10984 a practice nurse means a registered or enrolled nurse who is employed by, or whose services are otherwise retained by a medical practitioner or their practice. This includes a health service in relation to which a direction made under subsection 19(2) of the Health Insurance Act 1973 applies.

MN.13.1 Maternity Services by Participating Midwives - Overview

As at 1 November 2010, Medicare benefits are payable for antenatal, intrapartum and postnatal care for the first 6 weeks after the delivery, provided by eligible privately practising midwives. Eligible midwives can also request certain pathology and diagnostic imaging services for their patients and refer patients to obstetricians and paediatricians, as the clinical need arises. Each service that attracts a Medicare benefit is identified in the Medicare Benefits Schedule (MBS) by an item number. Each item describes the service that the item covers.

MN.13.2 Participating Midwives

To provide services under Medicare, the legislation requires that a midwife be a participating midwife. A participating midwife is an eligible midwife who provides services in a collaborative arrangement or collaborative arrangements with one or more medical practitioners, of a kind or kinds specified in the regulations.

For more details on collaborative arrangements required under the regulations see Point M.13.5.

MN.13.3 Eligible Midwives

Under the legislation, to be an eligible midwife the midwife must be registered or authorised (however described) under State and Territory law to practice midwifery. The midwife must also demonstrate that he or she has the appropriate qualifications and experience to meet the registration standard developed by the Nursing and Midwifery Board of Australia.

Information regarding eligibility can be found on the Nursing and Midwifery Board of Australia (NMBA) site of the Australian Health Practitioner Regulatory Agency (AHPRA) website at:

http://www.nursingmidwiferyboard.gov.au/.

MN.13.4 Midwife Professional Indemnity Insurance

Under National Law, which governs the National Registration and Accreditation Scheme (NRAS), it is a requirement for midwives to have appropriate professional indemnity insurance. All privately practising midwives who wish to provide private midwifery services in must have appropriate professional indemnity insurance from the date the State or Territory in which they were registered enacted National Law.

Further information about professional indemnity insurance for midwives can be found at:

http://www.health.gov.au/internet/main/publishing.nsf/Content/Maternity+Services+Review-Q&A-PIMI

MN.13.5 Collaborative Arrangements

To provide Medicare rebate-able services an eligible midwife must have a collaborative arrangement in place that must provide for consultation, referral or transfer of care as clinical needs dictate, to ensure safe, high quality maternity care.

Under the legislation a collaborative arrangement can be with the following "specified" medical practitioners:

- an obstetrician;
- a medical practitioner who provides obstetric services; or
- a medical practitioner employed or engaged by a hospital authority and authorised by the hospital authority to participate in a collaborative arrangement.

The types of practitioners listed 1) and 2) are defined in the Regulations as "obstetric specified medical practitioners".

Collaborative arrangement can be established in the following ways:

- where the midwife:

    - is employed or engaged by 1 or more obstetric specified medical practitioners or by an entity that employs or engages 1 or more obstetric specified medical practitioners; or
    - has an agreement, in writing, with an entity, other than a hospital, that employs or engages one or more obstetric specified medical practitioners, OR
- receiving patients by referral in writing to the midwife for midwifery treatment from a specified medical practitioner, OR
- having a signed written agreement with one or more specified medical practitioners, OR
- having an arrangement with and acknowledged by at least one specified medical practitioner
    - an arrangement requires that the eligible midwife must record the following in the midwife's written records:-
        - The name of at least one specified medical practitioner who is, or will be, collaborating with the midwife in the patient's care (a named medical practitioner);
        - That the midwife has told the patient that the midwife will be providing midwifery services to the patient in collaboration with one or more specified medical practitioners;
        - Acknowledgement by a named medical practitioner that the practitioner will be collaborating in the patient's care;
        - Plans for the circumstances in which the midwife will do any of the following:
            - consult with an obstetric specified medical practitioner;
            - refer the patient to a specified medical practitioner;
            - transfer the patient's care to an obstetric specified medical practitioner.
    - The midwife must also record the following in the midwife's written records:
        - Any consultation or other communication between the midwife and an obstetric specified medical practitioner about the patient's care;
        - Any referral of the patient by the midwife to a specified medical practitioner;
        - Any transfer by the midwife of the patient's care to an obstetric specified medical practitioner;
        - When the midwife gives a copy of the hospital booking letter for the patient to a named medical practitioner - acknowledgement that the named medical practitioner has received the copy;
        - When the midwife gives a copy of the patient's maternity care plan prepared by the midwife to a named medical practitioner - acknowledgement that the named medical practitioner has received the copy;
        - If the midwife requests diagnostic imaging or pathology services for the patient - when the midwife gives the results of the services to a named medical practitioner
        - That the midwife has given a discharge summary at the end of the midwife's care for the patient to:
            - a named medical practitioner; and
            - the patient's usual general practitioner, OR
- In relation to a hospital, the midwife is:
    - credentialed to provide midwifery services after successfully completing a formal process to assess the midwife's competence, performance and professional suitability; and
    - given clinical privileges for a defined scope of clinical practice for the hospital; and
    - permitted to provide midwifery care to his or her own patients at the hospital.

The legislation requires that collaborative arrangements must be in place at the time the participating midwife provides the service.

- Being employed or engaged by a medical practice or an entity or having a written agreement with an entity
  An entity may refer to, for example, a community health centre or a medical practice. For a midwife to have a collaborative arrangement in these circumstances, that midwife must be employed or engaged by or have a written agreement with an entity that also employs or engages 1 or more obstetric specified medical practitioners.
  The terms employ or engage covers both employees and contractors. This will cover an eligible midwife who is employed or engaged by a medical practice so long as that medical practice employs or engages at least one obstetrician or medical practitioner that provides obstetric services.

There must be at least one obstetric specified medical practitioner employed or engaged by the entity each time the midwife renders a service/performs treatment. However, there is no requirement that the consultation, referral or transfer of care must always be to the medical practitioner(s) employed/engaged by the entity.

- Referral from a medical practitioner
  A participating midwife's patient will be able to access the MBS and PBS if a patient has been referred in writing to the midwife by a specified medical practitioner. The arrangement must provide for consultation, referral and transfer of care should the clinical need arise.
- Written agreement with a medical practitioner
  A participating midwife's patient will be able to access the MBS and PBS if the nurse practitioner has a written agreement in place with one or more specified medical practitioners. The agreement must be signed by the nurse practitioner and doctor. The arrangement must provide for consultation, referral and transfer of care.
- Arrangement with, acknowledged by a medical practitioner
  Evidence of 'acknowledgement' by an obstetrician/GP obstetrician for each woman for whom the midwife provides care is a requirement to ensure that the medical practitioner being named understands and accepts the collaborative arrangement.
  The acknowledgement does not have to be obtained on an individual patient basis. This means that, for example, a midwife could obtain an acknowledgement from a specified medical practitioner that he or she will be the collaborating medical practitioner for some or all of the midwife's patients. Arrangements to collaborate could be obtained in a number of ways including signing of documents, email or fax confirmation, or verbal acknowledgement which the midwife documents in their written records.
  The midwife is required to record in written records communications in regard to consultations, referral and transfer of the woman's care with the medical practitioner, including information that has been forwarded to the medical practitioner. The midwife is also required to send a copy of all pathology and diagnostic imaging results to a named medical practitioner and to record in the midwife's written records when this occurs (however, there is no requirement that the midwife consult with a medical practitioner in relation to every test result). The purpose of sharing records with the collaborating medical practitioner is to prevent duplication of services and to ensure continuity of care.
- Collaborative arrangement with a hospital
  This type of collaborative arrangement applies where an eligible midwife is credentialed for a hospital, having successfully completed a formal assessment of his or her qualifications, skills, experience and professional standing. It is expected that the assessment would involve an appropriately qualified medical practitioner/s. The midwife is also required to have a defined scope of clinical practice at the hospital and be eligible to treat his or her own patients at the hospital. The hospital must employ or engage at least one obstetric specified medical practitioner. It is expected that the hospital will have a formal written agreement with such midwives, addressing consultation, referral and transfer of care, relevant clinical guidelines and locally determined policies.

MN.13.6 Provider Numbers

To access the Medicare arrangements, eligible midwives will need to apply to the Department of Human Services for a provider number. A separate provider number is required for each location at which a midwife practices.

Advice about registering with the Department of Human Services to provide midwifery services using items 82100 to 82140 inclusive, is available from the Department of Human Services provider inquiry line on 132 150.

Medicare provider application forms for midwives can be downloaded from the following site:

www.medicareaustralia.gov.au

MN.13.7 Schedule Fees and Medicare Benefits

Each midwifery service is identified in the MBS by an item number. The fee set for any item in the MBS is known as the "Schedule fee". The Schedule fee and Medicare benefit for each service is listed in the item description.

There are two levels of benefit payable for midwifery services:

75% of the Schedule fee for midwifery services rendered to privately insured patients as part of an episode of hospital treatment (other than for public patients); or

85% of the Schedule fee for antenatal and postnatal services rendered to non-admitted patients.

MN.13.8 Safety Nets

Where practitioners charge more than the Medicare benefit, the resultant out-of-pocket costs are the responsibility of the patient.

Assistance is provided to families and singles for out-of-pocket costs for out-of-hospital services through the "original" and "extended" Medicare safety nets:

- the original safety net provides that once the threshold is met, the Medicare benefit increases to 100 per cent of the Schedule fee. The threshold in 2019 is $470.00; and

- under the Extended Medicare Safety Net (EMSN), once certain thresholds are met, Medicare reimburses 80 per cent of the out-of-pocket costs. However, where the item has an EMSN benefit cap, there is a maximum limit on the EMSN benefit that will be paid for that item.

In 2019, the annual EMSN threshold for concession cardholders and people who receive Family Tax Benefits (Part A) is $680.70. For all other singles and families the annual threshold is $2,133.00. These amounts are indexed by Consumer Price Index on 1 January each year.

MN.13.9 Safety Net Capping for Midwifery Items

Midwifery services will be subject to a benefit limit or cap under the EMSN. This is in line with obstetric services which are also subject to a safety net cap. The caps that apply to midwifery services are outlined below:

Item	Maximum increase ($)
82100	21.70
82105	16.30
82110	21.70
82115	54.10
82130	16.30
82135	21.70
82140	16.30

MN.13.10 Where Medicare Benefits are not payable

Medicare benefits are not available:

a. for services listed in the MBS, where the service rendered does *not* meet the item description and associated requirements;

b. where the midwifery service is *not* personally performed by the participating midwife;

c. for MBS services that are time based, the inclusion of any time period in the consultation periods when the patient is *not* receiving active attention e.g. the time the provider may take to travel to the patient's home or where the patient is resting between blood pressure readings; and

d. services provided where the patient is not in attendance, such as the issuing of repeat prescriptions;

e. for telephone attendances;

f. group sessions; and

g. The issuing of repeat prescriptioins, updating patient notes or telephone consultations.

The fee charged under Medicare must not include the cost of services that are not part of the MBS service being claimed. Medicare benefits are not payable for good or appliances associated with the service, such as bandages or other skin dressings

Unless the Minister otherwise directs, Medicare benefits are not payable where funding has already been provided under an arrangement with the Commonwealth, state or a local governing body.

MN.13.11 Billing of Patient

Where the practitioner bills the patient for medical services rendered, the patient needs a properly itemised account/receipt to enable a claim to be made for Medicare benefits.

Under the provisions of the Health Insurance Act and Regulations, Medicare benefits are not payable in respect of a professional service unless there is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of the service, the following particulars:-

(a) Patient's name;

(b) The date on which the professional service was rendered;

(c) An item number or a description of the professional service sufficient to identify the item that relates to that service, including an indication where the service is rendered to a person while hospital treatment is provided in a hospital "admitted patient" immediately preceding the description of the service or an asterisk "*" directly after an item number where used;

(d) The name and practice address and provider number of the participating midwife who actually rendered the service; (where the participating midwife has more than one practice location recorded with the Department of Human Services, the provider number used should be that which is applicable to the practice location at or from which the service was given).

Only one original itemised account should be issued in respect of any one service and any duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

MN.13.12 Assignment of Benefits (Direct-Billing) Arrangements

Under the Health Insurance Act the Assignment of Benefit (direct-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need.

If a participating midwife direct-bills, the participating midwife undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:-

· The patient's Medicare card number must be quoted on all direct-bill forms for that patient.

· The basic forms provided are loose leaf to enable the patient details to be imprinted from the Medicare card.

· The forms include information required by Regulations under Subsection 19(6) of the Health Insurance Act.

· The practitioner must include the particulars relating to the professional service out on the assignment form before the patient signs the form and ensure that the patient to receive a copy of the form as soon as practicable after the patient signs it.

· Where a patient is unable to sign the assignment form the signature of the patient's parent, guardian or other responsible person (other than the practitioner, practitioner's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff) is acceptable. The reason the patient is unable to sign should also be stated.

The administration of the direct-billing arrangements under Medicare as well as the payment of Medicare benefits on patient claims is the responsibility of **the Department of Human Services**. Any enquiries in regard to these matters should therefore be directed to Medicare offices or enquiry points.

MN.13.13 Assignment of Benefit Forms

Participating midwives wishing to direct-bill are required to use a specific form available from the Department of Human Services. This stationary is available from the Department of Human Services. Note that these forms are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of the Department of Human Services. Further information about direct-billing stationary can be obtained by telephoning **132150**.

MN.13.14 Time Limits Applicable to Lodgement of Claims for Assigned Benefits

A time limit of two years applies to the lodgement of claims with Medicare under the direct-billing (assignment of benefit) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than two years earlier than the date the claim was lodged with Medicare.

Provision exists whereby in certain circumstances (e.g. hardship cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

MN.13.15 Overview of the Maternity Items

Antenatal, intrapartum and postnatal care provided by participating midwives are covered by MBS items 82100, 82105, 82110, 82115, 82120, 82125, 82130, 82135, 82140. These items cover nine specific types of service that allow the participating midwife to:

· undertake an initial antenatal attendance of more than 40 minutes duration (item 82100)

· provide a short antenatal attendance of up to 40 minutes duration (item 82105)

· provide a long antenatal attendance of more than 40 minutes duration (item 82110);

· make an assessment of and prepare a maternity care plan for a woman across a pregnancy that has progressed beyond 20 weeks (item 82115);

· undertake management of a confinement for up to 12 hours, including delivery (item 82120);

· undertake management of a confinement in excess of 12 hours including delivery (item 82125);

· provide a short postnatal attendance of up to 40 minutes duration (item 82130);

· provide long postnatal attendance of at least 40 minutes duration (item 82135); and

· provide a comprehensive postnatal check to a woman six weeks after the birth of her baby (item 82140).

MN.13.16 Maternity Services Attracting Medicare Rebates

Medicare Benefits are only payable for clinically relevant services. ***Clinically relevant*** in relation to midwifery care means a service generally accepted by the midwifery profession as necessary to the appropriate treatment of the patient's clinical condition.

Medicare benefits are only payable where the participating midwife provides care to not more than one patient on the one occasion.

Antenatal Care

Eligible maternity care plan service

There is one MBS item available for eligible midwife practitioners to undertake a comprehensive assessment of and prepare a written maternity care plan for a woman, who is not an admitted patient of a hospital, across a pregnancy that has progressed beyond 20 weeks. It is expected that the care plan would be agreed with the woman and detail such things as agreed expectation, health problems and care needs and appropriate referrals, medication and diagnostic tests.

Number of services

Only one (1) midwifery care plan is payable in any pregnancy.

Antenatal Attendances

Medicare benefits are payable for an antenatal service where a midwife provides a clinically relevant service in respect of a miscarriage. Medicare benefits are not payable for an antenatal attendance associated with the confinement. The confinement items 82120 and 82125 include all associated attendances.

Any clinically relevant indication that requires an antenatal attendance by a midwife on an admitted patient in hospital, but that is not associated with the confinement, will attract a Medicare benefit.

Number of services

Only one (1) initial antenatal attendance under item 82100 is payable in any pregnancy.

There is no limit attached to long and short antenatal attendances by a participating midwife. However, only clinically relevant attendances should be itemised under Medicare and services provided by participating midwives will be subject to Medicare Audit and Professional Review Processes.

Management of Confinement

The MBS includes two items for management of confinement by a participating midwife; 82120 for a confinement of up to 12 hours, and 82125 for a confinement where labour is in excess of 12 hours, and the woman's care has been transferred to another participating midwife.

Medicare benefits are payable under items 82120 and 82125 whether or not the participating midwife undertakes the delivery i.e. including where the woman's care is escalated to an obstetrician during labour or for the delivery.

Medicare benefits are only payable where the service is provided to a woman who is an admitted patient of a hospital, including a hospital birthing centre. For Medicare benefit purposes a confinement is taken to commence when the participating midwife attends a patient that is in labour and who has been admitted to the hospital for confinement and delivery The time period for these items is the period for which the midwife is in exclusive and continuous attendance on the woman for labour, and delivery where performed.

Medicare benefits are only payable for management of confinement where the participating midwife undertaking the service has provided the patient's antenatal care or who is a member of a practice that provided the patient's antenatal care.

It is not intended that these items be claimed routinely by midwives who do not intend to undertake the delivery i.e where the midwife has arranged beforehand for a medical practitioner to undertake the delivery. Where the midwife does not undertake the delivery it is because:

· care was transferred to a second midwife for management of labour which had exceeded 12 hours; or

· there was a clinical need to escalate care to an obstetrician or medical practitioner who provides obstetric services; or

· the patient's care was transferred from the first midwife to another participating midwife in exceptional circumstances.

Number of services

Only one (1) confinement item 82120 is payable in any pregnancy, except where exceptional circumstances have required the patient's care to be transferred from the first midwife to another participating midwife. In these circumstances, both midwives may bill an item 82120 service.

Medicare rebates are only payable for (1) confinement item 82125.

Postnatal Care

In addition to the long and short antenatal attendance items for postnatal care in the first 6 weeks post delivery the MBS provides for a 6 week postnatal check, after which the woman would be referred back to her usual GP.

