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# State Government Instruments

## Return to Work Act 2014

*Notice of Day Surgery Facilities*

*Preamble*

The *Scales of Charges for medical practitioners, medical and other charges*, published by the Minister for Industrial Relations in the Government Gazette on 14 June 2024 states that a day surgery facility means *“a facility (other than a private hospital or facility of a private hospital) designed for the provision of medical, surgical or related treatment or care on a same day basis that is declared by the Return to Work Corporation of South Australia by notice in the Gazette to be a day surgery facility”*.

Notice

In accordance with the power delegated to me by the current *Instrument of Delegation of the Return to Work Corporation of South Australia 2 February 2023*, I, Michael Francis, Chief Executive Officer, declare that each of the following facilities is a day surgery facility for the purposes of the *Scales of Charges for medical practitioners, medical and other charges*, published by the Minister for Industrial Relations in the Government Gazette on 14 June 2024. This list will have effect from 1 July 2024.

| **Provider ID** | **Name and Address** |
| --- | --- |
|  |  |
| 0067240H | Adelaide Ambulatory Day Surgery, Suites 10A, 50 Hutt Street, Adelaide SA 5000 |
| 0067180B | Adelaide City East Day Hospital, 309 Wakefield Street, Adelaide, SA 5000 |
| 0658181F | Adelaide Day Surgery, 18 North Terrace, Adelaide, SA 5000 |
| 0999771L | Adelaide Surgicentre, 89 King William Street, Kent Town SA 5067 |
| 0067310J | Advanced Oral And Maxillofacial Surgery, 238 Angas Street, Adelaide SA 5000 |
| 0067290X | Archer St Day Hospital, 163 Archer Street, North Adelaide SA 5006 |
| 0067120T | Bedford Day Surgery, 1284 South Road, Tonsley SA 5042 |
| 0931151B | Brighton Day Surgery, 1 Jetty Road, Brighton SA 5048 |
| 0930971X | Brighton Dialysis Clinic, 361-365 Brighton Road, Hove SA 5048 |
| 0067340B | Burnside Day Surgery, Suite 1, 535-537 Glynburn Road, Hazelwood Park SA 5066 |
| 0067220K | Central Day Surgery, 235 Greenhill Road, Dulwich SA 5065 |
| 0067100X | Dextra Surgical, 83 Kensington Road, Norwood SA 5067 |
| 0879791H | Glen Osmond Surgicentre, 45 Glen Osmond Road, Eastwood SA 5063 |
| 0657221Y | Glenelg Day Surgery, 24 Gordon Street, Glenelg SA 5045 |
| 0067210L | Greenhill Dental Day Surgery, 62 Greenhill Road, Wayville SA 5034 |
| 0657401W | Hamilton House Day Surgery, 470 Goodwood Road, Cumberland Park SA 5041 |
| 0067320H | Harley Day Surgery, 63 Palmer Place, North Adelaide SA 5006 |
| 0067330F | Hove Day Surgery, 387-389 Brighton Road, Hove SA 5048 |
| 0067150J | Icon Cancer Centre Adelaide, Suite 10, First Floor, Tennyson Centre, 520 South Road, Kurralta Park SA 5037 |
| 0067250F | Icon Cancer Centre Windsor Gardens, Tenancy 1, Level 1, 480 North East Road, Windsor Gardens SA 5087 |
| 0067230J | Lift Cancer Care Services, 7/506-520 South Road, Kurralta Park SA 5037 |
| 0873741Y | North Adelaide Day Surgery Centre, 174 Ward Street, North Adelaide SA 5006 |
| 0834441A | Northern Endoscopy Centre, 127 Frost Road, Salisbury South SA 5106 |
| 0067280Y | Norwood Day Surgery, 42 Nelson Street, Stepney SA 5069 |
| 0067140K | Oromax Day Surgery, Level 2, 66 Rundle Street, Kent Town SA 5067 |
| 0067000A | Parkview Day Surgery, 215 Greenhill Road, Eastwood SA 5063 |
| 0067040T | Payneham Dialysis Clinic, 2 Portrush Road, Payneham SA 5070 |
| 0065680Y | Ramsay Day Clinic Kahlyn, 40 Briant Road, Magill SA 5072 |
| 0067080H | Repromed Day Surgery, 180 Fullarton Road, Dulwich SA 5065 |
| 0067260B | Seaford Day Surgery ,4 Vista Parade, Seaford Heights SA 5169 |
| 0067200T | Southern Endoscopy Centre, 271 Brighton Road, Somerton Park SA 5144 |
| 0067130L | The Tennyson Centre Day Hospital, Tenancy 18, Level 1, 520 South Road, Kurralta Park SA 5037 |
| 0067160H | Vista Day Surgery, 57 Greenhill Road, Wayville SA 5034 |
| 0067270A | Windsor Gardens Day Surgery, Suite 1, Level 1, 480 North East Road, Windsor Gardens SA 5087 |
|  |  |

Dated: 3 June 2024

Michael Francis

Chief Executive Officer

Return to Work Act 2014

*Scales of Charges for Medical Practitioners, Medical and Other Charges*

*Preamble*

Subsection 33(12)(a) of the *Return to Work Act 2014* (the Act), provides that the Minister for Industrial Relations may, by notice in the Gazette, on the recommendation of the Return to Work Corporation of South Australia, publish “scales of charges for the purposes of this section (ensuring as far as practicable that the scales comprehensively cover the various kinds of services to which this section applies)”.

**Notice**

Pursuant to subsection 33(12)(a) of the Act, I publish the following scales of charges to have effect on and from 1 July 2024:

1. scales of charges set out in Schedules 1A and 1B for the provision of medical and related or supplementary services by registered medical practitioners;

2. scales of charges set out in Schedule 2 for the provision of services by chiropractors;

3. scales of charges set out in Schedule 3 for the provision of services by an exercise physiologists (being a class of services which have been authorised by the Corporation under subsection 33(2)(i) of the Act);

4. scales of charges set out in Schedule 4 for the provision of services by occupational therapists;

5. scales of charges set out in Schedule 5 for the provision of services by osteopaths;

6. scales of charges set out in Schedule 6 for the provision of services by physiotherapists;

7. scales of charges set out in Schedule 7 for the provision of services by psychologists;

8. scales of charges set out in Schedule 8 for the provision of services by speech pathologists;

9. scales of charges set out in Schedule 9 for the provision of services by audiologists or audiometrists;

10. scales of charges set out in Schedule 10 for provision of services by accredited mental health social workers (being a class of services which have been authorised by the Corporation under Section 33(2)(i) of the Act);

11. scales of charges set out in Schedule 11 for provision of services by counsellors (being a class of services which have been authorised by the Corporation under Section 33(2)(i) of the Act);

12. scales of charges set out in Schedule 12 for provision of services by mental health occupational therapists;

13. scales of charges set out in Schedule 13 for the provision of services in private hospitals and day surgery facilities.

14. scales of charges for the provision of public hospital compensable patient services, in incorporated hospitals (within the meaning of the *Health Care Act 2008*), being the scale of charges made under the *Health Care Act 2008* as currently in force.

15. In cases of major trauma or a seriously injured worker, the scales of charges in Schedules 2 and 4 to 7 inclusive determined by an hourly rate multiplied by a nominated maximum number of hours, do not apply to the services described therein, with the exception of scale of charges for consultations contained in Schedule 7.

**Interpretation**

16. In this notice and the Schedules hereto—

***Act*** means the *Return to Work Act 2014* (as amended);

***an approved return to work service provider*** means a provider approved by ReturnToWorkSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the *Application for Approval as a South Australian Return to Work Service Provider*;

***claims manager*** means the person with primary responsibility for management of the worker’s claim within ReturnToWorkSA or the claims agent;

***chiropractor*** means a person registered under the *Health Practitioner Regulation National Law (South Australia) Act 2010* to practice in the chiropractic profession (other than as a student);

***claims agent*** means a private sector body that is a party to an authorised contract or arrangement under Section 14 of the *Return to Work Corporation of South Australia Act 1994* involving the conferral of powers to manage and determine claims;

***day surgery facility*** means a facility (other than a private hospital or facility of a private hospital) designed for the provision of medical, surgical or related treatment or care on a same day basis that is declared by the Corporation by notice in the Gazette to be a day surgery facility;

***DF or derived fee***, for an item in Schedules 1A or 1B, means the derived fee determined in accordance with that item;

***GST*** means the tax payable under the GST law;

***GST law*** means—

(a) *A New Tax System (Goods and Services Tax) Act 1999* (Commonwealth); and

(b) the related legislation of the Commonwealth dealing with the imposition of a tax on the supply of goods, services and other things;

***impairment assessor*** means a person registered under the *Health Practitioner Regulation National Law (South Australia) Act 2010* to practice in the medical profession (other than a student) and who holds a current accreditation issued by the Minister to undertake whole person impairment assessments pursuant to Section 22 of the Act.

***major trauma i***ncludes the following:

• serious orthopaedic injuries with an Abbreviated Injury Severity Score of .3 or above

(+/- thoraco/abdominal/pelvic organ trauma .3 or above)

• serious soft tissue trauma requiring major plastic/reconstructive surgery

• serious injuries that lead to an intensive care or high dependency unit hospital stay and/or an inpatient rehabilitation hospital stay

***occupational therapist*** means a person registered as an occupational therapist under the *Health Practitioner Regulation National Law (South Australia) Act 2010* to participate in the occupational therapy profession (other than as a student);

***osteopath*** means a person registered under the *Health Practitioner Regulation National Law (South Australia) Act 2010* to practice in the osteopathy profession (other than as a student);

***physiotherapist*** means a person registered under the *Health Practitioner Regulation National Law (South Australia) Act 2010* to practice in the physiotherapist profession (other than as a student);

***psychologist*** means a person registered under the *Health Practitioner Regulation National Law (South Australia) Act 2010* to practice in the psychology profession (other than as a student);

***same day***, in relation to a service, means a service that is provided on a single calendar day;

self-insured employer means an employer that is registered by ReturnToWorkSA as a self-insured employer according to Part 9 Division 1 of the Act;

***seriously injured worker*** means a worker who is seriously injured as defined in Section 4 of the Act; and

***ReturnToWorkSA*** or ***Corporation*** means the Return to Work Corporation of South Australia.

17. If a charge prescribed in a scale of charges is expressed as an amount per hour—

(a) a charge is payable for services provided for less than or more than an hour; and

(b) the amount payable in such circumstances is to be determined by dividing the number of minutes taken to provide the service (rounded to the nearest 6 minutes) by 60, then multiplying by the hourly rate.

18. The scales of charges set out in this notice also apply for the purposes of Section 127A of the *Motor Vehicles Act 1959* subject to modifications specified by that section and modifications specified by any notice in the Gazette issued under that section.

**GST**

19. Where the supply of a service set out in a scale of charges is subject to GST, the maximum fee set out in (or determined as a derived fee in accordance with) the scale of charges in respect of the service is to be increased so that after deduction of the GST in relation to the service the amount of the fee remaining is equal to or less than the maximum fee set out in the scale of charges.

20. Where the maximum fee in respect of a service is determined as a derived fee in accordance with a scale of charges, the fee from which it is derived must not be increased under paragraph 14 to include GST when calculating the derived fee.