Number of services

Only one (1) postnatal check by a participating midwife is payable in any pregnancy.

There is no limit attached to long and short postnatal attendances by a participating midwife. However, only clinically relevant attendances should be itemised under Medicare and services provided by participating midwives will be subject to Medicare Audit and Professional Review Processes.

MN.13.17 Conditions Governing the Provision and Claiming of Items

Service length and type

Services under these items must be for the time period specified within the item descriptor.

Professional attendance for MBS items 82100, 82105, 82110, 82115, 82130, 82135, 82140 may be provided in an appropriate setting that includes but is not limited to: the woman's home, a midwifery group practice, a midwife practitioner's rooms or a medical practice.

MN.13.18 Referral Requirements

A participating midwife will be able to refer women to specialist obstetricians and paediatricians as clinical services dictate.

This measure does not include referral by a midwife for allied health care. If a participating midwife refers a patient to an allied health practitioner, no benefits would be payable for that service.

Medicare benefits are not payable specifically for services provided by a lactation consultant at this time. Medicare benefits would be payable for breast feeding support provide as part of the postnatal care by the participating midwife.

A referral is valid for 12 months to cover the confinement (antenatal, birthing and postnatal care for 6 weeks post delivery). Should there be a new pregnancy in that period, a new referral will be required.

A new pregnancy represents a new episode of care.

A referral to a specialist must be in writing in the form of a letter or a note to the specialist and must be signed and dated by the referring midwife. The referral must contain any information relevant to the patient and the specialist must have received the referral on or prior to providing a specialist consultation.

If a specialist provides a consultation without a referral, the specialist's consultation would not attract Medicare benefits at the specialist rate.

There are exemptions from this requirement in an emergency if the specialist considers the patient's condition requires immediate attention without a referral. In that situation, the specialist is taken to be the referring practitioner.

If a referral is lost, stolen or destroyed, the midwife would need to provide a replacement referral as soon as is practicable after the service is provided.

If the woman is a privately admitted patient of a hospital a letter or note is not required. The referring midwife would make a notation in the woman's hospital, which he or she would sign, approving the referral.

A referral is not required to transfer a woman's care during the intra-partum period under items 16527 and 16528. The midwife would make a signed notation in the woman's clinical record approving the transfer of care.

A referral is not required to refer the woman back to her GP after the 6 week postnatal period. The midwife would provide a discharge summary to the GP outlining her maternity history and any relevant clinical issues, which would also be recorded on the patient's notes.

MN.13.19 Requesting Requirements

Pathology Services

Determination of Necessity of Service

The participating midwife requesting a pathology service for a woman must determine that the pathology service is necessary.

Request for Service

The service may only be provided in response to a request from the treating practitioner and the request must be in writing (or, if oral, confirmed in writing within fourteen days).

Pathology Services approved for participating midwives

FBC (item 65070)	vaginal /anal swab/GBS (69312)* varicella 69384 - 69401 (antibody test) parvo virus 69384 - 69401
Hb (item 65060)	rubella titre syphilis Hep B/C - items 69405, 69408, 69411, 69413 or 69415 HIV
Group and antibodies (items 65090, 65093, 65096) glucose load (items 66545, 66548)	Serum Bilirubin (SBR); 66500
Downs Syndrome/ Spina Bifida (items 66743, 66750, 66751)	Direct Coombs; 65114
eye swab (69303)	Blood glucose level (item 66500)
skin swab (69306)	Cord PH and gases cord (O2 and CO2) (Item 66566)
skin scrapings (69309)	Group and Hold (item 65099)
Chlamydia (item 69316)	Coagulation Studies (items 65129, 65070)
Gonorrhea (item 69317)	Mid stream urine (item 69324)

Cervical screening (items 73070, 73071, 73075, 73076)	HCG (item 73529)

Diagnostic Imaging Services

Determination of Necessity of Service

The participating midwife requesting a diagnostic imaging service for a woman must determine that the diagnostic imaging service is necessary for the appropriate professional care of the patient.

Request for Service

The service may only be provided in response to a request from the treating practitioner, and the request must be in writing, signed and dated.

The request does not have to be in a particular form. However, legislation provides that a request must be in writing and contain sufficient information, in terms that are generally understood by the profession, to clearly identify the item/s of service requested. This includes, where relevant, noting on the request the clinical indication(s) for the requested service. The provision of additional relevant clinical information can often assist the service provider, and enhance the overall service provided to the patient.

It is not necessary that a written request for a diagnostic imaging service be addressed to a particular provider or that, if the request is addressed to a particular provider, the service must be rendered by that provider.

A single request may be used to order a number of diagnostic imaging services. However, all services provided under this request must be rendered within seven days after rendering the first service.

Ultrasound:

Routine morphology scan (item 55706)	Nuchal Translucency (item 55707)
Early dating scan (item 55700)	Post 22 weeks scan (item 55718)
Scan at 12-16 weeks (item 55704)	

MN.14.1 Participating Nurse Practitioners Services - Overview

As at 1 November 2010, Medicare benefits are payable for services provided by privately practising participating nurse practitioners in collaboration with other health care providers. Participating nurse practitioners can also request certain pathology and diagnostic imaging services for their patients and refer patients to specialist, as the clinical need arises. The nurse practitioner services that attract a Medicare benefit are identified in the Medicare Benefits Schedule (MBS) by an item number and the each item describes the service requirements and schedule fee.

MN.14.2 Eligible Nurse Practitioners

Under the legislation, to be an eligible nurse practitioner the nurse practitioner must be registered or authorised (however described) under State and Territory law. The nurse practitioner must also demonstrate that he or she has the appropriate qualifications and experience to meet the registration standard developed by the Nursing and Midwifery Board of Australia (NMBA).

This standard was developed for the purposes of the National Registration and Accreditation Scheme (NRAS), a single regulation and accreditation scheme for health professionals, including nurse practitioners. Additional information is available at the Australian Health Practitioners Regulation Agency (AHPRA) website at: http://www.ahpra.gov.au/index.php

MN.14.3 Provider Numbers

To access the Medicare arrangements, eligible nurse practitioners will need to apply to the Department of Human Services for a provider number. A separate provider number is required for each location at which a nurse practitioner practices.

Advice about registering with the Department of Human Services to provide nurse practitioner services using items 82200 to 82215 inclusive, is available from the Department of Human Services provider inquiry line on 132 150.

Medicare provider application forms for nurse practitioners can be downloaded from the Department of Human Services' website.

MN.14.4 Participating Nurse Practitioners

To provide services under Medicare, the legislation requires that a nurse practitioner be a participating nurse practitioner. A participating nurse practitioner is an eligible nurse practitioner who has a Medicare provider number and who provides Medicare services in a collaborative arrangement or collaborative arrangements with one or more medical practitioners, of a kind or kinds specified in the regulations.

MN.14.5 Collaborative Arrangements

Under the Medicare program collaboration is having arrangements in place with a medical practitioner/s to consult, refer or transfer care as clinical needs dictate, to ensure safe, high quality maternity care. Under Medicare a collaborative arrangement can be with any medical practitioner.

Collaborative arrangement can be established in the following ways:

a) being employed or engaged by 1 or more specified medical practitioners or by an entity that employs or engages 1 or more specified medical practitioners; OR

b) receiving patients by referral in writing to the nurse practitioner for treatment from a specified medical practitioner, OR

c) having a signed written agreement with one or more specified medical practitioners, OR

d) having an arrangement with and acknowledged by at least one specified medical practitioners. This includes keeping comprehensive notes on all instances of consultation, referral and transfer of care, diagnostic tests requested and the test results and providing the collaborating practitioner/s with those results.

The legislation requires that collaborative arrangements must be in place at the time the participating nurse practitioner provides the service. The legislation requires that for each kind of collaborative arrangement, at least one medical practitioner is needed; it is not possible for the nurse practitioner to have a collaborative arrangement with an entity such as a health service.

a) Being employed or engaged by a medical practice or an entity

An entity may refer to a hospital or community health centre. For a nurse practitioner to have a collaborative arrangement in these circumstances, that nurse practitioner must be employed or engaged by an entity that also employs or engages 1 or more specified medical practitioners.

The terms employ or engage covers both employees and contractors. This will cover an eligible nurse practitioner who is employed or engaged by a medical practice so long as that medical practice employs or engages at least one medical practitioner.

There must be at least one specified medical practitioner employed or engaged by the entity each time the nurse practitioner renders a service/performs treatment. However, there is no requirement that the consultation, referral or transfer of care must always be to the medical practitioner(s) employed/engaged by the entity.

b) Referral from a medical practitioner

A participating nurse practitioner's patient will be able to access the MBS and PBS if a patient has been referred in writing to the nurse practitioner by a specified medical practitioner. The arrangement must provide for consultation, referral and transfer of care should the clinical need arise.

c) Written agreement with a medical practitioner

A nurse practitioner's patient will be able to access the MBS and PBS if the nurse practitioner has a written agreement in place with one or more doctors. The agreement must be signed by the nurse practitioner and a doctor. The arrangement must deal with consultation, referral and transfer to a doctor.

d) Arrangement with, acknowledged by a medical practitioner.

Evidence of 'acknowledgement' by a medical practitioner for each patient for whom the nurse practitioner provides care is a requirement to ensure that the medical practitioner being named understands and accepts the collaborative arrangement.

The acknowledgement does not have to be obtained on an individual patient basis. This means that, for example, a nurse practitioner could obtain an acknowledgement from a specified medical practitioner that he or she will be the collaborating medical practitioner for some or all of the nurse practitioner's patients. Arrangements to collaborate could be obtained in a number of ways including signing of documents, email or fax confirmation, or verbal acknowledgement which the nurse practitioner documents in their written records.

The nurse practitioner is required to record in written records any communications in regard to consultations, referral and transfer of the patient's care with the medical practitioner, including information that has been forwarded to the medical practitioner. The nurse practitioner is also required to send a copy of all pathology and diagnostic imaging results to a named medical practitioner and to record in the nurse practitioner's written records when this occurs (however, there is no requirement that the nurse practitioner consult with a medical practitioner in relation to every test result). The purpose of sharing records with the collaborating medical practitioner is to prevent duplication of services and to ensure continuity of care.

Arrangements to collaborate could be obtained in a number of ways including signing of documents, email or fax confirmation, or verbal acknowledgement which the nurse practitioner documents in their written records.

MN.14.6 Schedule Fees and Medicare Benefits

Each nurse practitioner service is identified in the MBS by an item number. The fee set for any item in the MBS is known as the "Schedule fee". The Schedule fee and Medicare benefit for each service is listed in the item description. The Medicare benefit for nurse practitioner services rendered to non-admitted patients is 85% of the Schedule fee.

MN.14.7 Where Medicare Benefits are not payable

Medicare benefits are not available:

a. where the service rendered does not meet the item description and associated requirements;

b. where the nurse practitioner service is not personally performed by the participating nurse practitioner;

c. for any time period in the consultation periods when the patient is not receiving active attention e.g. the time the provider may take to travel to the patient's home or where the patient is resting between blood pressure readings;

d. services provided where the patient is not in attendance, such as the issuing of repeat prescriptions;

e. for telephone attendances; and

f. group sessions.

The fee charged under Medicare must not include the cost of services that are not part of the MBS service being claimed. Medicare benefits are not payable for good or appliances associated with the service, such as bandages or other skin dressings.

Unless the Minister otherwise directs, Medicare benefits are not payable where funding has already been provided under an arrangement with the Commonwealth, state or a local governing body.

MN.14.8 Billing of the Patient

Where the nurse practitioner bills the patient for medical services rendered, the patient needs a properly itemised account/receipt to enable a claim to be made for Medicare benefits.

Under the provisions of the Health Insurance Act and Regulations, Medicare benefits are not payable in respect of a professional service unless there is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of the service, the following particulars:

(a) Patient's name;

(b) The date on which the professional service was rendered;

(c) An item number or a description of the professional service sufficient to identify the item that relates to that service, including an indication where the service is rendered to a person while hospital treatment is provided in a hospital "admitted patient" immediately preceding the description of the service or an asterisk "*" directly after an item number where used;

(d) The name and practice address and provider number of the participating nurse practitioner who actually rendered the service; (where the participating nurse practitioner has more than one practice location recorded with the Department of Human Services, the provider number used should be that which is applicable to the practice location at or from which the service was given).

Only one original itemised account should be issued in respect of any one service and any duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

MN.14.9 Assignment of Benefits (Direct-Billing Arrangements

Under the Health Insurance Act the Assignment of Benefit (direct billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need.

If a participating nurse practitioner direct-bills, the participating nurse practitioner undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient.

Under these arrangements:

The patient's Medicare card number must be quoted on all direct bill forms for that patient.

The basic forms provided are loose leaf to enable the patient details to be imprinted from the Medicare card.

The forms include information required by Regulations under Subsection 19(6) of the Health Insurance Act.

The nurse practitioner must include the particulars relating to the professional service out on the assignment form before the patient signs the form and ensure that the patient to receive a copy of the form as soon as practicable after the patient signs it.

Where a patient is unable to sign the assignment form the signature of the patient's parent, guardian or other responsible person (other than the nurse practitioner, nurse practitioner's staff, hospital proprietor, hospital staff,

residential aged care facility proprietor or residential aged care facility staff) is acceptable. The reason the patient is unable to sign should also be stated.

The administration of the direct billing arrangements under Medicare as well as the payment of Medicare benefits on patient claims is the responsibility of the Department of Human Services. Any enquiries in regard to these matters should therefore be directed to Medicare offices or enquiry points.

MN.14.10 Assignment of Benefit Forms

Participating nurse practitioners wishing to direct-bill are required to use a specific form available from the Department of Human Services. This stationary is available from the Department of Human Services. Note that these forms are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of the Department of Human Services. Further information about direct-billing stationary can be obtained by telephoning 132150.

MN.14.11 Time Limits applicable to lodgement of claims for assigned benefits

A time limit of two years applies to the lodgement of claims with Medicare under the direct billing (assignment of benefit) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than two years earlier than the date the claim was lodged with Medicare.

Provision exists whereby in certain circumstances (e.g. hardship cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

MN.14.12 Overview of the Nurse Practitioner items

Services provided by participating nurse practitioners are covered by MBS items 82200, 82205, 82210, 82215. These items cover four time-tiered specific types of service that allow the participating nurse practitioner to perform a:

professional attendance for an obvious problem, straight forward in nature, with limited examination and management required (82200)

professional attendance for a patient presenting with clinical signs and symptoms with an easily identifiable underlying cause following a short consultation lasting less than 20 minutes duration (item 82205)

professional attendance for a patient presenting with clinical signs and symptoms with no obvious underlying cause requiring a more detailed consultation lasting at least than 20 minutes duration (item 82210);

professional attendance for a patient presenting with multiple clinical signs and symptoms with the possibility of multiple causes and outcomes requiring an extensive consultation of at least 40 minutes (item 82215);

MN.14.13 Nurse Practitioner services attracting Medicare rebates

Medicare Benefits are only payable for clinically relevant services. Clinically relevant in relation to nurse practitioner care means a service generally accepted by the nursing profession as necessary to the appropriate treatment of the patient's clinical condition.

Medicare benefits are only payable where the participating nurse practitioner provides care to not more than one patient on one occasion.

MN.14.14 Conditions governing the provision and claiming of items

Service length and type

Services under these items must be for the time period specified within the item descriptor.

Professional attendance for MBS items 82200, 82205, 82210, 82215, may be provided in an appropriate setting that includes but is not limited to: the patient's home, a nurse practitioner group practice, a nurse practitioner's rooms or a medical practice.

MN.14.15 Referral requirements

A participating nurse practitioner will be able to refer private patients to a specialist and consultant physician as clinical services dictate.

This measure does not include referral by a nurse practitioner for allied health care. If a participating nurse practitioner refers a patient to an allied health practitioner, no benefits would be payable for that service provided by the allied health professional.

A referral given by a participating nurse practitioner is valid until 12 months after the first service given in accordance with the referral.

If the referral is lost, stolen or destroyed, the nurse practitioner would need to provide a replacement referral as soon as is practicable after the service is provided.

A referral to a specialist must be in writing in the form of a letter or a note to the specialist and must be signed and dated by the referring nurse practitioner. The referral must contain any information relevant to the patient and the specialist must have received the referral on or prior to providing a specialist consultation.

There are exemptions from this requirement in an emergency if the specialist considers the patient's condition requires immediate attention without a referral. In that situation, the specialist is taken to be the referring practitioner.

MN.14.16 Requesting requirements

Pathology Services

Determination of Necessity of Service

The participating nurse practitioner requesting a pathology service for a patient must determine that the pathology service is necessary.

Request for Service

The service may only be provided in response to a request from the treating practitioner and the request must be in writing (or, if oral, confirmed in writing within fourteen days).

Pathology Services approved for participating nurse practitioners

Nurse practitioners may request MBS pathology items 65060 - 73810 (inclusive). Requesting pathology services must be within the nurse practitioner's scope of practice.

Further information

For further information about Medicare Benefits Schedule items, please go to the Department of Health's website at www.health.gov.au/mbsonline.

Diagnostic Imaging Services

Determination of Necessity of Service

The participating nurse practitioner requesting a diagnostic imaging service for a patient must determine that the diagnostic imaging service is necessary for the appropriate professional care of the patient.

Request for Service

The service may only be provided in response to a request from the treating nurse practitioner, and the request must be in writing, signed and dated. The legislation provides that a request must be in writing and contain sufficient information, in terms that are generally understood by the profession, to clearly identify the item/s of service requested. This includes, where relevant, noting on the request the clinical indication(s) for the requested service. The provision of additional relevant clinical information can often assist the service provider, and enhance the overall service provided to the patient.

It is not necessary that a written request for a diagnostic imaging service be addressed to a particular provider or that, if the request is addressed to a particular provider, the service must be rendered by that provider.

A single request may be used to order a number of diagnostic imaging services. However, all services provided under this request must be rendered within seven days after rendering the first service.

Ultrasound:

Subgroup 1: General Ultrasound

MBS item: 55036 (abdomen)

MBS items: 55070, 55076 (breast)

Subgroup 4: Urological

MBS item: 55600 (prostate)

Subgroup 5: Obstetric and Gynaecological

MBS item: 55768

Subgroup 6: Musculoskeletal

MBS items: 55800, 55804, 55808, 55812, 55816, 55820, 55824, 55828, 55832, 55836, 55840, 55844, 55848, 55850, 55852

X-ray:

Subgroup 1: Radiographic examination of the extremities

MBS items: 57509, 57515, 57521

subgroup 6: Radiographic examination of the thoracic region

MBS items: 58503 - 58527 (inclusive)

MN.15.1 Brain Stem Evoked Response Audiometry - (Item 82300)

Item 82300 can be claimed for the programming of a cochlear speech processor.

MN.15.2 Non-Determinate Audiometry - (Item 82306)

This refers to audiometry covering those services, one or more, referred to in Items 82309-82318 when not performed under the conditions set out in paragraph M15.3.

MN.15.3 Conditions for Audiology Services - (Items 82309 to 82318)

A service specified in Items 82309 to 82318 shall be taken to be a service for the purposes of payment of benefits if, and only if, it is rendered:

(a) in conditions that allow the establishment of determinate thresholds;

(b) in a sound attenuated environment with background noise conditions that comply with Australian Standard

AS/NZS 1269.3-2005; and

(c) using calibrated equipment that complies with Australian Standard AS IEC 60645.1-22002, ASIEC60645.2-2002 and AS IEC 60645.3-2002.

MN.15.4 Oto-Acoustic Emission Audiometry - (Item 82332)

Medicare benefits are not payable under Item 82332 for routine screening of infants. The equipment used to provide this service must be capable of displaying the recorded emission and not just a pass/fail indicator.

MN.15.5 Provision of Diagnostic Audiology Services by Audiologists - (Items 82300 to 82332)

OVERVIEW

The diagnostic audiology services available through MBS items 82300 to 82332 enable an eligible audiologist to perform diagnostic tests upon written request from an Ear, Nose and Throat (ENT) specialist (a specialist in the specialty of otolaryngology head and neck surgery); or for some services, a written request from a neurologist (a specialist or consultant physician in the specialty of neurology).

These diagnostic audiology services assist ENT specialists and neurologists in their medical diagnosis and/or treatment and/or management of ear disease or related disorders. The new diagnostic audiology items supplement the existing Otolaryngology items for services delivered by, or on behalf of medical practitioners (MBS items 11300 to 11339, excluding 11304).

Requesting arrangements

Medicare benefits are payable only under the following circumstances:

· For items 82300 and 82306, the written request must be made by an eligible practitioner who is a specialist in the specialty of otolaryngology head and neck surgery;

· For items 82309 to 82332, the written request must be made by an eligible practitioner who is a specialist in the specialty of otolaryngology head and neck surgery or a specialist or consultant physician in the specialty of neurology.

The written request must be in writing and must contain:

(a) the date of the request; and

(b) the name of the eligible practitioner who requested the service and either the address of his or her place of practice or the provider number in respect of his or her place of practice; and

(c) a description of the service which provides sufficient information to identify the service as relating to a particular item (but need not specify the item number).

Written requests should, where possible, note the clinical indication/s for the requested service/s.

A request may be for the performance of more than one diagnostic audiology service making up a single audiological assessment, but cannot be for more than one audiological assessment. This means that for Medicare benefits to be payable, any re-evaluation of the patient should be made at the discretion of the ENT specialist or neurologist through a separate request.

Audiologists do not have the discretion to self-determine diagnostic tests under items 82300 to 82332. If a written request is incomplete or requires clarification, the audiologist should contact the requesting ENT specialist or

neurologist for further information. If an audiologist considers that additional tests may be necessary, the audiologist should contact the requesting ENTspecialist or neurologist to discuss the need and if the requesting practitioner determines that additional tests are necessary, an amended or separate written request must be arranged.

It is recommended that audiologists retain the written request for 24 months from the date the service was rendered (for Medicare auditing purposes). A copy of the written request is not required to accompany Medicare claims or be attached to patients' itemised accounts/receipts or assignment of benefit forms.

Eligibility requirements for audiologists

The diagnostic audiology items (82300 to 82332) can only be claimed by audiologists who are registered with the Department of Human Services. To be eligible to register with the Department of Human Services to provide these services, audiologists must meet the following requirements:

Audiologists must be either:

· a 'Full Member' of the Audiological Society of Australia Inc (ASA), who holds a 'Certificate of Clinical Practice' issued by the ASA; or

· an 'Ordinary Member - Audiologist' or 'Fellow Audiologist' of the Australian College of Audiology (ACAud).

Registering with the Department of Human Services

Provider registration forms may be obtained from Medicare on 132 150 or at www.humanservices.gov.au.

Changes to provider details

Audiologists must notify the Department of Human Services in writing of all changes to mailing details to ensure that they continue to receive information about Medicare services.

Reporting requirements

Where an audiologist provides diagnostic audiology service/s to the patient under a written request, they must provide a copy of the results of the service/s performed together with relevant written comments on those results to the requesting ENT specialist or neurologist. It is recommended that these be provided within 7 days of the date the service was performed.

Out-of-pocket expenses and Medicare Safety Net

Audiologists can determine their own fees for the professional service. Charges in excess of the Medicare benefit are the responsibility of the patient. However, out-of-pocket costs will count toward the Medicare Safety Net for that patient.

Publicly funded services

Items 82300 to 82332 do not apply for services that are provided by any Commonwealth or state funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or state/territory government health clinic, items 82300 to 82332 can be claimed for services provided by audiologists salaried by, or contracted to, the service or health clinic. All requirements of the relevant item must be met, including registration of the audiologist with the Department of Human Services. Medicare services provided under a subsection 19(2) exemption must be bulk billed (i.e. the Medicare rebate is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

MN.16.1 Eating Disorders General Explanatory Notes

Eating Disorders General Explanatory Notes (items 82350-82383)

This note provides a general overview of the full range of 1 November 2019 eating disorders items and supporting information more specifically on the on the Category 8 – Miscellaneous Services: Group M16 – Eating disorders services (82350-82383).

It includes an overview of the items, model of care, patient eligibility, and inks to other guidance and resources.

Overview

All 1 November 2019 Eating Disorders new items:

The Eating Disorders items define services for which Medicare rebates are payable where service providers undertake assessment and management of patients with a diagnosis of anorexia nervosa and patients with other specified eating disorder diagnoses who meet the eligibility criteria (see – patient eligibility). It is expected that there will be a multidisciplinary approach to patient management through these items.

The items mean eligible patients are able to receive a Medicare rebate for development of an eating disorders treatment plan by a medical practitioner in general practice (Group A36, subgroup 1), psychiatry or paediatrics (Group A36, subgroup 2). Patients with an eating disorders treatment and management plan (EDP) will be eligible for comprehensive treatment and management services for a 12 month period, including:

- Up to 20 dietetic services under items 10954, 82350 and 82351.
- Up to 40 eating disorder psychological treatment services (EDPT service).
- Review and ongoing management services to ensure that the patient accesses the appropriate level of intervention (Group A36, subgroup 3).

An EDPT service includes mental health treatment services which are provided by an allied health professional or a medical practitioner in general practice with appropriate mental health training. These treatment services include:

- Medicare mental health treatment services currently provided to patients under the 'Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS ('Better Access') initiative.
    - This includes medical practitioner items 2721, 2723, 2725, 2727, 283, 285, 286, 287, 371, 372; and
    - This includes allied health items in Groups M6 and M7 of Category 8; and
- new items for EDPT services provided by suitably trained medical practitioners in general practice (items 90271, 90272, 90273, 90274, 90275, 90276, 90277, 90278, 90279, 90280, 90281, 90282)
- new items for EDPT services provided by eligible clinical psychologists (items 82352-82359), eligible psychologists (items 82360-82367), eligible occupational therapists (items 82368-82375) and eligible social workers (items 82376-82383)

For any particular patient, an eating disorder treatment and management plan expires at the end of a 12 month period following provision of that service. After that period, a patient will require a new EDP to continue accessing EDPT services.

Patient Eligibility

The eating disorder items are available to eligible patients in the community. These items do not apply to services provided to admitted (in-hospital) patients.

The referring practitioner is responsible for determining that a patient is eligible for an EDP and therefore EDPT and dietetic services.

'Eligible patient' defines the group of patients who can access the new eating disorder services. There are two cohorts of eligible patients.

- Patients with a clinical diagnosis of anorexia nervosa; or
- Patients who meet the eligibility criteria (below), and have a clinical diagnosis of any of the following conditions:
    - bulimia nervosa;
    - binge-eating disorder;
    - other specified feeding or eating disorder.

The eligibility criteria, for a patient, is:

- a person who has been assessed as having an Eating Disorder Examination Questionnaire score of 3 or more; and
- the condition is characterised by rapid weight loss, or frequent binge eating or inappropriate compensatory behaviour as manifested by 3 or more occurrences per week; and
- a person who has at least two of the following indicators:
    - clinically underweight with a body weight less than 85% of expected weight where weight loss is directly attributable to the eating disorder;
    - current or high risk of medical complications due to eating disorder behaviours and symptoms;
    - serious comorbid medical or psychological conditions significantly impacting on medical or psychological health status with impacts on function;
    - the person has been admitted to a hospital for an eating disorder in the previous 12 months;
    - inadequate treatment response to evidence based eating disorder treatment over the past six months despite active and consistent participation.

The Eating Disorders Items Stepped Model of Care

The eating disorder items incorporate a 'stepped model' for best practice care for eligible patients with eating disorders that comprise:

- assessment and treatment planning
- provision of and/or referral for appropriate evidence based eating disorder specific treatment services by allied mental health professionals and provision of services by dietitians
- review and ongoing management items to ensure that the patient accesses the appropriate level of intervention.

The Stepped Model

'STEP 1' – PLANNING (trigger eating disorders pathway) 90250-90257 and 90260-90263

An eligible patient receives an eating disorder plan (EDP) developed by a medical practitioner in general practice (items 90250-90257), psychiatry (items 90260-90262) or paediatrics (items 90261-90263).

'STEP 2' – COMMENCE INITIAL COURSE OF TREATMENT (psychological & dietetic services)

Once an eligible patient has an EDP in place, the 12 month period commences, and the patient is eligible for an initial course of treatment up to 20 dietetic services and 10 eating disorder psychological treatment (EDPT) services. A patient will be eligible for an additional 30 EDPT services in the 12 month period, subject to reviews from medical practitioners to determine appropriate intensity of treatment.

'STEP 3" – CONTINUE ON INITIAL COURSE OF TREATMENT 90264-90269 (managing practitioner review and progress up to 20 EDPT services)

It is expected that the managing practitioner will be reviewing the patient on a regular, ongoing and as required basis. However, a patient must have a review of the EDP (90264-90269), to assess the patient's progress against the EDP or update the EDP, before they can access more than 10 EDPT services. This is known as the 'first review'. The first review should be provided by the patient's managing practitioner, where possible.

'STEP 4' FORMAL SPECIALIST AND PRACTITIONER REVIEW 90266-90269 (continue beyond 20 EDPT services)

A patient must have two additional reviews before they can access more than 20 EDPT services. One review (the 'second review') must be performed by a medical practitioner in general practice (who is expected to be the managing practitioner), and the other (the 'third review') must be performed by a paediatrician (90267 or 90269) or psychiatrist (90266 or 90268). Should both recommend the patient requires more intensive treatment, the patient would be able to access an additional 10 EDPT services in the 12 month period. These reviews are required to determine that the patient has not responded to treatment at the lower intensity levels.

The patient's managing practitioner should be provided with a copy of the specialist review.

The specialist review by the psychiatrist or paediatrician can occur at any point before 20 EDPT services. The practitioner should refer the patient for specialist review as early in the treatment process as appropriate. If the practitioner is of the opinion that the patient should receive more than 20 EDPT services, the referral should occur at the first practitioner review (after the first course of treatment) if it has not been initiated earlier.

Practitioners should be aware that the specialist review can be provided via telehealth (90268 and 90269). Where appropriate, provision has been made for practitioner participation on the patient-end of the telehealth consultation.

It is expected that the managing practitioner will be reviewing the patient on a regular, ongoing and as required basis. However, a patient must have a review of the EDP (90264-90269), to assess the patient's progress against the EDP or update the EDP, before they can access the next course of treatment.

'STEP 5' ACCESS TO MAXIMUM INTENSITY OF TREATMENT 90266-90269 (continue beyond 30 EDPT services)

To access more than 30 EDPT treatment services in the 12 month period, patients are required to have an additional review (the 'fourth review') to ensure the highest intensity of treatment is appropriate. Subject to this review, a patient could access the maximum of 40 EDPT treatment services in a 12 month period. The fourth review should be provided by the patient's managing practitioner, where possible.

An Integrated Team Approach

A patient's family and/or carers should be involved in the treatment planning and discussions where appropriate. The family can be involved in care options throughout the diagnosis and assessment, and are usually the support unit that help to bridge the gap between initial diagnosis and eating disorder specific treatment.

The National Standards for the safe treatment of eating disorders specify a multi-disciplinary treatment approach that provides coordinated psychological, physical, behavioural, nutritional and functional care to address all aspects of eating disorders. People with eating disorders require integrated inter-professional treatment that is able to work within a framework of shared goals, care plans and client and family information. Frequent communication is required between treatment providers to prevent deterioration in physical and mental health (RANZCP Clinical Guidelines: Hay et al., 2014). Consider regular case conferencing to ensure that the contributing team members are able to work within a shared care plan and with client and carers to achieve best outcomes.

Clinical guidelines and other resources

Eating Disorders Training

It is expected that allied health professionals who are providing services under these items have appropriate training, skills and experience in treatment of patients with eating disorders and meet the national workforce core

competencies for the safe and effective identification of and response to eating disorders more information available at National Eating Disorders Collaboration

Training Services

Allied health professionals should contact their professional organisation to identify education and training which may assist to practitioners to gain the skills and knowledge to provide services under these items.

The following organisations provide training which may assist practitioners to meet the workforce competency standards:

- The Australia and New Zealand Academy of eating disorders (ANZAED) - National
- InsideOut Institute - National
- The Victorian Centre of Excellence in Eating Disorders (CEED) - VIC
- Queensland Eating Disorder Service (QuEDS) - QLD
- Statewide Eating Disorder Service (SEDS) - SA
- WA Eating Disorders Outreach & Consultation Service (WAEDOCS) – WA

This list is not exhaustive, but has been included to provide examples on the types of training available which may assist practitioners to upskill in this area.

MN.16.2 Eating Disorders Dietetic Tratment Services

Eating Disorders Dietetic Treatment Services (82350 and 82351)

This note provides information on the Category 8 – Miscellaneous Services: Group M16 – Subgroup 1 (82350-82351) and should be read in conjunction with MN.16.1 Eating Disorders General Explanatory Notes.

Eating Disorder Dietetic Treatment Services Overview

Provision of eating disorder dietetic services by a suitably trained Dietitian (82350 and 82351) are for patients with anorexia nervosa and other patients with complex presentations of diagnosed eating disorders who meet the eligibility requirements and would benefit from a structured approach to the management of their treatment needs in the community setting.

A patient with an EDP plan can access up to 20 dietetic services under items 10954, 82350 and 82351 in a 12 Month Period. For any particular patient, an eating disorder treatment and management plan expires at the end of a 12 month period following provision of that service. After that period, a patient will require a new EDP to continue accessing eating disorders dietetic services.

Provider Eligibility

In order to provide eating disorder dietetic services, Dietitians must be an 'Accredited Practising Dietitian' as recognised by the Dietitians Association of Australia (DAA).

Checking patient eligibility for services

Note: The 12 month period commences from the date of the EDP.

Patients seeking rebates for eating disorders dietetic services must have had an Eating Disorder Treatment Plan (EDP) 90250-90257 or 90260-90263 in the previous 12 Months. The plan must require that the patient needs dietetic services for treatment of their eating disorder, and the patient must be provided with a referral for access to the dietetic health services.

If the EDP service has not yet been claimed, the Department of Human Services will not be aware of the patient's eligibility. In this case the allied health professional should, with the patient's permission, contact the practitioner who developed the plan to ensure the relevant service has been provided to the patient.

Support:

If there is any doubt about whether a patient has had a claim for an eating disorder service, health professionals can access the Health Professionals Online System (HPOS). HPOS is a fast and secure way for health professionals and administrators to check if a patient is eligible for a Medicare benefit for a specific item on the date of the proposed service. However, this system will only return advice that the service/item is payable or not payable.

Patients can also access their own claiming history with a My Health Record or by establishing a Medicare online account through myGov or the Express Plus Medicare mobile app.

Alternatively, health professionals can call the Department of Human Services on 132 150 to check this information, while patients can seek clarification by calling 132 011.

Additional Claiming Information (general conditions and limitations)

Reporting Back

After each course of treatment, the relevant dietitian is required to provide the referring medical practitioner with a written report on assessments carried out, treatment provided and recommendations for future management of the patient's condition. This reporting is required after the first service, as clinically required following subsequent services and after the final service.

This reporting will inform the managing practitioner's reviews of the EDP and enable the practitioner to assess the patient's progress and response to treatment.

Written reports should include, at a minimum:

- any investigations, tests, and/or assessments carried out on the patient;
- any treatment provided; and
- future management of the patient's condition or problem.

The report to the Practitioner must be kept for 2 years from the date of service.

Where appropriate, it is expected that the report will also be provided to the patients and/or the patient's family/carer (with the patient's agreement).

MN.16.3 Eating Disorders Psychological Treatment (EDPT) Services

Eating Disorders Psychological Treatment (EDPT) services (82352-82383)

This note provides information on the Category 8 – Miscellaneous Services: Group M16 – Subgroups 2-5 (82352-82383) and should be read in conjunction with MN.16.1 Eating Disorders General Explanatory Notes

For the purpose of this note Allied mental health professional is the generic term used to describe providers eligible to provider services under these items, including; clinical psychologists, registered psychologists, eligible accredited mental health social workers and eligible occupational therapists.