Dated: 6 June 2024

Hon Kyam Maher MLC

Minister for Industrial Relations and Public Sector

Schedule 1a

*Scale of Charges—Clinical Medical Services*

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| **Item No.** | **Description** | **Max Fee (excl. GST)** |
| --- | --- | --- |
|  |  |  |
| **GROUP A1—GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES** | | |
| **Level A** | | |
| 00003 | 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 | $51.00 |
| 00004 | 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. | $118.00 |
| **Level B** | | |
| 00023 | Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 6 minutes and 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 | $102.00 |
| 00024 | 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 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 | $162.00 |
| **Level C** | | |
| 00036 | 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 | $188.00 |
| 00037 | 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; (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 | $240.00 |
| **Level D** | | |
| 00044 | 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 | $285.00 |
| 00047 | 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; (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 | $335.00 |
| 00123 | Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 60 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 | $286.80 |
| 00124 | 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 this Schedule applies), lasting at least 60 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 place on one occasion each patient | $330.30 |
| **GROUP A3—SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES** | | |
| 00104 | 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 | $205.00 |
| 00105 | 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 | $110.00 |
| 00106 | 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) | $205.00 |
| 00107 | 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 | $280.00 |
| 00108 | 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 | $182.00 |
| 00109 | 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) | $320.00 |
| 00111 | 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 $330.20 or more For any particular patient, once only on the same day | $110.00 |
| 00115 | Professional attendance at consulting rooms or in hospital on a day by a medical practitioner (the attending practitioner) who is a specialist or consultant physician in the practice of the attending practitioner s specialty after referral of the patient to the attending practitioner by a referring practitioner an attendance after the initial attendance in a single course of treatment, if: (a) the attending practitioner performs a scheduled operation on the patient on the same day; and (b) the operation is a service 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 that item applies is $330.20 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 day For any particular patient, once only on the same day | $112.00 |
| **GROUP A4—CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES** | | |
| 00110 | 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 | $390.00 |
| 00116 | 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 | $180.00 |
| 00117 | 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 $330.20 or more For any particular patient, once only on the same day | $180.00 |
| 00119 | 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 | $180.00 |
| 00120 | 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 minor attendance, if: (a) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (b) the consultant physician 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 $330.20 or more For any particular patient, once only on the same day | $180.00 |
| 00122 | 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 | $470.00 |
| 00128 | 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 | $209.70 |
| 00131 | 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 | $180.00 |
| 00132 | Professional attendance of at least 45 minutes duration for an initial assessment of a patient with at least two morbidities where the patient is referred by a referring practitioner, and where  a) assessment is undertaken that covers:  - a comprehensive history, including psychosocial history and medication review;  - comprehensive multi or detailed single organ system assessment;  - the formulation of differential diagnoses; and  b) a treatment and management plan is developed and provided to the referring practitioner that involves:  - an opinion on diagnosis and risk assessment  - treatment options and decisions including suggestions to facilitate a return to work  - medication recommendations.  Not being an attendance on a patient in respect of whom, an attendance under items 110, 116 and 119 has been received on the same day by the same consultant physician.  Note1: Item 132 is only available once in the preceding 12 months.  Note 2: A written copy of the treatment and management plan must be provided to the patient, the referring practitioner and relevant allied health provider involved in treatment. | $680.00 |
| 00133 | Professional attendance of at least 20 minutes duration subsequent to the first attendance in a single course of treatment for a review of a patient with at least two morbidities where  a) a review is undertaken that covers:  - review of initial presenting problem/s and results of diagnostic investigations  - review of responses to treatment and medication plans initiated at time of initial consultation comprehensive multi or detailed single organ system assessment,  - review of original and differential diagnoses; and  b) a modified treatment and management plan is provided to the referring practitioner (see Note 3) that involves, where appropriate:  - a revised opinion on the diagnosis and risk assessment  - treatment options and decisions including suggestions to facilitate a return to work  - revised medication recommendations.  Not being an attendance on a patient in respect of whom, an attendance under item 110, 116 and 119 has been received on the same day by the same consultant physician.  Being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under item 132 by the same consultant physician, payable no more than twice in any 12 month period. The subsequent attendance under item 133 is to be provided by either the same consultant physician or a locum tenens.  Note1: Item 133 is only available twice in the preceding 12 months.  Note 2: Should further reviews of the treatment and management plan be required, the appropriate item for such service/s is 116.  Note 3: A written copy of the treatment and management plan must be provided to the patient, referring practitioner and relevant allied health provider involved in treatment. | $340.00 |
| **GROUP A28—CONSULTANT PHYSICIAN OR SPECIALIST IN GERIATRIC MEDICINE** | | |
| 00141 | 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 | $730.60 |
| 00143 | 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 (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 | $456.80 |
| 00145 | 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 practitioner in the preceding 12 months | $885.60 |
| 00147 | 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 | $553.50 |
| **GROUP A5—PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES** | | |
| 00160 | 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 | $405.00 |
| 00161 | 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 | $655.00 |
| 00162 | 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 | $890.00 |
| 00163 | 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 | $1105.00 |
| 00164 | 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 | $1310.00 |
| **GROUP A6—GROUP THERAPY** | | |
| 00170 | 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 | $252.50 |
| 00171 | 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 | $266.00 |
| 00172 | 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 | $311.30 |
| **GROUP A7—ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS** | | |
| **Acupuncture** | | |
| 00193 | Professional attendance by a medical practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia as an acupuncturist, at a place other than a hospital, for treatment 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 medical practitioner 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 | $80.30 |
| 00195 | 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 | $139.30 |
| 00197 | Professional attendance by a medical practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia as an acupuncturist, at a place other than a hospital, for treatment 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 medical practitioner 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 | $137.10 |