Eating Disorder Psychological Treatment (EDPT) Services Overview

Provision of EDPT services by a suitably trained Allied mental health professional (82352-82383) are for patients with anorexia nervosa and other patients with complex presentations of diagnosed eating disorders who meet the eligibility requirements and would benefit from a structured approach to the management of their treatment needs in the community setting.

There are 24 items for the provision of eating disorder specific evidence based psychological treatment services by eligible allied mental health professionals:

- clinical psychologists (item 82352-82359)
- registered psychologists (item 82360-82367)
- occupational therapists (82368- 82375)
- accredited mental health social workers (items 82376-82383)

Psychological Treatment Service

Patients seeking rebates for EDPT services must have had an EDP 90250-90257 or 90260-90263 in the previous 12 Months.

An 'eating disorder psychological treatment service' (EDPT) is defined in the MN.16.1 Eating Disorders General Explanatory Note. For any particular patient, an eating disorder treatment and management plan expires at the end of a 12 month period following provision of that service. After that period, a patient will require a new EDP to continue accessing EDPT services.

Rendering an EDPT item

Who can provide the service

In order to provide EDPT services, the allied mental health professional must be recognised by the Department of Human Services as eligible to provide focussed psychological strategies (FPS) services under the Better Access to Mental Health items (see Provider Eligibility for more information).

What is Involved in an EDPT service

The eating disorder items incorporate a 'stepped model' for best practice care for eligible patients with eating disorders. Under the Eating Disorders Items Stepped Model of Care a course of treatment is defined as 10 eating disorder psychological treatment (EDPT) services. It is required that a patient must have a review (an EDR item in subgroup 3 of A36) after each course of treatment (see MN.16.1 Eating Disorders General Explanatory Notes).

A range of acceptable treatments has been approved for use by practitioners in this context. It is expected that professionals will have the relevant education and training to deliver these services. The approved treatments are:

- Family Based Treatment for Eating Disorders (EDs) (including whole family, Parent Based Therapy, parent only or separated therapy)
- Adolescent Focused Therapy for EDs
- Cognitive Behavioural Therapy (CBT) for EDs (CBT-ED)
- CBT-Anorexia Nervosa (AN) (CBT-AN)
- CBT for Bulimia Nervosa (BN) and Binge-eating Disorder (BED) (CBT-BN and CBT-BED)
- Specialist Supportive Clinical Management (SSCM) for EDs
- Maudsley Model of Anorexia Treatment in Adults (MANTRA)
- Interpersonal Therapy (IPT) for BN, BED
- Dialectical Behavioural Therapy (DBT) for BN, BED
- Focal psychodynamic therapy for EDs

After each course of treatment, the relevant allied mental health professional is required to provide the referring medical practitioner with a written report on assessments carried out, treatment provided and recommendations for future management of the patient's condition. This reporting is required after the first service, as clinically required following subsequent services and after the final service.

This reporting will inform the managing practitioner's reviews of the EDP and enable the practitioner to assess the patient's progress and response to treatment.

Written reports should include, at a minimum:

- any investigations, tests, and/or assessments carried out on the patient;

- any treatment provided; and
- future management of the patient's condition or problem.

The report to the Practitioner must be kept for 2 years from the date of service.

Where appropriate, it is expected that the report will also be provided to the patients and/or the patient's family/carer (with the patient's agreement).

Checking patient eligibility for services

Note: The 12 month period commences from the date of the EDP.

Patients seeking rebates for EDPT services must have had an EDP 90250-90257 or 90260-90263 in the previous 12 Months. The plan must require that the patient needs mental health services for treatment of their eating disorder, and the patient must be provided with a referral for access to the allied health services.

If the EDP service has not yet been claimed, the Department of Human Services will not be aware of the patient's eligibility. In this case the allied health professional should, with the patient's permission, contact the practitioner who developed the plan to ensure the relevant service has been provided to the patient.

Support:

If there is any doubt about whether a patient has had a claim for an eating disorder service, health professionals can access the Health Professionals Online System (HPOS). HPOS is a fast and secure way for health professionals and administrators to check if a patient is eligible for a Medicare benefit for a specific item on the date of the proposed service. However, this system will only return advice that the service/item is payable or not payable.

Patients can also access their own claiming history with a My Health Record or by establishing a Medicare online account through myGov or the Express Plus Medicare mobile app.

Alternatively, health professionals can call the Department of Human Services on 132 150 to check this information, while patients can seek clarification by calling 132 011.

Provider Eligibility

Advice about registering with the Department of Human Services to provide focussed psychological strategies - allied mental health services is available from the Department of Human Services provider inquiry line on 132 150.

Eligible clinical psychologist - MN.6.4 - Clinical Psychologist Professional Eligibility

Eligible allied health professionals

A person is an allied health professional in relation to the provision of Better Access to Mental Health items if the person meets one of the following requirements:

- the person is a psychologist who holds general registration in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided;
- the person is a member of the Australian Association of Social Workers (AASW) and certified by AASW as the meeting the standards for mental health set out in the document published by AASW titled 'Practice Standards for Mental Health Social Workers 2014' as in force on 25 September 2014;
- the person:
    - is an occupational therapist who is registered with the Australian Health Practitioners Regulatory Agency as a person who can provide that kind of service under the applicable law in force in the State or Territory in which the service is provided; and
    - is accredited by Occupational Therapy Australia as:
        - having a minimum of two years experience in mental health; and

- having undertaken to observe the standards set out in the document published by Occupational Therapy Australia's 'Australian Competency Standards for Occupational Therapists in Mental Health' as in force on 1 November 2006; and
- having undertaken to observe the standards set out in the 2018 'Australian Occupational Therapy Competency Standards' published the Occupational Therapy Board of Australia.

Continuing professional development (CPD) for Occupational Therapists and Social Workers providing focussed psychological strategies (FPS) services

Occupational therapists and accredited mental health social workers providing FPS services are required to have completed 10hours FPS CPD. A CPD year for the purposes of these items is from 1 July to 30 June annually.

Part-time allied mental health professionals are required to have 10 hours of FPS related CPD, the same as full-time allied mental health professionals.

Occupational Therapists and Social Workers who are registered during the course of the CPD year, their obligation to undertake CPD will be on a pro-rata basis. The amount of units will be calculated from the 1st of the month immediately succeeding the month they obtained initial registration. The obligation will be one-twelfth of the yearly requirement for each month.

CPD activities must be relevant to delivering FPS services. Acceptable CPD activities where the content is related to FPS can include formal postgraduate education, workshops, seminars, lectures, journal reading, writing papers, receipt of supervision and peer consultation, and online training.

There is flexibility in the CPD activities that can be undertaken to meet individual professional needs and their practice/client base and client needs. For example, activities could also include assessment and treatment of specific disorders and client types such as youth, or different modalities and delivery such as working with groups.

Additional Claiming Information (general conditions and limitations)

Other than Consultation Room (items 82354, 82357, 82362, 82365, 82370, 82373, 82378, 82381)

It is expected that this service would be provided only for patients who are unable to attend the practice.

MN.16.4 Eating Disorders Services Telehealth

Eating Disorders Services Telehealth – (items 82351, 82353, 82356, 82359, 82361, 82364, 82367, 82369, 82372, 82375, 82377, 82380, 82383)

This note provides telehealth supporting information for eating disorders Items provided via telehealth by a medical practitioner in general practice and should be read in conjunction with Eating Disorders General Explanatory Notes.

Eligible Geographical Areas

Geographic eligibility for eating disorders telehealth services funded under Medicare (in Group M16) is determined according to the Modified Monash Model (MMM) classifications. Telehealth Eligible Areas are those areas that are within MMM classifications 4 to 7. Patients and providers are able to check their eligibility using the Modified Monash Model locator on the Department of Health's website at Health Workforce Locator.

There is a requirement for the patient and practitioner to be located a minimum of 15 kilometres apart at the time of the consultation. Minimum distance between practitioner and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the practitioner is not permitted to travel to an area outside the minimum 15 kilometres distance in order to claim a video consultation.

Record Keeping

Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Aftercare Rule

Video consultations are subject to the same aftercare rules as allied health practitioners providing face-to-face consultations.

Multiple Attendances on the Same Day

In some situations a patient may receive a consultation via video conference and a face-to-face consultation by the same or different clinical psychologist on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same clinical psychologist, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Clinical psychologists will need to provide the times of each consultation on the patient's account or bulk-billing voucher.

Referrals

The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

M1. MANAGEMENT OF BULK-BILLED SERVICES

	Group M1. Management Of Bulk-Billed Services
10990	A medical service to which an item in this table (other than this item or item 10991) applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in respect of the fees for: (i) this item; and (ii) the other item in this table applying to the service (See para MN.1.1 of explanatory notes to this Category) **Fee:** $7.50 **Benefit:** 85% = $6.40
10991	A medical service to which an item in this table (other than this item or item 10990) applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder: and (c) the person is not an admitted patient of a hospital: and (d) the service is bulk-billed in respect of the fees for: (i) this item: and (ii) the other item in this table applying to the service (e) the service is provided at, or from, a practice location in: (i) a regional, rural or remote area; or (ii) Tasmania; or (iii) a geographical area included in any of the following ssd spatial units: (a) Beaudesert Shire Part a (b) Belconnen (c) Darwin City (d) Eastern Outer Melbourne (e) East Metropolitan, Perth (f) Frankston City (g) Gosford-Wyong (h) Greater Geelong City Part a (i) Gungahlin-Hall (j) Ipswich City (part in bsd) (k) Litchfield Shire (l) Melton-Wyndham (m) Mornington Peninsula Shire (n)Newcastle (o) North Canberra (p) Palmerston-East Arm (q) Pine Rivers Shire (r) Queanbeyan (s) South Canberra (t) South Eastern Outer Melbourne (u) Southern Adelaide (v) South West Metropolitan, Perth (w) Thuringowa City Part a (x) Townsville City Part a (y) Tuggeranong (z) Weston Creek-Stromlo (za) Woden Valley (zb)Yarra Ranges Shire Part a; or (iv) the geographical area included in the sla spatial unit of Palm Island (ac) (See para MN.1.1 of explanatory notes to this Category) **Fee:** $11.35 **Benefit:** 85% = $9.65
10992	A medical service to which item 585, 588, 591, 594, 599, 600, 761, 763, 766, 769, 772, 776, 788, 789, 5003, 5010, 5023, 5028, 5043, 5049, 5063, 5067, 5220, 5223, 5227, 5228, 5260, 5263, 5265 or 5267 applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and (d) the service is not provided in consulting rooms; and (e) the service is provided in one of the following eligible areas:

(i) a regional, rural or remote area; or

(ii) Tasmania; or

(iii) A geographical area included in any of the following SSD spatial units:

(A) Beaudesert Shire Part A

(B) Belconnen

(C) Darwin City

(D) Eastern Outer Melbourne

(E) East Metropolitan, Perth

(F) Frankston City

(G) Gosford-Wyong

(H) Greater Geelong City Part A

(I) Gungahlin-Hall

(J) Ipswich City (part in BSD)

(K) Litchfield Shire

(L) Melton-Wyndham

(M) Mornington Peninsula Shire

(N) Newcastle

(O) North Canberra

(P) Palmerston-East Arm

(Q) Pine Rivers Shire

(R) Queanbeyan

(S) South Canberra

(T) South Eastern Outer Melbourne

(U) Southern Adelaide

(V) South West Metropolitan, Perth

(W) Thuringowa City Part A

(X) Townsville City Part A

(Y) Tuggeranong

M1. MANAGEMENT OF BULK-BILLED SERVICES	
	(Z) Weston Creek-Stromlo (ZA) Woden Valley (ZB) Yarra Ranges Shire Part A; or (iv) the geographical area included in the SLA spatial unit of Palm Island (AC) (f) the service is provided by, or on behalf of, a medical practitioner whose practice location is not in an eligible area; and (g) the service is bulk billed in respect of the fees for: (i) this item; and (ii) the other item in this table applying to the service. (See para MN.1.2 of explanatory notes to this Category) **Fee:** $11.35 **Benefit:** 85% = $9.65
M3. ALLIED HEALTH SERVICES	
	Group M3. Allied Health Services
10950	ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH SERVICE Aboriginal or Torres Strait Islander health service provided to a person by an eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner if: (a) the service is provided to a person who has: • a chronic condition; and • complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements, multidisciplinary care plan or shared care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (c):

(i) if the service is the only service under the referral - in relation to that service; or

(ii) if the service is the first or the last service under the referral - in relation to that service; or

(iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and

(h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit;

- to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year

(See para MN.3.4, MN.3.5, MN.3.1, MN.3.2, MN.3.3 of explanatory notes to this Category)
Fee: $63.25 **Benefit:** 85% = $53.80
Extended Medicare Safety Net Cap: $189.75

10951

DIABETES EDUCATION SERVICE

Diabetes education health service provided to a person by an eligible diabetes educator if:

(a) the service is provided to a person who has:

- a chronic condition; and
- complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and

(b) the service is recommended in the person's Team Care Arrangements, multidisciplinary care plan or shared care plan as part of the management of the person's chronic condition and complex care needs; and

(c) the person is referred to the eligible diabetes educator by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and

(d) the person is not an admitted patient of a hospital; and

(e) the service is provided to the person individually and in person; and

(f) the service is of at least 20 minutes duration; and

(g) after the service, the eligible diabetes educator gives a written report to the referring medical practitioner mentioned in paragraph (c):

(i) if the service is the only service under the referral - in relation to that service; or

(ii) if the service is the first or the last service under the referral - in relation to that service; or

(iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and

(h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the

private health insurance benefit;

- to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year

(See para MN.3.4, MN.3.5, MN.3.1, MN.3.2, MN.3.3 of explanatory notes to this Category)
Fee: $63.25 **Benefit:** 85% = $53.80
Extended Medicare Safety Net Cap: $189.75

10952

AUDIOLOGY

Audiology health service provided to a person by an eligible audiologist if:

(a) the service is provided to a person who has:

- a chronic condition; and
- complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and

(b) the service is recommended in the person's Team Care Arrangements, multidisciplinary care plan or shared can plan as part of the management of the person's chronic condition and complex care needs; and

(c) the person is referred to the eligible audiologist by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and

(d) the person is not an admitted patient of a hospital; and

(e) the service is provided to the person individually and in person; and

(f) the service is of at least 20 minutes duration; and

(g) after the service, the eligible audiologist gives a written report to the referring medical practitioner mentioned in paragraph (c):

(i) if the service is the only service under the referral - in relation to that service; or

(ii) if the service is the first or the last service under the referral - in relation to that service; or

(iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and

(h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit;

- to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year

(See para MN.3.4, MN.3.5, MN.3.1, MN.3.2, MN.3.3 of explanatory notes to this Category)
Fee: $63.25 **Benefit:** 85% = $53.80
Extended Medicare Safety Net Cap: $189.75

M3. ALLIED HEALTH SERVICES	
10953	EXERCISE PHYSIOLOGY Exercise physiology service provided to a person by an eligible exercise physiologist if: (a) the service is provided to a person who has: • a chronic condition; and • complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements, multidisciplinary care plan or shared care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible exercise physiologist by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible exercise physiologist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year (See para MN.3.4, MN.3.5, MN.3.1, MN.3.2, MN.3.3 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
10954	DIETETICS SERVICES Dietetics health service provided to a person by an eligible dietician if: (a) the service is provided to a person who has: • a chronic condition; and • complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care

	facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements, multidisciplinary care plan or shared care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible dietician by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible dietician gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year (See para MN.3.4, MN.3.5, MN.3.1, MN.3.2, MN.3.3 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
10956	MENTAL HEALTH SERVICE Mental health service provided to a person by an eligible mental health worker if: (a) the service is provided to a person who has: • a chronic condition; and • complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements, multidisciplinary care plan or shared care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible mental health worker by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and

(d) the person is not an admitted patient of a hospital; and

(e) the service is provided to the person individually and in person; and

(f) the service is of at least 20 minutes duration; and

(g) after the service, the eligible mental health worker gives a written report to the referring medical practitioner mentioned in paragraph (c):

(i) if the service is the only service under the referral - in relation to that service; or

(ii) if the service is the first or the last service under the referral - in relation to that service; or

(iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and

(h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit;

- to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year

(See para MN.3.4, MN.3.5, MN.3.1, MN.3.2, MN.3.3 of explanatory notes to this Category)
Fee: $63.25 **Benefit:** 85% = $53.80
Extended Medicare Safety Net Cap: $189.75

OCCUPATIONAL THERAPY

Occupational therapy health service provided to a person by an eligible occupational therapist if:

(a) the service is provided to a person who has:

- a chronic condition; and
- complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and

(b) the service is recommended in the person's Team Care Arrangements, multidisciplinary care plan or shared care plan as part of the management of the person's chronic condition and complex care needs; and

(c) the person is referred to the eligible occupational therapist by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and

(d) the person is not an admitted patient of a hospital; and

(e) the service is provided to the person individually and in person; and

(f) the service is of at least 20 minutes duration; and

(g) after the service, the eligible occupational therapist gives a written report to the referring medical practitioner mentioned in paragraph (c):

10958

(i) if the service is the only service under the referral - in relation to that service; or

(ii) if the service is the first or the last service under the referral - in relation to that service; or

(iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and

(h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit;

- to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year

(See para MN.3.4, MN.3.5, MN.3.1, MN.3.2, MN.3.3 of explanatory notes to this Category)
Fee: $63.25 **Benefit:** 85% = $53.80
Extended Medicare Safety Net Cap: $189.75

10960

PHYSIOTHERAPY

Physiotherapy health service provided to a person by an eligible physiotherapist if:

(a) the service is provided to a person who has:

- a chronic condition; and
- complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and

(b) the service is recommended in the person's Team Care Arrangements, multidisciplinary care plan or shared care plan as part of the management of the person's chronic condition and complex care needs; and

(c) the person is referred to the eligible physiotherapist by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and