| 00199 | Professional attendance by a medical practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia as an acupuncturist, at a place other than a hospital, for treatment 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 medical practitioner 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 | $229.40 |
| **Non-Specialist Practitioner attendances to which no other item applies** | | |
| 00179 | Professional attendance at consulting rooms lasting not more than 5 minutes (other than a service to which any other item applies) by a prescribed medical practitioner in an eligible area each attendance | $26.50 |
| 00181 | 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 | $63.30 |
| 00185 | Professional attendance at consulting rooms lasting more than 5 minutes but not more than 25 minutes (other than a service to which any other item applies) by a prescribed medical practitioner in an eligible area each attendance | $58.10 |
| 00187 | 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. | $93.70 |
| 00189 | Professional attendance at consulting rooms lasting more than 25 minutes but not more than 45 minutes (other than a service to which any other applies) by a prescribed medical practitioner in an eligible area each attendance | $112.60 |
| 00191 | 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. | $146.10 |
| 00203 | Professional attendance at consulting rooms lasting more than 45 minutes but not more than 60 minutes (other than a service to which any other item applies) by a prescribed medical practitioner in an eligible area each attendance | $165.50 |
| 00206 | 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 | $197.10 |
| 00301 | Professional attendance at consulting rooms lasting more than 60 minutes (other than a service to which any other item in this Schedule applies) by a prescribed medical practitioner in an eligible area each attendance | $229.40 |
| 00303 | Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item applies) lasting more than 60 minutes an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area each patient | $264.30 |
| **Non-Specialist Practitioner prolonged attendances to which no other item applies** | | |
| 00214 | Professional attendance by a prescribed medical practitioner for a period of not less than one hour but less than 2 hours (other than a service to which another item applies) on a patient in imminent danger of death | $342.10 |
| 00215 | Professional attendance by a prescribed 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 | $570.30 |
| 00218 | Professional attendance by a prescribed medical practitioner 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 | $798.10 |
| 00219 | Professional attendance by a prescribed 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 | $1026.30 |
| 00220 | Professional attendance by a prescribed 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 | $1140.40 |
| **Non-specialist Practitioner group therapy** | | |
| 00221 | Professional attendance for the purpose of Group therapy lasting at least one hour given under the direct continuous supervision of a prescribed medical practitioner, involving members of a family and persons with close personal relationships with that family each Group of 2 patients | $181.70 |
| 00222 | Professional attendance for the purpose of Group therapy lasting at least one hour given under the direct continuous supervision of a prescribed medical practitioner, involving members of a family and persons with close personal relationships with that family each Group of 3 patients | $191.30 |
| 00223 | Professional attendance for the purpose of Group therapy lasting at least one hour given under the direct continuous supervision of a prescribed medical practitioner, involving members of a family and persons with close personal relationships with that family each Group of 4 or more patients | $232.80 |
| **Non-Specialist Practitioner health assessments** | | |
| 00177 | Professional attendance on a patient who is 30 years of age or over for a heart health assessment by medical practitioner at consulting rooms(other than a specialist or consultant physician) lasting at least 20 minutes and including: (a) collection of relevant information, including taking a patient history; and (b) a basic physical examination, which must include recording blood pressure and cholesterol; and (c) initiating interventions and referrals as indicated; and (d) implementing a management plan; and (e) providing the patient with preventative health care advice and information. | $120.60 |
| 00224 | Professional attendance by a prescribed 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 | $91.80 |
| 00225 | Professional attendance by a prescribed 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 | $213.00 |
| 00226 | Professional attendance by a prescribed 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 | $293.90 |
| 00227 | Professional attendance by a prescribed 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 and referrals as indicated; and(d) providing a comprehensive preventive health care management plan for the patient | $415.30 |
| 00228 | Professional attendance by a prescribed medical practitioner at consulting rooms or in a place other than a hospital or a residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent applicable not more than once in a 9 month period and only if the following items are not applicable within the same 9 month period:(a) item 715;(b) item 92004 or 92011 of the Telehealth and Telephone Determination | $327.80 |
| **Non-Specialist Practitioner management plans, team care arrangements and  multidisciplinary care plans and case conferences** | | |
| 00229 | Attendance by a prescribed 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 235 to 240 and 735 to 758 apply) | $222.80 |
| 00230 | Attendance by a prescribed 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 235 to 240 and 735 to 758 apply) | $176.60 |
| 00231 | Either:(a) contribution to a multidisciplinary care plan, for a patient, prepared by another provider; or(b) contribution to a review of a multidisciplinary care plan, for a patient, prepared by another provider; by a prescribed medical practitioner, other than a service associated with a service to which any of items 235 to 240 and 735 to 758 apply | $108.70 |
| 00232 | Either:(a) contribution to a multidisciplinary care plan, for a patient in a residential aged care facility, prepared by that facility, or contribution to a review of a multidisciplinary care plan, for a patient, prepared by such a facility; or(b) contribution to a multidisciplinary care plan, for a patient, prepared by another provider before the patient is discharged from a hospital or contribution to a review of a multidisciplinary care plan, for a patient, prepared by another provider; by a prescribed medical practitioner, other than a service associated with a service to which any of items 235 to 240 and 735 to 758 apply | $108.70 |
| 00233 | Attendance by a prescribed medical practitioner:(a) to review a GP management plan prepared by a medical practitioner (or an associated medical practitioner); or(b) to coordinate a review of team care arrangements which have been coordinated by the medical practitioner (or the associated medical practitioner) | $111.30 |
| **Non-Specialist Practitioner domiciliary and residential medication management review** | | |
| 00245 | Participation by a prescribed medical practitioner in a Domiciliary Medication Management Review (DMMR) for a patient living in a community setting, in which the prescribed 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 the patient s 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, and only if item 900 does not apply in the same 12 month period, except if there has been a significant change in the patient s condition or medication regimen requiring a new DMMR | $239.20 |
| 00249 | Participation by a prescribed 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 | $163.90 |
| **Non-Specialist Practitioner mental health care** | | |
| 00272 | Professional attendance by a prescribed medical practitioner (who has not undertaken mental health skills training), lasting at least 20 minutes but less than 40 minutes, for the preparation of a GP mental health treatment plan for a patient | $110.70 |
| 00276 | Professional attendance by a prescribed medical practitioner (who has not undertaken mental health skills training), lasting at least 40 minutes, for the preparation of a GP mental health treatment plan for a patient | $163.00 |