(d) the person is not an admitted patient of a hospital; and

(e) the service is provided to the person individually and in person; and

(f) the service is of at least 20 minutes duration; and

(g) after the service, the eligible physiotherapist gives a written report to the referring medical practitioner mentioned in paragraph (c):

(i) if the service is the only service under the referral - in relation to that service; or

(ii) if the service is the first or the last service under the referral - in relation to that service; or

(iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and

(h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the

private health insurance benefit;

- to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year

(See para MN.3.4, MN.3.5, MN.3.1, MN.3.2, MN.3.3 of explanatory notes to this Category)
Fee: $63.25 **Benefit:** 85% = $53.80
Extended Medicare Safety Net Cap: $189.75

10962

PODIATRY

Podiatry health service provided to a person by an eligible podiatrist if:

(a) the service is provided to a person who has:

- a chronic condition; and
- complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and

(b) the service is recommended in the person's Team Care Arrangements, multidisciplinary care plan or shared care plan as part of the management of the person's chronic condition and complex care needs; and

(c) the person is referred to the eligible podiatrist by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and

(d) the person is not an admitted patient of a hospital; and

(e) the service is provided to the person individually and in person; and

(f) the service is of at least 20 minutes duration; and

(g) after the service, the eligible podiatrist gives a written report to the referring medical practitioner mentioned in paragraph (c):

(i) if the service is the only service under the referral - in relation to that service; or

(ii) if the service is the first or the last service under the referral - in relation to that service; or

(iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and

(h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit;

- to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year

(See para MN.3.4, MN.3.5, MN.3.1, MN.3.2, MN.3.3 of explanatory notes to this Category)
Fee: $63.25 **Benefit:** 85% = $53.80
Extended Medicare Safety Net Cap: $189.75

M3. ALLIED HEALTH SERVICES	
10964	CHIROPRACTIC SERVICE Chiropractic health service provided to a person by an eligible chiropractor if: (a) the service is provided to a person who has: • a chronic condition; and • complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements, multidisciplinary care plan or shared care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible chiropractor by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible chiropractor gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year (See para MN.3.4, MN.3.5, MN.3.1, MN.3.2, MN.3.3 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
10966	OSTEOPATHY Osteopathy health service provided to a person by an eligible osteopath if: (a) the service is provided to a person who has: • a chronic condition; and • complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care

	facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements, multidisciplinary care plan or shared care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible osteopath by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible osteopath gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year (See para MN.3.4, MN.3.5, MN.3.1, MN.3.2, MN.3.3 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
10968	PSYCHOLOGY Psychology health service provided to a person by an eligible psychologist if: (a) the service is provided to a person who has: • a chronic condition; and • complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements, multidisciplinary care plan or shared care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible psychologist by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and

	(d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible psychologist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year (See para MN.3.4, MN.3.5, MN.3.1, MN.3.2, MN.3.3 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
10970	SPEECH PATHOLOGY Speech pathology health service provided to a person by an eligible speech pathologist if: (a) the service is provided to a person who has: • a chronic condition; and • complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements, multidisciplinary care plan or shared care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible speech pathologist by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible speech pathologist gives a written report to the referring medical practitioner mentioned in paragraph (c):

M3. ALLIED HEALTH SERVICES	
	(i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year (See para MN.3.4, MN.3.5, MN.3.1, MN.3.2, MN.3.3 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
M6. PSYCHOLOGICAL THERAPY SERVICES	
	Group M6. Psychological Therapy Services
80000	Professional attendance for the purpose of providing psychological assessment and therapy for a mental disorder by a **clinical psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting more than 30 minutes but less than 50 minutes, where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 283 to 287; 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). (Professional attendance at consulting rooms) (See para MN.6.1 of explanatory notes to this Category) **Fee:** $101.35 **Benefit:** 85% = $86.15 **Extended Medicare Safety Net Cap:** $304.05
80001	Professional attendance for the purpose of providing psychological assessment and therapy for a mental disorder by a **clinical psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting more than 30 minutes but less than 50 minutes, where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics if: • the attendance is by video conference; and • the patient is not an admitted patient; and • the patient is located within a telehealth eligible area; and • the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist.

M6. PSYCHOLOGICAL THERAPY SERVICES	
	Psychological therapy services delivered by video conference are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80001, 80011, 80101, 80111, 80126, 80136, 80151 and 80161 apply). Psychological therapy services delivered by video conference time limits include the maximum ten planned sessions in a calendar year services to which items 283 to 287; 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply. (See para MN.6.5 of explanatory notes to this Category) **Fee:** $101.35 **Benefit:** 85% = $86.15 **Extended Medicare Safety Net Cap:** $304.05
80005	Professional attendance at a place other than consulting rooms. As per the service requirements outlined for item 80000. (See para MN.6.1 of explanatory notes to this Category) **Fee:** $126.65 **Benefit:** 85% = $107.70 **Extended Medicare Safety Net Cap:** $379.95
80010	Professional attendance for the purpose of providing psychological assessment and therapy for a mental disorder by a **clinical psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting at least 50 minutes, where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 283 to 287; 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). (Professional attendance at consulting rooms) (See para MN.6.1 of explanatory notes to this Category) **Fee:** $148.80 **Benefit:** 85% = $126.50 **Extended Medicare Safety Net Cap:** $446.40
80011	Professional attendance for the purpose of providing psychological assessment and therapy for a mental disorder by a **clinical psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting at least 50 minutes, where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics if: • the attendance is by video conference; and • the patient is not an admitted patient; and • the patient is located within a telehealth eligible area; and • the patient is, at the time of the attendance , at least 15 kilometres by road from the clinical psychologist. Psychological therapy services delivered by video conference are time limited, being deliverable in up

M6. PSYCHOLOGICAL THERAPY SERVICES	
	to ten planned sessions in a calendar year (including services to which items 80001, 80011, 80101, 80111, 80126, 80136, 80151 and 80161 apply). Psychological therapy services delivered by video conference time limits include the maximum ten planned sessions in a calendar year services to which items 283 to 287; 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply. (See para MN.6.5 of explanatory notes to this Category) **Fee:** $148.80 **Benefit:** 85% = $126.50 **Extended Medicare Safety Net Cap:** $446.40
80015	Professional attendance at a place other than consulting rooms As per the service requirements outlined for item 80010. (See para MN.6.1 of explanatory notes to this Category) **Fee:** $174.10 **Benefit:** 85% = $148.00 **Extended Medicare Safety Net Cap:** $500.00
80020	Professional attendance for the purpose of providing psychological therapy for a mental disorder by a **clinical psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80020, 80021, 80120, 80121, 80145, 80146, 80170 and 80171 apply). GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT (See para MN.6.1 of explanatory notes to this Category) **Fee:** $37.80 **Benefit:** 85% = $32.15 **Extended Medicare Safety Net Cap:** $113.40
80021	Professional attendance for the purpose of providing psychological therapy for a mental disorder by a **clinical psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics if: • the attendance is by video conference; and • the patient is not an admitted patient; and • the patient is located within a telehealth eligible area; and • the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist. Group psychological therapy services delivered by video conference are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80021, 80121, 80146

M6. PSYCHOLOGICAL THERAPY SERVICES	
	and 80171 apply). Group psychological therapy services delivered by video conference time limits include the maximum ten planned sessions in a calendar year services to which items 80020, 80120, 80145 and 80170 apply. - GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT (See para MN.6.5 of explanatory notes to this Category) **Fee:** $37.80 **Benefit:** 85% = $32.15 **Extended Medicare Safety Net Cap:** $113.40
M7. FOCUSSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	
	Group M7. Focussed Psychological Strategies (Allied Mental Health)
80100	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 283 to 287; 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). (Professional attendance at consulting rooms) (See para MN.7.1 of explanatory notes to this Category) **Fee:** $71.80 **Benefit:** 85% = $61.05 **Extended Medicare Safety Net Cap:** $215.40
80101	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics if: • the attendance is by video conference; and • the patient is not an admitted patient; and • the patient is located within a telehealth eligible area; and • the patient is, at the time of the attendance, at least 15 kilometres by road from the psychologist. Focussed psychological strategies delivered by video conference are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80001, 80011, 80101, 80111, 80126, 80136, 80151 and 80161 apply). Focussed psychological strategies delivered by video conference time limits include the maximum ten planned sessions in a calendar year services to which items 283 to 287; 2721 to 2727; 80000 to 80015;

M7. FOCUSSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	
	80100 to 80115; 80125 to 80140; 80150 to 80165 apply. (See para MN.7.2 of explanatory notes to this Category) **Fee:** $71.80 **Benefit:** 85% = $61.05 **Extended Medicare Safety Net Cap:** $215.40
80105	Professional attendance at a place other than consulting rooms. As per the psychologist service requirements outlined for item 80100. (See para MN.7.1 of explanatory notes to this Category) **Fee:** $97.70 **Benefit:** 85% = $83.05 **Extended Medicare Safety Net Cap:** $293.10
80110	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 283 to 287; 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). (Professional attendance at consulting rooms) (See para MN.7.1 of explanatory notes to this Category) **Fee:** $101.35 **Benefit:** 85% = $86.15 **Extended Medicare Safety Net Cap:** $304.05
80111	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics if: • the attendance is by video conference; and • the patient is not an admitted patient; and • the patient is located within a telehealth eligible area; and • the patient is, at the time of the attendance, at least 15 kilometres by road from the psychologist. Focussed psychological strategies delivered by video conference are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80001, 80011, 80101, 80111, 80126, 80136, 80151 and 80161 apply). Focussed psychological strategies delivered by video conference time limits include the maximum ten planned sessions in a calendar year services to which items 283 to 287; 2721 to 2727; 80000 to 80015;

M7. FOCUSSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	
	80100 to 80115; 80125 to 80140; 80150 to 80165 apply. (See para MN.7.2 of explanatory notes to this Category) **Fee:** $101.35 **Benefit:** 85% = $86.15 **Extended Medicare Safety Net Cap:** $304.05
80115	Professional attendance at a place other than consulting rooms. As per the psychologist service requirements outlined for item 80110. (See para MN.7.1 of explanatory notes to this Category) **Fee:** $127.30 **Benefit:** 85% = $108.25 **Extended Medicare Safety Net Cap:** $381.90
80120	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80020, 80021, 80120, 80121, 80145, 80146, 80170 and 80171 apply). GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT (See para MN.7.1 of explanatory notes to this Category) **Fee:** $25.85 **Benefit:** 85% = $22.00 **Extended Medicare Safety Net Cap:** $77.55
80121	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics if: • the attendance is by video conference; and • the patient is not an admitted patient; and • the patient is located within a telehealth eligible area; and • the patient is, at the time of the attendance, at least 15 kilometres by road from the psychologist. Group focussed psychological strategies delivered by video conference are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80021, 80121, 80146 and 80171 apply). Group focussed psychological strategies delivered by video conference time limits include the maximum ten planned sessions in a calendar year services to which items 80020, 80120, 80145 and 80170 apply.

M7. FOCUSSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	
	GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT (See para MN.7.2 of explanatory notes to this Category) **Fee:** $25.85 **Benefit:** 85% = $22.00 **Extended Medicare Safety Net Cap:** $77.55
80125	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an **occupational therapist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 283 to 287; 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). (Professional services at consulting rooms) (See para MN.7.1 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
80126	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an **occupational therapist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics if: • the attendance is by video conference; and • the patient is not an admitted patient; and • the patient is located within a telehealth eligible area; and • the patient is, at the time of the attendance, at least 15 kilometres by road from the occupational therapist. Focussed psychological strategies delivered by video conference are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80001, 80011, 80101, 80111, 80126, 80136, 80151 and 80161 apply). Focussed psychological strategies delivered by video conference time limits include the maximum ten planned sessions in a calendar year services to which items 283 to 287; 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply. (See para MN.7.2 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
80130	Professional attendance at a place other than consulting rooms.

	As per the occupational therapist service requirements outlined for item 80125. (See para MN.7.1 of explanatory notes to this Category) **Fee:** $89.10 **Benefit:** 85% = $75.75 **Extended Medicare Safety Net Cap:** $267.30
80135	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an **occupational therapist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 283 to 287; 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). (Professional attendance at consulting rooms) (See para MN.7.1 of explanatory notes to this Category) **Fee:** $89.35 **Benefit:** 85% = $75.95 **Extended Medicare Safety Net Cap:** $268.05
80136	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an **occupational therapist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics if: • the attendance is by video conference; and • the patient is not an admitted patient; and • the patient is located within a telehealth eligible area; and • the patient is, at the time of the attendance, at least 15 kilometres by road from the occupational therapist. Focussed psychological strategies delivered by video conference are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80001, 80011, 80101, 80111, 80126, 80136, 80151 and 80161 apply). Focussed psychological strategies delivered by video conference time limits include the maximum ten planned sessions in a calendar year services to which items 283 to 287; 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply. (See para MN.7.2 of explanatory notes to this Category) **Fee:** $89.35 **Benefit:** 85% = $75.95 **Extended Medicare Safety Net Cap:** $268.05
80140	Professional attendance at a place other than consulting rooms.

M7. FOCUSSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	
	As per the occupational therapist service requirements outlined for item 80135. (See para MN.7.1 of explanatory notes to this Category) **Fee:** $115.15 **Benefit:** 85% = $97.90 **Extended Medicare Safety Net Cap:** $345.45
80145	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an **occupational therapist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80020, 80021, 80120, 80121, 80145, 80146, 80170 and 80171 apply). GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT (See para MN.7.1 of explanatory notes to this Category) **Fee:** $22.70 **Benefit:** 85% = $19.30 **Extended Medicare Safety Net Cap:** $68.10
80146	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an **occupational therapist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics if: • the attendance is by video conference; and • the patient is not an admitted patient; and • the patient is located within a telehealth eligible area; and • the patient is, at the time of the attendance, at least 15 kilometres by road from the occupational therapist. Group focussed psychological strategies delivered by video conference are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80021, 80121, 80146 and 80171 apply). Group focussed psychological strategies delivered by video conference time limits include the maximum ten planned sessions in a calendar year services to which items 80020, 80120, 80145 and 80170 apply. GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT (See para MN.7.2 of explanatory notes to this Category) **Fee:** $22.70 **Benefit:** 85% = $19.30 **Extended Medicare Safety Net Cap:** $68.10
80150	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **social worker** registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than

	50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 283 to 287; 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). (Professional attendance at consulting rooms) (See para MN.7.1 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
80151	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **social worker** registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics if: • the attendance is by video conference; and • the patient is not an admitted patient; and • the patient is located within a telehealth eligible area; and • the patient is, at the time of the attendance, at least 15 kilometres by road from the social worker. Focussed psychological strategies delivered by video conference are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80001, 80011, 80101, 80111, 80126, 80136, 80151 and 80161 apply). Focussed psychological strategies delivered by video conference time limits include the maximum ten planned sessions in a calendar year services to which items 283 to 287; 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply. (See para MN.7.2 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
80155	Professional attendance at a place other than consulting rooms. As per the social worker service requirements outlined for item 80150. (See para MN.7.1 of explanatory notes to this Category) **Fee:** $89.10 **Benefit:** 85% = $75.75 **Extended Medicare Safety Net Cap:** $267.30
80160	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **social worker** registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the

	patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 283 to 287; 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). (Professional attendance at consulting rooms) (See para MN.7.1 of explanatory notes to this Category) **Fee:** $89.35 **Benefit:** 85% = $75.95 **Extended Medicare Safety Net Cap:** $268.05
80161	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **social worker** registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics if: • the attendance is by video conference; and • the patient is not an admitted patient; and • the patient is located within a telehealth eligible area; and • the patient is, at the time of the attendance, at least 15 kilometres by road from the social worker. Focussed psychological strategies delivered by video conference are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80001, 80011, 80101, 80111, 80126, 80136, 80151 and 80161 apply). Focussed psychological strategies delivered by video conference time limits include the maximum ten planned sessions in a calendar year services to which items 283 to 287; 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply. (See para MN.7.2 of explanatory notes to this Category) **Fee:** $89.35 **Benefit:** 85% = $75.95 **Extended Medicare Safety Net Cap:** $268.05
80165	Professional attendance at a place other than consulting rooms. As per the social worker service requirements outlined for item 80160. (See para MN.7.1 of explanatory notes to this Category) **Fee:** $115.15 **Benefit:** 85% = $97.90 **Extended Medicare Safety Net Cap:** $345.45
80170	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **social worker** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the

M7. FOCUSSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	
	patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80020, 80021, 80120, 80121, 80145, 80146, 80170 and 80171 apply). GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT (See para MN.7.1 of explanatory notes to this Category) **Fee:** $22.70 **Benefit:** 85% = $19.30 **Extended Medicare Safety Net Cap:** $68.10
80171	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **social worker** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics if: • the attendance is by video conference; and • the patient is not an admitted patient; and • the patient is located within a telehealth eligible area; and • the patient is, at the time of the attendance, at least 15 kilometres by road from the social worker. Group focussed psychological strategies delivered by video conference are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80021, 80121, 80146 and 80171 apply). Group focussed psychological strategies delivered by video conference time limits include the maximum ten planned sessions in a calendar year services to which items 80020, 80120, 80145 and 80170 apply. GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT (See para MN.7.2 of explanatory notes to this Category) **Fee:** $22.70 **Benefit:** 85% = $19.30 **Extended Medicare Safety Net Cap:** $68.10

M8. PREGNANCY SUPPORT COUNSELLING	
	Group M8. Pregnancy Support Counselling
81000	Provision of a non-directive pregnancy support counselling service to a person who is currently pregnant or who has been pregnant in the preceding 12 months, by an eligible psychologist, where the patient is referred to the psychologist by a medical practitioner (including a general practitioner, but not a specialist or consultant physician), and lasting at least 30 minutes. The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