| 00277 | Professional attendance by a prescribed medical practitioner to:(a) review a GP mental health treatment plan which a medical practitioner, or an associated medical practitioner, has prepared; or(b) to review a Psychiatrist Assessment and Management Plan | $110.70 |
| 00279 | Professional attendance by a prescribed medical practitioner, in relation to a mental disorder, lasting at least 20 minutes and involving:(a) taking relevant history and identifying the presenting problem (to the extent not previously recorded); and(b) providing treatment and advice; and(c) if appropriate, referral for other services or treatments; and(d) documenting the outcomes of the consultation | $110.70 |
| 00281 | Professional attendance by a prescribed medical practitioner (who has undertaken mental health skills training), lasting at least 20 minutes but less than 40 minutes, for the preparation of a GP mental health treatment plan for a patient | $140.80 |
| 00282 | Professional attendance by a prescribed medical practitioner (who has undertaken mental health skills training), lasting at least 40 minutes, for the preparation of a GP mental health treatment plan for a patient | $207.10 |
| 00283 | Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service:(a) for providing focussed psychological strategies for mental disorders that have been assessed by a medical practitioner; and(b) lasting at least 30 minutes but less than 40 minutes | $143.20 |
| 00285 | 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 | $175.60 |
| 00286 | Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service:(a) for providing focussed psychological strategies for mental disorders that have been assessed by a medical practitioner; and(b) lasting at least 40 minutes | $205.20 |
| 00287 | 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 | $235.00 |
| 00309 | Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service:(a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and(b) lasting at least 30 minutes but less than 40 minutes | $129.30 |
| 00311 | Professional attendance at a place other than consulting rooms by a medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 30 minutes but less than 40 minutes | $165.40 |
| 00313 | Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service:(a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and(b) lasting at least 40 minutes | $184.90 |
| 00315 | Professional attendance at a place other than consulting rooms by a medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 40 minutes | $221.10 |
| **Non-Specialist Practitioner after-hours attendances to which no other item applies** | | |
| 00733 | Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which another item applies) by a prescribed medical practitioner each attendance | $44.80 |
| 00737 | 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 prescribed medical practitioner each attendance | $75.70 |
| 00741 | 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 prescribed medical practitioner each attendance | $129.70 |
| 00745 | Professional attendance at consulting rooms of more than 45 minutes in duration but not more than 60 minutes (other than a service to which another item applies) by a prescribed medical practitioner each attendance | $181.90 |
| 00761 | 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 | $80.80 |
| 00763 | 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 | $110.50 |
| 00766 | 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 | $162.50 |
| 00769 | 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 | $212.80 |
| 00772 | 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 | $111.00 |
| 00776 | 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 | $140.60 |
| 00788 | 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 | $192.60 |
| 00789 | 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 | $242.90 |
| 02197 | Professional attendance at consulting rooms of more than 60 minutes in duration (other than a service to which another item applies) by a prescribed medical practitioner each attendance. | $264.30 |
| **Non-Specialist Practitioner pregnancy support counselling** | | |
| 00792 | Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, lasting at least 20 minutes, 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 4001, 81000, 81005, 81010, 92136, 92137, 92138, 92139, 93026 or 93029, applies in relation to that pregnancy | $118.50 |
| **GROUP A8—CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES** | | |
| 00289 | Professional attendance lasting at least 45 minutes, by a consultant physician in the practice of the consultant physician s specialty of psychiatry, following referral of the patient to the consultant psychiatrist by a referring practitioner, for a patient aged under 25, if the consultant psychiatrist: (a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of a complex neurodevelopmental disorder (such as autism spectrum disorder) is made (if appropriate, using information provided by an eligible allied health provider); and (b) develops a treatment and management plan, which must include: (i) documentation of the confirmed diagnosis; and (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and (iii) a risk assessment; and (iv) treatment options (which may include biopsychosocial recommendations); and (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 135, 137, 139, 92140, 92141, 92142 or 92434) Applicable only once per lifetime | $680.00 |
| 00291 | Professional attendance lasting more than 45 minutes 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, by a medical practitioner in general practice (including a general practitioner, but not a specialist or consultant physician) or a participating nurse practitioner, for an assessment or management; and (b) during the attendance, the consultant: (i) if it is clinically appropriate to do so uses an appropriate outcome tool; and (ii) carries out a mental state examination; and (iii) undertakes a comprehensive diagnostic assessment; and (c) the consultant decides that it is clinically appropriate for the patient to be managed by the referring practitioner without ongoing management by the consultant; and (d) within 2 weeks after the attendance, the consultant prepares and gives to the referring practitioner a written report, which includes: (i) the comprehensive diagnostic assessment of the patient; and (ii) a management plan for the patient for the next 12 months that comprehensively evaluates the patient s biopsychosocial factors and makes recommendations to the referring practitioner to manage the patient s ongoing care in a biopsychosocial model; and (e) if clinically appropriate, the consultant explains the diagnostic assessment and management plan, and gives a copy, to: (i) the patient; and (ii) the patient s carer (if any), if the patient agrees; and (f) in the preceding 12 months, a service to which this item or item 92435 applies has not been provided to the patient | $890.00 |
| 00293 | Professional attendance lasting more than 30 minutes, but not more than 45 minutes, 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 accordance with a management plan prepared by the consultant in accordance with item 291 or item 92435; and (b) the attendance follows referral of the patient to the consultant, by the medical practitioner or participating nurse practitioner managing the patient, for review of the management plan and the associated comprehensive diagnostic assessment; and (c) during the attendance, the consultant: (i) if it is clinically appropriate to do so uses an appropriate outcome tool; and (ii) carries out a mental state examination; and (iii) reviews the comprehensive diagnostic assessment and undertakes additional assessment as required; and (iv) reviews the management plan; and (d) within 2 weeks after the attendance, the consultant prepares and gives to the referring practitioner a written report, which includes: (i) the revised comprehensive diagnostic assessment of the patient; and (ii) a revised management plan including updated recommendations to the referring practitioner to manage the patient s ongoing care in a biopsychosocial model; and (e) if clinically appropriate, the consultant explains the diagnostic assessment and management plan, and gives a copy, to: (i) the patient; and (ii) the patient s carer (if any), if the patient agrees; and (f) in the preceding 12 months, a service to which item 291 or item 92435 applies has been provided to the patient; and (g) in the preceding 12 months, a service to which this item or item 92436 applies has not been provided to the patient | $595.00 |
| 00296 | 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, or any of items 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 has applied in the preceding 24 months | $485.00 |
| 00297 | 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 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, or any of items 296, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 has applied in the preceding 24 months (H) | $485.00 |
| 00299 | 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, or any of items 296, 297, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 has applied in the preceding 24 months | $575.00 |
| 00300 | 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, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient | $108.00 |
| 00302 | 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, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient | $215.00 |
| 00304 | 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, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient | $325.00 |
| 00306 | 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, but not more than 75 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient | $490.00 |
| 00308 | 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, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient | $545.00 |
| 00310 | 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, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient | $108.00 |
| 00312 | 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, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient | $215.00 |
| 00314 | 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, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient | $325.00 |
| 00316 | 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, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient | $490.00 |
| 00318 | 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, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient | $545.00 |
| 00319 | 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 lasting more than 45 minutes at consulting rooms, if: (a) the formulation of the patient s clinical presentation indicates intensive psychotherapy is a clinically appropriate and indicated treatment; and (b) that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 91873 and 92437 applies have not exceeded 160 attendances in a calendar year for the patient | $435.00 |
| 00320 | 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 | $108.00 |
| 00322 | 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 | $215.00 |
| 00324 | 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 | $325.00 |
| 00326 | 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 | $490.00 |
| 00328 | 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 | $550.00 |
| 00330 | 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 | $178.00 |
| 00332 | 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 | $290.00 |
| 00334 | 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 | $395.00 |
| 00336 | 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 | $565.00 |
| 00338 | 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 | $605.00 |
| 00341 | An interview, lasting not more than 15 minutes, of a person other than the patient when the patient is not in 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, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 343, 345, 347, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient | $72.60 |
| 00342 | 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 | $134.00 |
| 00343 | An interview, lasting more than 15 minutes but not more than 30 minutes, of a person other than the patient when the patient is not in 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, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 341, 345, 347, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient | $144.90 |
| 00344 | 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 | $174.00 |
| 00345 | An interview, lasting more than 30 minutes but not more than 45 minutes, of a person other than the patient when the patient is not in 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, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 341, 343, 347, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient | $223.10 |
| 00346 | 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 referred to the consultant physician by a referring practitioner-each patient | $260.00 |
| 00347 | An interview, lasting more than 45 minutes but not more than 75 minutes, of a person other than the patient when the patient is not in 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, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 341, 343, 345, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient | $307.80 |
| 00349 | An interview, lasting more than 75 minutes, of a person other than the patient when the patient is not in 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, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 341, 343, 345, 347, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient | $357.20 |
| **GROUP A13—PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES** | | |
| 00410 | 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. | $47.00 |
| 00411 | 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; 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. | $95.00 |
| 00412 | 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. | $174.00 |
| 00413 | 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. | $265.00 |
| 00414 | 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 | $98.00 |
| 00415 | 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. | $140.00 |
| 00416 | 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 | $210.00 |
| 00417 | 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. | $275.00 |
| **GROUP A21—PROFESSIONAL ATTENDANCES AT RECOGNISED EMERGENCY DEPARTMENTS OF PRIVATE HOSPITALS** | | |
| **Consultations** | | |
| 05001 | Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist s specialty of emergency medicine involving medical decision making of ordinary complexity | $150.00 |
| 05011 | Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist s specialty of emergency medicine involving medical decision-making of ordinary complexity | $250.00 |
| 05012 | Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist s specialty of emergency medicine involving medical decision-making of complexity that is more than ordinary but is not high | $395.00 |
| 05014 | Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist s specialty of emergency medicine involving medical decision-making of complexity that is more than ordinary but is not high | $495.00 |
| 05016 | Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist s specialty of emergency medicine involving medical decision-making of high complexity | $665.00 |
| 05019 | Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist s specialty of emergency medicine involving medical decision-making of high complexity | $765.00 |
| 05021 | Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) involving medical decision-making of ordinary complexity | $150.00 |
| 05027 | Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) involving medical decision-making of ordinary complexity | $250.00 |
| 05030 | Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) involving medical decision-making of complexity that is more than ordinary but is not high | $395.00 |
| 05032 | Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) involving medical decision-making of complexity that is more than ordinary but is not high | $495.00 |
| 05033 | Professional attendance, on a patient 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) involving medical decision-making of high complexity | $665.00 |
| 05036 | Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) involving medical decision-making of high complexity | $765.00 |
| **Prolonged professional attendances** | | |
| 05039 | 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 for preparation of goals of care by the specialist for a gravely ill patient lacking current goals of care if: (a) the specialist takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the first attendance by the specialist for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is in conjunction with, or after, an attendance on the patient by the specialist that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 | $360.00 |
| 05041 | 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 for preparation of goals of care by the specialist for a gravely ill patient lacking current goals of care if: (a) the specialist takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the first attendance by the specialist for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is not in conjunction with, or after, an attendance on the patient by the specialist that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019; and (d) the attendance is for at least 60 minutes | $680.00 |