M8. PREGNANCY SUPPORT COUNSELLING	
	This service may be provided by a psychologist who is registered with Medicare Australia as meeting the credentialling requirements for provision of this service. It may not be provided by a psychologist who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination. To a maximum of three non-directive pregnancy support counselling services per patient, per pregnancy from any of the following items -81000, 81005, 81010 and 4001 (See para MN.8.4, MN.8.1, MN.8.2, MN.8.3 of explanatory notes to this Category) **Fee:** $74.30 **Benefit:** 85% = $63.20 **Extended Medicare Safety Net Cap:** $222.90
81005	Provision of a non-directive pregnancy support counselling service to a person who is currently pregnant or who has been pregnant in the preceding 12 months, by an eligible social worker, where the patient is referred to the social worker by a medical practitioner (including a general practitioner, but not a specialist or consultant physician), and lasting at least 30 minutes. The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate. This service may be provided by a social worker who is registered with Medicare Australia as meeting the credentialling requirements for provision of this service. It may not be provided by a social worker who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination. To a maximum of three non-directive pregnancy support counselling services per patient, per pregnancy from any of the following items -81000, 81005, 81010 and 4001 (See para MN.8.4, MN.8.1, MN.8.2, MN.8.3 of explanatory notes to this Category) **Fee:** $74.30 **Benefit:** 85% = $63.20 **Extended Medicare Safety Net Cap:** $222.90
81010	Provision of a non-directive pregnancy support counselling service to a person who is currently pregnant or who has been pregnant in the preceding 12 months, by an eligible mental health nurse, where the patient is referred to the mental health nurse by a medical practitioner (including a general practitioner, but not a specialist or consultant physician), and lasting at least 30 minutes. The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate. This service may be provided by a mental health nurse who is registered with Medicare Australia as meeting the credentialling requirements for provision of this service. It may not be provided by a mental health nurse who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination. To a maximum of three non-directive pregnancy support counselling services per patient, per pregnancy from any of the following items - 81000, 81005, 81010 and 4001 (See para MN.8.4, MN.8.1, MN.8.2, MN.8.3 of explanatory notes to this Category)

M8. PREGNANCY SUPPORT COUNSELLING	
	Fee: $74.30 **Benefit:** 85% = $63.20 **Extended Medicare Safety Net Cap:** $222.90

M9. ALLIED HEALTH GROUP SERVICES	
	Group M9. Allied Health Group Services
81100	DIABETES EDUCATION SERVICE - ASSESSMENT FOR GROUP SERVICES Diabetes education health service provided to a person by an eligible diabetes educator for the purposes of ASSESSING a person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs, and preparing the person for the group services, if: (a) the service is provided to a person who has type 2 diabetes; and (b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or a GP Management Plan [ie item 721 or 732], or if the person is a resident of an aged care facility, their medical practitioner has contributed to a multidisciplinary care plan [ie item 731]; and (c) the person is referred to an eligible diabetes educator by the medical practitioner using a referral form that has been issued by the Department of Health, or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 45 minutes duration; and (g) after the service, the eligible diabetes educator gives a written report to the referring medical practitioner mentioned in paragraph (c); and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit. Benefits are payable once only in a calendar year for this or any other Assessment for Group Services item (including services to which items 81100, 81110 and 81120 apply). (See para MN.9.4, MN.9.6, MN.9.3, MN.9.1, MN.9.7, MN.9.2 of explanatory notes to this Category) **Fee:** $81.15 **Benefit:** 85% = $69.00 **Extended Medicare Safety Net Cap:** $243.45
81105	DIABETES EDUCATION SERVICE - GROUP SERVICE Diabetes education health service provided to a person by an eligible diabetes educator, as a GROUP SERVICE for the management of type 2 diabetes if: (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item

81100, 81110 or 81120; and

(b) the service is provided to a person who is part of a group of between 2 and 12 patients inclusive; and

(c) the person is not an admitted patient of a hospital; and

(d) the service is provided to a person involving the personal attendance by an eligible diabetes educator; and

(e) the service is of at least 60 minutes duration; and

(f) after the last service in the group services program provided to the person under items 81105, 81115 or 81125, the eligible diabetes educator prepares, or contribute to, a written report to be provided to the referring medical practitioner; and

(g) an attendance record for the group is maintained by the eligible diabetes educator; and

(h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit;

- to a maximum of eight GROUP SERVICES (including services to which items 81105, 81115 and 81125 apply) in a calendar year.

(See para MN.9.6, MN.9.3, MN.9.1, MN.9.7, MN.9.2, MN.9.5 of explanatory notes to this Category)
Fee: $20.20 **Benefit:** 85% = $17.20
Extended Medicare Safety Net Cap: $60.60

81110

EXERCISE PHYSIOLOGY SERVICE - ASSESSMENT FOR GROUP SERVICES

Exercise physiology health service provided to a person by an eligible exercise physiologist for the purposes of ASSESSING a person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs, and preparing the person for the group services, if:

(a) the service is provided to a person who has type 2 diabetes; and

(b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or a GP Management Plan [ie item 721 or 732, or if the person is a resident of an aged care facility, their medical practitioner has contributed to a multidisciplinary care plan [ie item 731]; and

(c) the person is referred to an eligible exercise physiologist by the medical practitioner using a referral form that has been issued by the Department of Health, or a referral form that contains all the components of the form issued by the Department; and

(d) the person is not an admitted patient of a hospital; and

(e) the service is provided to the person individually and in person; and

(f) the service is of at least 45 minutes duration; and

	(g) after the service, the eligible exercise physiologist gives a written report to the referring medical practitioner mentioned in paragraph (c); and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit. Benefits are payable once only in a calendar year for this or any other Assessment for Group Services item (including services to which items 81100, 81110 and 81120 apply). (See para MN.9.4, MN.9.6, MN.9.3, MN.9.1, MN.9.7, MN.9.2 of explanatory notes to this Category) **Fee:** $81.15 **Benefit:** 85% = $69.00 **Extended Medicare Safety Net Cap:** $243.45
81115	EXERCISE PHYSIOLOGY SERVICE - GROUP SERVICE Exercise physiology health service provided to a person by an eligible exercise physiologist, as a GROUP SERVICE for the management of type 2 diabetes if: (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120; and (b) the service is provided to a person who is part of a group of between 2 and 12 patients inclusive; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to a person involving the personal attendance by an eligible exercise physiologist; and (e) the service is of at least 60 minutes duration; and (f) after the last service in the group services program provided to the person under items 81105, 81115 or 81125, the eligible exercise physiologist prepares, or contribute to, a written report to be provided to the referring medical practitioner; and (g) an attendance record for the group is maintained by the eligible exercise physiologist; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of eight GROUP SERVICES (including services to which items 81105, 81115 and 81125 apply) in a calendar year. (See para MN.9.6, MN.9.3, MN.9.1, MN.9.7, MN.9.2, MN.9.5 of explanatory notes to this Category) **Fee:** $20.20 **Benefit:** 85% = $17.20 **Extended Medicare Safety Net Cap:** $60.60
81120	DIETETICS SERVICE - ASSESSMENT FOR GROUP SERVICES

Dietetics health service provided to a person by an eligible dietitian for the purposes of ASSESSING a person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs, and preparing the person for the group services, if:

(a) the service is provided to a person who has type 2 diabetes; and

(b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or a GP Management Plan [ie item 721 or 732], or if the person is a resident of an aged care facility, their medical practitioner has contributed to a multidisciplinary care plan [ie item 731]; and

(c) the person is referred to an eligible dietitian by the medical practitioner using a referral form that has been issued by the Department of Health, or a referral form that contains all components of the form issued by the Department; and

(d) the person is not an admitted patient of a hospital; and

(e) the service is provided to the person individually and in person; and

(f) the service is of at least 45 minutes duration; and

(g) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c); and

(h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit.

Benefits are payable once only in a calendar year for this or any other Assessment for Group Services item (including services to which items 81100, 81110 and item 81120 apply).

(See para MN.9.4, MN.9.6, MN.9.3, MN.9.1, MN.9.7, MN.9.2 of explanatory notes to this Category)
Fee: $81.15 **Benefit:** 85% = $69.00
Extended Medicare Safety Net Cap: $243.45

81125

DIETETICS SERVICE - GROUP SERVICE

Dietetics health service provided to a person by an eligible dietitian, as a GROUP SERVICE for the management of type 2 diabetes if:

(a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120; and

(b) the service is provided to a person who is part of a group of between 2 and 12 patients inclusive; and

(c) the person is not an admitted patient of a hospital; and

(d) the service is provided to a person involving the personal attendance by an eligible dietitian; and

M9. ALLIED HEALTH GROUP SERVICES	
	(e) the service is of at least 60 minutes duration; and (f) after the last service in the group services program provided to the person under items 81105, 81115 or 81125, the eligible dietitian prepares, or contribute to, a written report to be provided to the referring medical practitioner; and (g) an attendance record for the group is maintained by the eligible dietitian; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of eight GROUP SERVICES (including services to which items 81105, 81115 and 81125 apply) in a calendar year. (See para MN.9.6, MN.9.3, MN.9.1, MN.9.7, MN.9.2, MN.9.5 of explanatory notes to this Category) **Fee:** $20.20 **Benefit:** 85% = $17.20 **Extended Medicare Safety Net Cap:** $60.60

M10. AUTISM, PERVASIVE DEVELOPMENTAL DISORDER AND DISABILITY SERVICES	
	Group M10. Autism, Pervasive Developmental Disorder And Disability Services
	PSYCHOLOGY Psychology health service provided to a child, aged under 13 years, by an eligible psychologist where: (a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child's pervasive developmental disorder (PDD) or disability treatment plan, developed by the practitioner; and (c) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (d) the psychologist attending the child is registered with the Department of Human Services as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration.
82000	

	These items are limited to a maximum of four services per patient, consisting of any combination of the following items – 82000, 82005, 82010 and 82030 (See para MN.10.1 of explanatory notes to this Category) **Fee:** $101.35 **Benefit:** 85% = $86.15 **Extended Medicare Safety Net Cap:** $304.05
82005	SPEECH PATHOLOGY Speech pathology health service provided to a child, aged under 13 years, by an eligible speech pathologist where: (a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child's pervasive developmental disorder (PDD) or disability treatment plan, developed by the practitioner; and (c) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner: and (d) the speech pathologist attending the child is registered with the Department of Human Services as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration. These items are limited to a maximum of four services per patient, consisting of any combination of the following items – 82000, 82005, 82010 and 82030 (See para MN.10.1 of explanatory notes to this Category) **Fee:** $89.35 **Benefit:** 85% = $75.95 **Extended Medicare Safety Net Cap:** $268.05
82010	OCCUPATIONAL THERAPY Occupational therapy health service provided to a child, aged under 13 years, by an eligible occupational therapist where:

	(a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child's pervasive developmental disorder (PDD) or disability treatment plan, developed by the practitioner; and (c) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (d) the occupational therapist attending the child is registered with the Department of Human Services as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration. These items are limited to a maximum of four services per patient, consisting of any combination of the following items – 82000, 82005, 82010 and 82030 (See para MN.10.1 of explanatory notes to this Category) **Fee:** $89.35 **Benefit:** 85% = $75.95 **Extended Medicare Safety Net Cap:** $268.05
82015	PSYCHOLOGY Psychology health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) or an eligible disability by an eligible psychologist where: (a) the child has been diagnosed with PDD or an eligible disability; and (b) the child has received a PDD or disability treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD or disability treatment plan; and (d) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and

	(e) the psychologist attending the child is registered with the Department of Human Services as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration. These items are limited to a maximum of 20 services per patient, consisting of any combination of items ─ 82015, 82020, 82025 and 82035 (See para MN.10.1 of explanatory notes to this Category) **Fee:** $101.35 **Benefit:** 85% = $86.15 **Extended Medicare Safety Net Cap:** $304.05
82020	SPEECH PATHOLOGY Speech pathology health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) or an eligible disability by an eligible speech pathologist where: (a) the child has been diagnosed with PDD or an eligible disability; and (b) the child has received a PDD or disability treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD or disability treatment plan; and (d) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (e) the speech pathologist attending the child is registered with the Department of Human Services as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration. These items are limited to a maximum of 20 services per patient, consisting of any combination of items ─ 82015, 82020, 82025 and 82035 (See para MN.10.1 of explanatory notes to this Category) **Fee:** $89.35 **Benefit:** 85% = $75.95 **Extended Medicare Safety Net Cap:** $268.05

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82025	OCCUPATIONAL THERAPY Occupational therapy health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) or an eligible disability by an eligible occupational therapist where: (a) the child has been diagnosed with PDD or an eligible disability; and (b) the child has received a PDD or disability treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD or disability treatment plan; and (d) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (e) the occupational therapist attending the child is registered with the Department of Human Services as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration. These items are limited to a maximum of 20 services per patient, consisting of any combination of items – 82015, 82020, 82025 and 82035 (See para MN.10.1 of explanatory notes to this Category) **Fee:** $89.35 **Benefit:** 85% = $75.95 **Extended Medicare Safety Net Cap:** $268.05
82030	AUDIOLOGY, OPTOMETRY, ORTHOPTIC OR PHYSIOTHERAPY Audiology, optometry, orthoptic or physiotherapy health service provided to a child, aged under 13 years, by an eligible audiologist, optometrist, orthoptist or physiotherapist where: (a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child's pervasive developmental disorder

	(PDD) or disability treatment plan, developed by the practitioner; and (c) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (d) the audiologist, optometrist, orthoptist or physiotherapist attending the child is registered with the Department of Human Services as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration. These items are limited to a maximum of four services per patient, consisting of any combination of the following items - 82000, 82005, 82010 and 82030 (See para MN.10.1 of explanatory notes to this Category) **Fee:** $89.35 **Benefit:** 85% = $75.95 **Extended Medicare Safety Net Cap:** $268.05
82035	AUDIOLOGY, OPTOMETRY, ORTHOPTIC OR PHYSIOTHERAPY Audiology, optometry, orthoptic or physiotherapy health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) or eligible disability by an eligible audiologist, optometrist, orthoptist or physiotherapist where: (a) the child has been diagnosed with PDD or eligible disability; and (b) the child has received a PDD or disability treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD or disability treatment plan; and (d) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (e) the audiologist, optometrist, orthoptist or physiotherapist attending the child is registered with the Department of Human Services as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and

M10. AUTISM, PERVASIVE DEVELOPMENTAL DISORDER AND DISABILITY SERVICES	
	(h) the service lasts at least 30 minutes in duration. These items are limited to a maximum of 20 services per patient, consisting of any combination of items - 82015, 82020, 82025 and 82035 (See para MN.10.1 of explanatory notes to this Category) **Fee:** $89.35 **Benefit:** 85% = $75.95 **Extended Medicare Safety Net Cap:** $268.05

M11. ALLIED HEALTH SERVICES FOR INDIGENOUS AUSTRALIANS WHO HAVE HAD A HEALTH CHECK	
	Group M11. Allied Health Services For Indigenous Australians Who Have Had A Health Check
	ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH SERVICE provided to a person who is of Aboriginal and Torres Strait Islander descent by an eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner if: (a) either: • a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or • the person's shared care plan identifies the need for follow-up allied health services; and (b) the person is referred to the eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters
81300	- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a

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	calendar year (See para MN.11.1 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
81305	DIABETES EDUCATION HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible diabetes educator if: (a) either: • a medical practitioner has identified a need for follow-up allied health services; or • the person's shared care plan identifies the need for follow-up allied health services; and (b) the person is referred to the eligible diabetes educator by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible diabetes educator gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters; - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para MN.11.1 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
81310	AUDIOLOGY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible audiologist if: (a) either: • a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or • the person's shared care plan identifies the need for follow-up allied health services; and (b) the person is referred to the eligible audiologist by the medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form

	issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible audiologist gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters; - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para MN.11.1 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
81315	EXERCISE PHYSIOLOGY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible exercise physiologist if: (a) either: • a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or • the person's shared care plan identifies the need for follow-up allied health services; and (b) the person is referred to the eligible exercise physiologist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible exercise physiologist gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those

	matters; - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para MN.11.1 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
81320	DIETETICS HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible dietitian if: (a) either: • a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or • the person's shared care plan identifies the need for follow-up allied health services; and (b) the person is referred to the eligible dietitian by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para MN.11.1 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
81325	MENTAL HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible mental health worker if: (a) either:

	• a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or • the person's shared care plan identifies the need for follow-up allied health services; and (b) the person is referred to the eligible mental health worker by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible mental health worker gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para MN.11.1 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
81330	OCCUPATIONAL THERAPY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible occupational therapist if (a) either: • a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or • the person's shared care plan identifies the need for follow-up allied health services; and (b) the person is referred to the eligible occupational therapist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible occupational therapist gives a written report to the referring medical

	practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para MN.11.1 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
81335	PHYSIOTHERAPY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible physiotherapist if: (a) either: • a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or • the person's shared care plan identifies the need for follow-up allied health services; and (b) the person is referred to the eligible physiotherapist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible physiotherapist gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para MN.11.1 of explanatory notes to this Category)

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	Fee: $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
81340	PODIATRY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible podiatrist if: (a) either: • a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or • the person's shared care plan identifies the need for follow-up allied health services; and (b) the person is referred to the eligible podiatrist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible podiatrist gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para MN.11.1 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
81345	CHIROPRACTIC HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible chiropractor if: (a) either: • a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or • the person's shared care plan identifies the need for follow-up allied health services; and (b) the person is referred to the eligible chiropractor by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form

	issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible chiropractor gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para MN.11.1 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
81350	OSTEOPATHY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible osteopath if: (a) either: • a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or • the person's shared care plan identifies the need for follow-up allied health services; and (b) the person is referred to the eligible osteopath by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible osteopath gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to the service; or

	(iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para MN.11.1 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
81355	PSYCHOLOGY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible psychologist if: (a) either: • a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or • the person's shared care plan identifies the need for follow-up allied health services; and (b) the person is referred to the eligible psychologist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible psychologist gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para MN.11.1 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
81360	SPEECH PATHOLOGY HEALTH SERVICE provided to a person who is of Aboriginal or Torres

M11. ALLIED HEALTH SERVICES FOR INDIGENOUS AUSTRALIANS WHO HAVE HAD A HEALTH CHECK	
	Strait Islander descent by an eligible speech pathologist if: (a) either: • a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or • the person's shared care plan identifies the need for follow-up allied health services; and (b) the person is referred to the eligible speech pathologist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible speech pathologist gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para MN.11.1 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75

M12. SERVICES PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER	1. TELEHEALTH SUPPORT SERVICE ON BEHALF OF A MEDICAL PRACTITIONER
	Group M12. Services Provided By A Practice Nurse Or Aboriginal And Torres Strait Islander Health Practitioner On Behalf Of A Medical Practitioner
	Subgroup 1. Telehealth Support Service On Behalf Of A Medical Practitioner
10983	Attendance by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner, to provide clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist, consultant physician or

psychiatrist; and

(b) is not an admitted patient; and

(c) either:

(i) is located both:

(A) within a telehealth eligible area; and

(B) at the time of the attendance-at least 15 kms by road from the specialist, physician or psychiatrist mentioned in paragraph (a); or

(ii) is a patient of:

(A) an Aboriginal Medical Service; or

(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies

(See para MN.12.5 of explanatory notes to this Category)
Fee: $32.90 **Benefit:** 100% = $32.90
Extended Medicare Safety Net Cap: $98.70

Group M12. Services Provided By A Practice Nurse Or Aboriginal And Torres Strait Islander Health Practitioner On Behalf Of A Medical Practitioner

Subgroup 2. Telehealth Support Service On Behalf Of A Medical Practitioner At A Residential Aged Care Facility

Service by a practice nurse or Aboriginal health worker or Aboriginal and Torres Strait Islander health practitioner provided on behalf of, and under the supervision of, a medical practitioner that requires the provision of clinical support to a patient who is:

a) a care recipient receiving care in a residential aged care service (other than a self-contained unit); or

b) at consulting rooms situated within such a complex if the patient is a care recipient receiving care in a residential aged care service (excluding accommodation in a self-contained unit);

and who is participating in a video consultation with a specialist or consultant physician.

(See para MN.12.5 of explanatory notes to this Category)
Fee: $32.90 **Benefit:** 100% = $32.90
10984 **Extended Medicare Safety Net Cap:** $98.70

	Group M12. Services Provided By A Practice Nurse Or Aboriginal And Torres Strait Islander Health Practitioner On Behalf Of A Medical Practitioner
	Subgroup 3. Services Provided By A Practice Nurse Or Aboriginal And Torres Strait Islander Health Practitioner On Behalf Of A Medical Practitioner
10987	Follow up service provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner, on behalf of a medical practitioner, for an Indigenous person who has received a health assessment if: a) The service is provided on behalf of and under the supervision of a medical practitioner; and b) the person is not an admitted patient of a hospital; and c) the service is consistent with the needs identified through the health assessment; - to a maximum of 10 services per patient in a calendar year (See para MN.12.3 of explanatory notes to this Category) **Fee:** $24.40 **Benefit:** 100% = $24.40 **Extended Medicare Safety Net Cap:** $73.20
10988	Immunisation provided to a person by an Aboriginal and Torres Strait Islander health practitioner if: (a) the immunisation is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the person is not an admitted patient of a hospital. (See para MN.12.1 of explanatory notes to this Category) **Fee:** $12.20 **Benefit:** 100% = $12.20 **Extended Medicare Safety Net Cap:** $36.60
10989	Treatment of a person's wound (other than normal aftercare) provided by an Aboriginal and Torres Strait Islander health practitioner if: (a) the treatment is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the person is not an admitted patient of a hospital. (See para MN.12.2 of explanatory notes to this Category) **Fee:** $12.20 **Benefit:** 100% = $12.20 **Extended Medicare Safety Net Cap:** $36.60
10997	Service provided to a person with a chronic disease by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner if: (a) the service is provided on behalf of and under the supervision of a medical practitioner; and (b) the person is not an admitted patient of a hospital; and (c) the person has a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan in place; and

M12. SERVICES PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER	3. SERVICES PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER
	(d) the service is consistent with the GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan to a maximum of 5 services per patient in a calendar year (See para MN.12.4 of explanatory notes to this Category) **Fee:** $12.20 **Benefit:** 100% = $12.20 **Extended Medicare Safety Net Cap:** $36.60

M13. MIDWIFERY SERVICES	1. MBS ITEMS FOR PARTICIPATING MIDWIVES
	Group M13. Midwifery Services
	Subgroup 1. MBS Items For Participating Midwives
82100	Initial antenatal professional attendance by a participating midwife, lasting at least 40 minutes, including all of the following: (a) taking a detailed patient history; (b) performing a comprehensive examination; (c) performing a risk assessment; (d) based on the risk assessment - arranging referral or transfer of the patient's care to an obstetrician; (e) requesting pathology and diagnostic imaging services, when necessary; (f) discussing with the patient the collaborative arrangements for her maternity care and recording the arrangements in the midwife's written records in accordance with section 6 of the Health Insurance Regulations 2018. Payable once only for any pregnancy. (See para MN.13.16 of explanatory notes to this Category) **Fee:** $54.25 **Benefit:** 85% = $46.15 **Extended Medicare Safety Net Cap:** $21.70
82105	Short antenatal professional attendance by a participating midwife, lasting up to 40 minutes. (See para MN.13.16 of explanatory notes to this Category) **Fee:** $32.80 **Benefit:** 75% = $24.60 85% = $27.90 **Extended Medicare Safety Net Cap:** $16.30
82110	Long antenatal professional attendance by a participating midwife, lasting at least 40 minutes. (See para MN.13.16 of explanatory notes to this Category) **Fee:** $54.25 **Benefit:** 75% = $40.70 85% = $46.15 **Extended Medicare Safety Net Cap:** $21.70
82115	Professional attendance by a participating midwife, lasting at least 90 minutes, for assessment and

	preparation of a maternity care plan for a patient whose pregnancy has progressed beyond 20 weeks, if: (a) the patient is not an admitted patient of a hospital; and (b) the participating midwife undertakes a comprehensive assessment of the patient; and (c) the participating midwife develops a written maternity care plan that contains: · outcomes of the assessment; and · details of agreed expectations for care during pregnancy, labour and delivery; and · details of any health problems or care needs; and · details of collaborative arrangements that apply for the patient; and · details of any medication taken by the patient during the pregnancy, and any additional medication that may be required by the patient; and · details of any referrals or requests for pathology services or diagnostic imaging services for the patient during the pregnancy, and any additional referrals or requests that may be required for the patient; and (d) the maternity care plan is explained and agreed with the patient; and (e) the fee does not include any amount for the management of the labour and delivery. (Includes any antenatal attendance provided on the same occasion). Payable once only for any pregnancy. (See para MN.13.16 of explanatory notes to this Category) **Fee:** $324.10 **Benefit:** 85% = $275.50 **Extended Medicare Safety Net Cap:** $54.10
82120	Management of confinement for up to 12 hours, including delivery (if undertaken), if: (a) the patient is an admitted patient of a hospital; and (b) the attendance is by a participating midwife who: (i) provided the patient's antenatal care; or (ii) is a member of a practice that provided the patient's antenatal care. (Includes all attendances related to the confinement by the participating midwife)

	Payable once only for any pregnancy (See para MN.13.16 of explanatory notes to this Category) **Fee:** $765.35 **Benefit:** 75% = $574.05 **Extended Medicare Safety Net Cap:** $500.00
82125	Management of confinement, including delivery (if undertaken) when care is transferred from 1 participating midwife to another participating midwife (the second participating midwife), if: (a) the patient is an admitted patient of a hospital; and (b) the patient's confinement is for longer than 12 hours; (c) the second participating midwife: (i) has provided the patient's antenatal care; or (ii) is a member of a practice that has provided the patient's antenatal care. (Includes all attendances related to the confinement by the second participating midwife) Payable one only for any pregnancy. (See para MN.13.16 of explanatory notes to this Category) **Fee:** $765.35 **Benefit:** 75% = $574.05 **Extended Medicare Safety Net Cap:** $500.00
82130	Short Postnatal Attendance Short postnatal professional attendance by a participating midwife, lasting up to 40 minutes, within 6 weeks after delivery. (See para MN.13.16 of explanatory notes to this Category) **Fee:** $54.25 **Benefit:** 75% = $40.70 85% = $46.15 **Extended Medicare Safety Net Cap:** $16.30
82135	Long Postnatal Attendance Long postnatal professional attendance by a participating midwife, lasting at least 40 minutes, within 6 weeks after delivery. (See para MN.13.16 of explanatory notes to this Category) **Fee:** $79.75 **Benefit:** 75% = $59.85 85% = $67.80 **Extended Medicare Safety Net Cap:** $21.70
82140	Six Week Postnatal Attendance Postnatal professional attendance by a participating midwife on a patient not less than 6 weeks but not more than 7 weeks after delivery of a baby, including: (a) a comprehensive examination of patient and baby to ensure normal postnatal recovery; and (b) referral of the patient to a general practitioner for the ongoing care of the patient and baby

	Payable once only for any pregnancy. (See para MN.13.16 of explanatory notes to this Category) **Fee:** $54.25 **Benefit:** 85% = $46.15 **Extended Medicare Safety Net Cap:** $16.30

M13. MIDWIFERY SERVICES 2. TELEHEALTH ATTENDANCES

	Group M13. Midwifery Services
	Subgroup 2. Telehealth Attendances
82150	A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating midwife that requires the provision of clinical support to a patient who: a) is participating in a video consultation with a specialist practising in his or her speciality of obstetrics or a specialist or consultant physician practising in his or her speciality of paediatrics; and b) is not an admitted patient; and c) is located: (i) both: (A) within a telehealth eligible area; and (B) at the time of the attendance - at least 15 kms by road from the specialist or consultant physician mentioned in paragraph (a); or (ii) in Australia if the patient is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the Act applies. (See para MN.12.5 of explanatory notes to this Category) **Fee:** $28.75 **Benefit:** 85% = $24.45 **Extended Medicare Safety Net Cap:** $86.25
82151	A professional attendance lasting at least 20 minutes (whether or not continuous) by a participating midwife that requires the provision of clinical support to a patient who: a) is participating in a video consultation with a specialist practising in his or her speciality of obstetrics or a specialist or consultant physician practising in his or her speciality of paediatrics; and b) is not an admitted patient; and c) is located: (i) both:

	(A) within a telehealth eligible area; and (B) at the time of the attendance - at least 15 kms by road from the specialist or consultant physician mentioned in paragraph (a); or (ii) in Australia if the patient is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the Act applies. (See para MN.12.5 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 85% = $46.40 **Extended Medicare Safety Net Cap:** $163.65
82152	A professional attendance lasting at least 40 minutes (whether or not continuous) by a participating midwife that requires the provision of clinical support to a patient who: a) is participating in a video consultation with a specialist practising in his or her speciality of obstetrics or a specialist or consultant physician practising in his or her speciality of paediatrics; and b) is not an admitted patient; and c) is located: (i) both: (A) within a telehealth eligible area; and (B) at the time of the attendance - at least 15 kms by road from the specialist or consultant physician mentioned in paragraph (a); or (ii) in Australia if the patient is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the Act applies. (See para MN.12.5 of explanatory notes to this Category) **Fee:** $80.20 **Benefit:** 85% = $68.20 **Extended Medicare Safety Net Cap:** $240.60

	Group M14. Nurse Practitioners
	Subgroup 1. Nurse Practitioners
82200	Professional attendance by a participating nurse practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management. (See para MN.14.12 of explanatory notes to this Category) **Fee:** $9.75 **Benefit:** 85% = $8.30

	Extended Medicare Safety Net Cap: $29.25
82205	Professional attendance by a participating nurse practitioner lasting less than 20 minutes and including any of the following: a) taking a history; b) undertaking clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care, for 1 or more health related issues, with appropriate documentation. (See para MN.14.12 of explanatory notes to this Category) **Fee:** $21.30 **Benefit:** 85% = $18.15 **Extended Medicare Safety Net Cap:** $63.90
82210	Professional attendance by a participating nurse practitioner lasting at least 20 minutes and including any of the following: a) taking a detailed history; b) undertaking clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care, for 1 or more health related issues, with appropriate documentation. (See para MN.14.12 of explanatory notes to this Category) **Fee:** $40.40 **Benefit:** 85% = $34.35 **Extended Medicare Safety Net Cap:** $121.20
82215	Professional attendance by a participating nurse practitioner lasting at least 40 minutes and including any of the following: a) taking an extensive history; b) undertaking clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care,

	for 1 or more health related issues, with appropriate documentation. (See para MN.14.12 of explanatory notes to this Category) **Fee:** $59.50 **Benefit:** 85% = $50.60 **Extended Medicare Safety Net Cap:** $178.50

	Group M14. Nurse Practitioners
	Subgroup 2. Telehealth Attendance
82220	A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating nurse practitioner that requires the provision of clinical support to a patient who: a) is participating in a video consultation with a specialist or consultant physician; and b) is not an admitted patient; and c) is located: (i) both: (A) within a telehealth eligible area; and (B) at the time of the attendance - at least 15 kms by road from the specialist or consultant physician mentioned in paragraph (a); or (ii) in Australia if the patient is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the Act applies. (See para MN.12.5 of explanatory notes to this Category) **Fee:** $28.75 **Benefit:** 85% = $24.45 **Extended Medicare Safety Net Cap:** $86.25
82221	A professional attendance lasting at least 20 minutes (whether or not continuous) by a participating nurse practitioner that requires the provision of clinical support to a patient who: a) is participating in a video consultation with a specialist or consultant physician; and b) is not an admitted patient; and c) is located: (i) both: (A) within a telehealth eligible area; and (B) at the time of the attendance - at least 15 kms by road from the specialist or consultant physician mentioned in paragraph (a); or (ii) in Australia if the patient is a patient of:

(A) an Aboriginal Medical Service; or

(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the Act applies.

(See para MN.12.5 of explanatory notes to this Category)
Fee: $54.55 **Benefit:** 85% = $46.40
Extended Medicare Safety Net Cap: $163.65

A professional attendance lasting at least 40 minutes (whether or not continuous) by a participating nurse practitioner that requires the provision of clinical support to a patient who:

a) is participating in a video consultation with a specialist or consultant physician; and

b) is not an admitted patient; and

c) is located:

(i) both:

(A) within a telehealth eligible area; and

(B) at the time of the attendance - at least 15 kms by road from the specialist or consultant physician mentioned in paragraph (a); or

(ii) in Australia if the patient is a patient of:

(A) an Aboriginal Medical Service; or

(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the Act applies.

(See para MN.12.5 of explanatory notes to this Category)
Fee: $80.20 **Benefit:** 85% = $68.20
82222 **Extended Medicare Safety Net Cap:** $240.60

M14. NURSE PRACTITIONERS — 3. TELEHEALTH ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY

Group M14. Nurse Practitioners

Subgroup 3. Telehealth Attendance At A Residential Aged Care Facility

A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating nurse practitioner that requires the provision of clinical support to a patient who:

a) is participating in a video consultation with a specialist or consultant physician; and

b) either:

(i) is a care recipient receiving care in a residential care service; or

(ii) is at consulting rooms situated within such a complex if the patient is a care recipient receiving care in a residential aged care service; and

c) the professional attendance is not provided at a self-contained unit.

82223 (See para MN.12.5 of explanatory notes to this Category)

M14. NURSE PRACTITIONERS	3. TELEHEALTH ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
	Fee: $28.75 **Benefit:** 85% = $24.45 **Extended Medicare Safety Net Cap:** $86.25
82224	A professional attendance lasting at least 20 minutes (whether or not continuous) by a participating nurse practitioner that requires the provision of clinical support to a patient who: a) is participating in a video consultation with a specialist or consultant physician; and b) either: (i) is a care recipient receiving care in a residential care service; or (ii) is at consulting rooms situated within such a complex if the patient is a care recipient receiving care in a residential aged care service; and c) the professional attendance is not provided at a self-contained unit (See para MN.12.5 of explanatory notes to this Category) **Fee:** $54.55 **Benefit:** 85% = $46.40 **Extended Medicare Safety Net Cap:** $163.65
82225	A professional attendance lasting at least 40 minutes (whether or not continuous) by a participating nurse practitioner that requires the provision of clinical support to a patient who: a) is participating in a video consultation with a specialist or consultant physician; and b) either: (i) is a care recipient receiving care in a residential care service; or (ii) is at consulting rooms situated within such a complex if the patient is a care recipient receiving care in a residential aged care service; and c) the professional attendance is not provided at a self-contained unit (See para MN.12.5 of explanatory notes to this Category) **Fee:** $80.20 **Benefit:** 85% = $68.20 **Extended Medicare Safety Net Cap:** $240.60

M15. DIAGNOSTIC AUDIOLOGY SERVICES

	Group M15. Diagnostic Audiology Services
82300	Audiology health service, consisting of BRAIN STEM EVOKED RESPONSE AUDIOMETRY, performed on a person by an eligible audiologist if: (a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and (b) the eligible practitioner is a specialist in the specialty of otolaryngology head and neck surgery; and (c) the service is not performed for the purpose of a hearing screening; and (d) the person is not an admitted patient of a hospital; and