| 05042 | Professional attendance at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) for preparation of goals of care by the practitioner for a gravely ill patient lacking current goals of care if: (a) the practitioner takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the first attendance by the practitioner for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is in conjunction with, or after, an attendance on the patient by the practitioner that is described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 | $360.00 |
| 05044 | Professional attendance at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) for preparation of goals of care by the practitioner for a gravely ill patient lacking current goals of care if: (a) the practitioner takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the first attendance by the practitioner for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is not in conjunction with, or after, an attendance on the patient by the practitioner that is described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (d) the attendance is for at least 60 minutes | $680.00 |
| **GROUP A11—URGENT ATTENDANCE AFTER HOURS** | | |
| **After hours** | | |
| 00585 | 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 | $250.60 |
| 00588 | 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 | $250.60 |
| 00591 | 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 | $193.20 |
| 00594 | Professional attendance by a medical practitioner each additional patient at an attendance that qualifies for item 585, 588 or 591 in relation to the first patient | $80.90 |
| 00599 | 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 | $560.00 |
| 00600 | 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 | $250.90 |
| **GROUP A14—HEALTH ASSESSMENTS** | | |
| 00699 | Professional attendance on a patient who is 30 years of age or over for a heart health assessment by a general practitioner at consulting rooms lasting at least 20 minutes and including: collection of relevant information, including taking a patient history; and a basic physical examination, which must include recording blood pressure and cholesterol; and initiating interventions and referrals as indicated; and implementing a management plan; and providing the patient with preventative health care advice and information. | $150.60 |
| 00701 | 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 | $94.80 |
| 00703 | 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 | $218.30 |
| 00705 | 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 | $301.10 |
| 00707 | 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 | $425.20 |
| 00715 | 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 | $335.80 |
| **GROUP A15—GP MANAGEMENT PLANS TEAM CARE ARRANGEMENTS MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES** | | |
| 00721 | Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) for the preparation of a gp management plan (gpmp) for a patient (not being a service associated with a service to which items 735 to 758 apply).this cdm service is for a patient who has at least one medical condition that:(a) has been (or is likely to be) present for at least six months; or(b) is terminal.a rebate will not be paid within twelve months of a previous claim for item 721, or within three months of a claim for items 729, 731 or 732 (for a review of a gpmp), except where there are exceptional circumstances that require the preparation of a new gpmp. | $228.70 |
| 00723 | Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to coordinate the development of team care arrangements (tcas) for a patient (not being a service associated with a service to which items 735 to 758 apply).this cdm service is for a patient who:(a) has at least one medical condition that: i. has been (or is likely to be) present for at least six months; or ii. is terminal; and (b) requires ongoing care from at least three collaborating health or care providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner. a rebate will not be paid within twelve months of a previous claim for item 723, or within three months of a claim for item 732 (for a review of tcas), except where there are exceptional circumstances that require the coordination of new tcas. | $180.70 |
| 00732 | Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to: (a) review a GP management plan to which item 721 applies. Where these services were provided by that medical practitioner (or an associated medical practitioner). The CDM service is for a patient who has at least one medical condition that has been (or is likely to be) present for at least six months. If following a review of the GPMP variations or changes are agreed then those amendments must be in writing with a copy given to the patient. (b) Coordinate a review of team care arrangements to which item 723 applies. This CDM service is for a patient who has at least one medical condition that has been (or is likely to be) present for at least six months, and also requires ongoing care from at least three collaborating health or care providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner. If following a review of the TCA variations or changes are agreed then the medical practitioner shall provide a written copy of the variations or changes to the collaborating health or care providers and to the patient. Each service to which item 732 applies may only be claimed once in a three-month period, except where there are exceptional circumstances that necessitate earlier performance of the service to the patient. | $114.30 |
| **GROUP A17—DOMICILIARY MEDICATION MANAGEMENT REVIEW** | | |
| 00900 | Participation by a general practitioner (not including a specialist or consultant physician) 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, and only if item 245 does not apply in the same 12 month period, except if there has been a significant change in the patient s condition or medication regimen requiring a new DMMR | $336.50 |
| 00903 | Participation by a general practitioner (not including a specialist or consultant physician) in a residential medication management review (RMMR) for a patient who is a care recipient in 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 249 has applied, unless there has been a significant change in the resident s medical condition or medication management plan requiring a new RMMR. | $230.30 |
| **GROUP A20—GP MENTAL HEALTH TREATMENT** | | |
| **GP mental health care plans** | | |
| 02700 | 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 | $157.10 |
| 02701 | 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 | $231.10 |
| 02712 | 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 Management Plan | $179.10 |
| 02713 | 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 | $148.50 |
| 02715 | 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 | $199.60 |
| 02717 | 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 | $293.70 |
| **Focussed psychological strategies** | | |
| 02721 | 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 | $177.10 |
| 02723 | 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 | $227.00 |
| 02725 | 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 | $237.80 |
| 02727 | 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 | $285.20 |
| 02739 | Professional attendance at consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 30 minutes, but less than 40 minutes | $161.60 |
| 02741 | Professional attendance at a place other than consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 30 minutes, but less than 40 minutes | $206.80 |
| 02743 | Professional attendance at consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 40 minutes | $231.20 |
| 02745 | Professional attendance at a place other than consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 40 minutes | $276.40 |
| **GROUP A24—PAIN AND PALLIATIVE MEDICINE** | | |
| **Pain medicine attendances** | | |
| 02801 | 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 | $390.00 |
| 02806 | 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 | $180.00 |
| 02814 | 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 | $180.00 |
| 02824 | 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 | $470.00 |
| 02832 | 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 | $250.00 |
| 02840 | 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 | $250.00 |
| **Pain medicine case conferences** | | |
| 02946 | 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 | $330.00 |
| 02949 | 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 | $495.00 |
| 02954 | 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 | $660.00 |
| 02958 | 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 | $205.00 |