	(e) the service is performed on the person individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and (g) a service to which item 11300 applies has not been performed on the person on the same day. (See para MN.15.1, MN.15.5 of explanatory notes to this Category) **Fee:** $156.40 **Benefit:** 85% = $132.95 **Extended Medicare Safety Net Cap:** $469.20
82306	Audiology health service, consisting of NON-DETERMINATE AUDIOMETRY performed on a person by an eligible audiologist if: (a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and (b) the eligible practitioner is a specialist in the specialty of otolaryngology head and neck surgery; and (c) the service is not performed for the purpose of a hearing screening; and (d) the person is not an admitted patient of a hospital; and (e) the service is performed on the person individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and (g) a service to which item 11306 applies has not been performed on the person on the same day. (See para MN.15.2, MN.15.5 of explanatory notes to this Category) **Fee:** $17.80 **Benefit:** 85% = $15.15 **Extended Medicare Safety Net Cap:** $53.40
82309	Audiology health service, consisting of an AIR CONDUCTION AUDIOGRAM performed on a person by an eligible audiologist if: (a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and (b) the eligible practitioner is: (i) a specialist in the specialty of otolaryngology head and neck surgery; or (ii) a specialist or consultant physician in the specialty of neurology; and (c) the service is not performed for the purpose of a hearing screening; and (d) the person is not an admitted patient of a hospital; and (e) the service is performed on the person individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the

	eligible practitioner who requested the service; and (g) a service to which item 11309 applies has not been performed on the person on the same day. (See para MN.15.3, MN.15.5 of explanatory notes to this Category) **Fee:** $21.40 **Benefit:** 85% = $18.20 **Extended Medicare Safety Net Cap:** $64.20
82312	Audiology health service, consisting of an AIR AND BONE CONDUCTION AUDIOGRAM OR AIR CONDUCTION AND SPEECH DISCRIMINATION AUDIOGRAM performed on a person by an eligible audiologist if: (a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and (b) the eligible practitioner is: (i) a specialist in the specialty of otolaryngology head and neck surgery; or (ii) a specialist or consultant physician in the specialty of neurology; and (c) the service is not performed for the purpose of a hearing screening; and (d) the person is not an admitted patient of a hospital; and (e) the service is performed on the person individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and (g) a service to which item 11312 applies has not been performed on the person on the same day. (See para MN.15.3, MN.15.5 of explanatory notes to this Category) **Fee:** $30.20 **Benefit:** 85% = $25.70 **Extended Medicare Safety Net Cap:** $90.60
82315	Audiology health service, consisting of an AIR AND BONE CONDUCTION AND SPEECH DISCRIMINATION AUDIOGRAM performed on a person by an eligible audiologist if: (a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and (b) the eligible practitioner is: (i) a specialist in the specialty of otolaryngology head and neck surgery; or (ii) a specialist or consultant physician in the specialty of neurology; and (c) the service is not performed for the purpose of a hearing screening; and (d) the person is not an admitted patient of a hospital; and (e) the service is performed on the person individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed,

	together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and (g) a service to which item 11315 applies has not been performed on the person on the same day. (See para MN.15.3, MN.15.5 of explanatory notes to this Category) **Fee:** $40.00 **Benefit:** 85% = $34.00 **Extended Medicare Safety Net Cap:** $120.00
82318	Audiology health service, consisting of an AIR AND BONE CONDUCTION AND SPEECH DISCRIMINATION AUDIOGRAM WITH OTHER COCHLEAR TESTS performed on a person by an eligible audiologist if: (a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and (b) the eligible practitioner is: (i) a specialist in the specialty of otolaryngology head and neck surgery; or (ii) a specialist or consultant physician in the specialty of neurology; and (c) the service is not performed for the purpose of a hearing screening; and (d) the person is not an admitted patient of a hospital; and (e) the service is performed on the person individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and (g) a service to which item 11318 applies has not been performed on the person on the same day. (See para MN.15.3, MN.15.5 of explanatory notes to this Category) **Fee:** $49.40 **Benefit:** 85% = $42.00 **Extended Medicare Safety Net Cap:** $148.20
82324	Audiology health service, consisting of an IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed on a person by an eligible audiologist (not being a service associated with a service to which item 82309, 82312, 82315 or 82318 applies) if: (a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and (b) the eligible practitioner is: (i) a specialist in the specialty of otolaryngology head and neck surgery; or (ii) a specialist or consultant physician in the specialty of neurology; and (c) the service is not performed for the purpose of a hearing screening; and (d) the person is not an admitted patient of a hospital; and

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	(e) the service is performed on the person individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and (g) a service to which item 11324 applies has not been performed on the person on the same day. (See para MN.15.3, MN.15.5 of explanatory notes to this Category) **Fee:** $26.70 **Benefit:** 85% = $22.70 **Extended Medicare Safety Net Cap:** $80.10
82327	Audiology health service, consisting of an IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed on a person by an eligible audiologist (being a service associated with a service to which item 82309, 82312, 82315 or 82318 applies) if: (a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and (b) the eligible practitioner is: (i) a specialist in the specialty of otolaryngology head and neck surgery; or (ii) a specialist or consultant physician in the specialty of neurology; and (c) the service is not performed for the purpose of a hearing screening; and (d) the person is not an admitted patient of a hospital; and (e) the service is performed on the person individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and (g) a service to which item 11327 applies has not been performed on the person on the same day. (See para MN.15.3, MN.15.5 of explanatory notes to this Category) **Fee:** $16.05 **Benefit:** 85% = $13.65 **Extended Medicare Safety Net Cap:** $48.15
82332	Audiology health service, consisting of an OTO-ACOUSTIC EMISSION AUDIOMETRY for the detection of permanent congenital hearing impairment, performed by an eligible audiologist on an infant or child in circumstances in which: (a) the service is performed pursuant to a written request made by an eligible practitioner who is: (i) a specialist in the specialty of otolaryngology head and neck surgery; or (ii) a specialist or consultant physician in the specialty of neurology; and (b) the infant or child is at risk due to 1 or more of the following factors: (i) admission to a neonatal intensive care unit; (ii) family history of hearing impairment;

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	(iii) intra-uterine or perinatal infection (either suspected or confirmed); (iv) birthweight less than 1.5kg; (v) craniofacial deformity; (vi) birth asphyxia; (vii) chromosomal abnormality, including Down Syndrome; (viii) exchange transfusion; and (c) middle ear pathology has been excluded by specialist opinion; and (d) the infant or child is not an admitted patient of a hospital; and (e) the service is performed on the infant or child individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and (g) a service to which item 11332 applies has not been performed on the infant or child on the same day. (See para MN.15.4, MN.15.5 of explanatory notes to this Category) **Fee:** $47.60 **Benefit:** 85% = $40.50 **Extended Medicare Safety Net Cap:** $142.80

M16. EATING DISORDERS SERVICES	1. EATING DISORDERS DIETITIAN HEALTH SERVICES
	Group M16. Eating Disorders Services
	Subgroup 1. Eating disorders dietitian health services
New 82350	Dietetics health service provided to an eligible patient by an eligible dietitian if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the service is provided to the person individually and in person; and (d) the service is of at least 20 minutes in duration (See para MN.16.1, MN.16.2 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
New 82351	Dietetics health service provided to an eligible patient by an eligible dietitian if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the attendance is by video conference; and

M16. EATING DISORDERS SERVICES	1. EATING DISORDERS DIETITIAN HEALTH SERVICES
	(d) the patient is located within a telehealth eligible area; and (e) the patient is, at the time of the attendance, at least 15 kilometres by road from the dietitian; and (f) the service is of at least 20 minutes duration (See para MN.16.1, MN.16.2, MN.16.4 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75

M16. EATING DISORDERS SERVICES	2. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE CLINICAL PSYCHOLOGISTS
	Group M16. Eating Disorders Services
	Subgroup 2. Eating disorder psychological treatment services provided by eligible clinical psychologists
New 82352	Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible clinical psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the service is provided to the person individually and in person; and (d) the service is at least 30 minutes but less than 50 minutes in duration. (See para MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $101.35 **Benefit:** 85% = $86.15 **Extended Medicare Safety Net Cap:** $304.05
New 82353	Eating disorder psychological treatment service provided to an eligible patient by an eligible clinical psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the attendance is by video conference; and (d) the patient is located within a telehealth eligible area; and (e) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and (f) the service is at least 30 minutes but less than 50 minutes in duration. (See para MN.16.1, MN.16.3, MN.16.4 of explanatory notes to this Category) **Fee:** $101.35 **Benefit:** 85% = $86.15 **Extended Medicare Safety Net Cap:** $304.05
New 82354	Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible clinical psychologist if:

	(a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the service is provided to the person individually and in person; and the service is at least 30 minutes but less than 50 minutes in duration. (See para MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $126.65 **Benefit:** 85% = $107.70 **Extended Medicare Safety Net Cap:** $379.95
New 82355	Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible clinical psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the service is provided to the person individually and in person; and (d) the service is at least 50 minutes in duration. (See para MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $148.80 **Benefit:** 85% = $126.50 **Extended Medicare Safety Net Cap:** $446.40
New 82356	Eating disorder psychological treatment service provided to an eligible patient by an eligible clinical psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) attendance is by video conference; and (d) the patient is located within a telehealth eligible area; and (e) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and (f) the service is at least 50 minutes in duration. (See para MN.16.1, MN.16.3, MN.16.4 of explanatory notes to this Category) **Fee:** $148.80 **Benefit:** 85% = $126.50 **Extended Medicare Safety Net Cap:** $446.40
New 82357	Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible clinical psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the service is provided to the person individually and in person; and

M16. EATING DISORDERS SERVICES	2. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE CLINICAL PSYCHOLOGISTS
	(d) the service is at least 50 minutes in duration. (See para MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $174.10 **Benefit:** 85% = $148.00 **Extended Medicare Safety Net Cap:** $500.00
New 82358	Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible clinical psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the service is provided in person; and (d) the service is at least 60 minutes in duration. (See para MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $37.80 **Benefit:** 85% = $32.15 **Extended Medicare Safety Net Cap:** $113.40
New 82359	Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible clinical psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the attendance is by video conference; and (d) the patient is located within a telehealth eligible area; and (e) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and (f) the service is at least 60 minutes in duration. (See para MN.16.1, MN.16.3, MN.16.4 of explanatory notes to this Category) **Fee:** $37.80 **Benefit:** 85% = $32.15 **Extended Medicare Safety Net Cap:** $113.40

M16. EATING DISORDERS SERVICES	3. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE PSYCHOLOGISTS
	Group M16. Eating Disorders Services
	Subgroup 3. Eating disorder psychological treatment services provided by eligible psychologists
New 82360	Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and

	(c) the service is provided to the person individually and in person; and (d) the service is at least 20 minutes but less than 50 minutes in duration. (See para MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $71.80 **Benefit:** 85% = $61.05 **Extended Medicare Safety Net Cap:** $215.40
New 82361	Eating disorder psychological treatment service provided to an eligible patient by an eligible psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the attendance is by video conference; and (d) the patient is located within a telehealth eligible area; and (e) the patient is, at the time of the attendance, at least 15 kilometres by road from the psychologist; and (f) the service is at least 20 minutes but less than 50 minutes in duration. (See para MN.16.1, MN.16.3, MN.16.4 of explanatory notes to this Category) **Fee:** $71.80 **Benefit:** 85% = $61.05 **Extended Medicare Safety Net Cap:** $215.40
New 82362	Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the service is provided to the person individually and in person; and (d) the service is at least 20 minutes but less than 50 minutes in duration. (See para MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $97.70 **Benefit:** 85% = $83.05 **Extended Medicare Safety Net Cap:** $293.10
New 82363	Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the service is provided to the person individually and in person; and (d) the service is at least 50 minutes in duration. (See para MN.16.1, MN.16.3 of explanatory notes to this Category)

	Fee: $101.35 **Benefit:** 85% = $86.15 **Extended Medicare Safety Net Cap:** $304.05
New 82364	Eating disorder psychological treatment service provided to an eligible patient by an eligible psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the attendance is by video conference; and (d) the patient is located within a telehealth eligible area; and (e) the patient is, at the time of the attendance, at least 15 kilometres by road from the psychologist; and (f) the service is at least 50 minutes in duration. (See para MN.16.1, MN.16.3, MN.16.4 of explanatory notes to this Category) **Fee:** $101.35 **Benefit:** 85% = $86.15 **Extended Medicare Safety Net Cap:** $304.05
New 82365	Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the service is provided to the person individually and in person; and (d) the service is at least 50 minutes in duration. (See para MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $127.30 **Benefit:** 85% = $108.25 **Extended Medicare Safety Net Cap:** $381.90
New 82366	Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the service is provided in person; and (d) the service is at least 60 minutes in duration. (See para MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $25.85 **Benefit:** 85% = $22.00 **Extended Medicare Safety Net Cap:** $77.55

New 82367	Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the attendance is by video conference; and (d) the patient is located within a telehealth eligible area; and (e) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and (f) the service is at least 60 minutes in duration. (See para MN.16.1, MN.16.3, MN.16.4 of explanatory notes to this Category) **Fee:** $25.85 **Benefit:** 85% = $22.00 **Extended Medicare Safety Net Cap:** $77.55

M16. EATING DISORDERS SERVICES	**4. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE OCCUPATIONAL THERAPISTS**
	Group M16. Eating Disorders Services
	Subgroup 4. Eating disorder psychological treatment services provided by eligible occupational therapists
New 82368	Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible occupational therapist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the service is provided to the person individually and in person; and (d) the service is at least 20 minutes but less than 50 minutes in duration. (See para MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
New 82369	Eating disorder psychological treatment service provided to an eligible patient by an eligible occupational therapist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the attendance is by video conference; and (d) the patient is located within a telehealth eligible area; and (e) the patient is, at the time of the attendance, at least 15 kilometres by road from the psychologist; and

	(f) the service is at least 20 minutes but less than 50 minutes in duration. (See para MN.16.1, MN.16.3, MN.16.4 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
New 82370	Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible occupational therapist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the service is provided to the person individually and in person; and (d) the service is at least 20 minutes but less than 50 minutes in duration. (See para MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $89.10 **Benefit:** 85% = $75.75 **Extended Medicare Safety Net Cap:** $267.30
New 82371	Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible occupational therapist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the service is provided to the person individually and in person; and (d) the service is at least 50 minutes in duration. (See para MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $89.35 **Benefit:** 85% = $75.95 **Extended Medicare Safety Net Cap:** $268.05
New 82372	Eating disorder psychological treatment service provided to an eligible patient by an eligible occupational therapist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the attendance is by video conference; and (d) the patient is located within a telehealth eligible area; and (e) the patient is, at the time of the attendance, at least 15 kilometres by road from the psychologist; and (f) the service is at least 50 minutes in duration. (See para MN.16.1, MN.16.3, MN.16.4 of explanatory notes to this Category) **Fee:** $89.35 **Benefit:** 85% = $75.95 **Extended Medicare Safety Net Cap:** $268.05

New 82373	Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible occupational therapist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the service is provided to the person individually and in person; and (d) the service is at least 50 minutes in duration. (See para MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $115.15 **Benefit:** 85% = $97.90 **Extended Medicare Safety Net Cap:** $345.45
New 82374	Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible occupational therapist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the service is provided in person; and (d) the service is at least 60 minutes in duration (See para MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $22.70 **Benefit:** 85% = $19.30 **Extended Medicare Safety Net Cap:** $68.10
New 82375	Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible occupational therapist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the attendance is by video conference; and (d) the patient is located within a telehealth eligible area; and (e) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and (f) the service is at least 60 minutes in duration. (See para MN.16.1, MN.16.3, MN.16.4 of explanatory notes to this Category) **Fee:** $22.70 **Benefit:** 85% = $19.30 **Extended Medicare Safety Net Cap:** $68.10

M16. EATING DISORDERS SERVICES	**5. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE SOCIAL WORKERS**
	Group M16. Eating Disorders Services
	Subgroup 5. Eating disorder psychological treatment services provided by eligible social workers
New	Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an

82376	eligible social worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the service is provided to the person individually and in person; and (d) the service is at least 20 minutes but less than 50 minutes in duration (See para MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
New 82377	Eating disorder psychological treatment service provided to an eligible patient by an eligible social worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the attendance is by video conference; and (d) the patient is located within a telehealth eligible area; and (e) the patient is, at the time of the attendance, at least 15 kilometres by road from the psychologist; and (f) the service is at least 20 minutes but less than 50 minutes in duration (See para MN.16.1, MN.16.3, MN.16.4 of explanatory notes to this Category) **Fee:** $63.25 **Benefit:** 85% = $53.80 **Extended Medicare Safety Net Cap:** $189.75
New 82378	Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible social worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the service is provided to the person individually and in person; and (d) the service is at least 20 minutes but less than 50 minutes in duration. (See para MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $89.10 **Benefit:** 85% = $75.75 **Extended Medicare Safety Net Cap:** $267.30
New 82379	Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible social worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and

	(c) the service is provided to the person individually and in person; and (d) the service is at least 50 minutes in duration. (See para MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $89.35 **Benefit:** 85% = $75.95 **Extended Medicare Safety Net Cap:** $268.05
New 82380	Eating disorder psychological treatment service provided to an eligible patient by an eligible social worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the attendance is by video conference; and (d) the patient is located within a telehealth eligible area; and (e) the patient is, at the time of the attendance, at least 15 kilometres by road from the psychologist; and (f) the service is at least 50 minutes in duration. (See para MN.16.1, MN.16.3, MN.16.4 of explanatory notes to this Category) **Fee:** $89.35 **Benefit:** 85% = $75.95 **Extended Medicare Safety Net Cap:** $268.05
New 82381	Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible social worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the service is provided to the person individually and in person; and (d) the service is at least 50 minutes in duration (See para MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $115.15 **Benefit:** 85% = $97.90 **Extended Medicare Safety Net Cap:** $345.45
New 82382	Eating disorder psychological treatment service provided to a person as part of a group of 6 to 10 patients (but not as an admitted patient of a hospital) by an eligible social worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the service is provided in person; and (d) the service is at least 60 minutes in duration. (See para MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $22.70 **Benefit:** 85% = $19.30

M16. EATING DISORDERS SERVICES	5. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE SOCIAL WORKERS
	Extended Medicare Safety Net Cap: $68.10
New 82383	Eating disorder psychological treatment service provided to a person as part of a group of 6 to 10 patients (but not as an admitted patient of a hospital) by an eligible social worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the person is not an admitted patient of a hospital; and (c) the attendance is by video conference; and (d) the patient is located within a telehealth eligible area; and (e) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and (f) the service is at least 60 minutes in duration. (See para MN.16.1, MN.16.3, MN.16.4 of explanatory notes to this Category) **Fee:** $22.70 **Benefit:** 85% = $19.30 **Extended Medicare Safety Net Cap:** $68.10

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