| 02972 | 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 | $325.00 |
| 02974 | 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 | $445.00 |
| 02978 | 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) | $330.00 |
| 02984 | 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) | $495.00 |
| 02988 | 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) | $660.00 |
| 02992 | 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) | $205.00 |
| 02996 | 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) | $325.00 |
| 03000 | 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) | $445.00 |
| **Palliative medicine attendances** | | |
| 03005 | 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 | $390.00 |
| 03010 | 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 | $180.00 |
| 03014 | 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 | $250.00 |
| 03018 | 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 | $470.00 |
| 03023 | 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 | $250.00 |
| 03028 | 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 | $250.00 |
| **Palliative medicine case conferences** | | |
| 03032 | 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 | $330.00 |
| 03040 | 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 | $495.00 |
| 03044 | 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 | $660.00 |
| 03051 | 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 | $205.00 |
| 03055 | 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 | $325.00 |
| 03062 | 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 | $445.00 |
| 03069 | 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) | $330.00 |
| 03074 | 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) | $495.00 |
| 03078 | 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) | $660.00 |
| 03083 | 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) | $205.00 |
| 03088 | 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) | $325.00 |
| 03093 | 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) | $445.00 |
| **GROUP A27—PREGNANCY SUPPORT COUNSELLING** | | |
| 04001 | 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 patient 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. | $166.40 |
| **GROUP A22—GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES** | | |
| 05000 | 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 | $71.00 |
| 05003 | 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 | $142.00 |
| 05010 | 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 | $142.00 |
| 05020 | Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 6 minutes and 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 | $142.00 |
| 05023 | 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 | $210.00 |
| 05028 | 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 | $210.00 |
| 05040 | 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 | $260.00 |
| 05043 | 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 | $325.00 |
| 05049 | 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 | $325.00 |
| 05060 | 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 | $400.00 |
| 05063 | 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 | $470.00 |
| 05067 | 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 | $470.00 |
| 05071 | Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 60 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 | $330.40 |
| **GROUP A26—NEUROSURGERY ATTENDANCES TO WHICH NO OTHER ITEM APPLIES** | | |
| 06007 | 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 | $315.00 |
| 06009 | 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 | $112.00 |
| 06011 | 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 | $220.00 |
| 06013 | 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 | $305.00 |
| 06015 | 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 | $390.00 |
| **GROUP A31—ADDICTION MEDICINE** | | |
| **Addiction Medicine Attendances** | | |
| 06018 | 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 | $470.00 |
| 06019 | 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 | $250.00 |
| 06023 | 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 | $680.00 |
| 06024 | 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 | $340.00 |
| **Group Therapy** | | |
| 06028 | 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 | $134.00 |
| **GROUP A32—SEXUAL HEALTH MEDICINE** | | |
| **Sexual Health Medicine Attendances** | | |
| 06051 | 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 | $296.10 |
| 06052 | 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 | $148.00 |
| 06057 | 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 | $517.60 |
| 06058 | 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 | $259.20 |
| **Home Visits** | | |
| 06062 | 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 | $359.20 |
| 06063 | 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 | $217.30 |
| **GROUP A37—CARDIOTHORACIC SURGEON ATTENDENCE FOR LEAD EXTRACTION** | | |
| 90300 | Professional attendance by a cardiothoracic surgeon in the practice of the surgeon s speciality, if: (a) the service is: (i) performed in conjunction with a service (the lead extraction service) to which item 38358 applies; or (ii) performed in conjunction with a service (the leadless pacemaker extraction service) to which item 38373 or 38374 applies; and (b) the surgeon: (i) is providing surgical backup for the provider (who is not a cardiothoracic surgeon) who is performing the lead extraction service or the leadless pacemaker extraction service; and (ii) is present for the duration of the lead extraction service or the leadless pacemaker extraction service, other than during the low risk pre and post extraction phases; and (iii) is able to immediately scrub in and perform a thoracotomy if major complications occur (H) | $1647.90 |
| **GROUP A40—TELEHEALTH AND PHONE ATTENDANCE SERVICES** | | |
| **General practice telehealth services** | | |
| 91790 | Telehealth 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 management. NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $51.00 |
| 91792 | Telehealth attendance by a medical practitioner of not more than 5 minutes. NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $51.00 |
| 91794 | Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of not more than 5 minutes NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $26.50 |
| 91800 | Telehealth attendance by a general practitioner lasting at least 6 minutes but less than 20 minutes if the attendance includes any of the following that are clinically relevant:(a) taking a short patient history;(b) arranging any necessary investigation;(c) implementing a management plan;(d) providing appropriate preventative health care | $102.00 |
| 91801 | Telehealth attendance by a general practitioner lasting at least 20 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a detailed patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care. NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $188.00 |
| 91802 | Telehealth attendance by a general practitioner lasting at least 40 minutes if the attendance includes any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care. NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $285.00 |
| 91803 | Telehealth attendance by a medical practitioner of more than 5 minutes in duration but not more than 25 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care. NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $102.00 |
| 91804 | Telehealth attendance by a medical practitioner of more than 25 minutes in duration but not more than 45 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a detailed patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care; NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $188.00 |
| 91805 | Telehealth attendance by a medical practitioner (not including a general practitioner) of more than 45 minutes in duration but not more than 60 minutes if the attendance includes any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $285.00 |
| 91806 | Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of more than 5 minutes in duration but not more than 25 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $58.10 |
| 91807 | Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of more than 25 minutes in duration but not more than 45 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a detailed patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $112.60 |
| 91808 | Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of more than 45 minutes in duration but not more than 60 minutes if the attendance includes any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $165.50 |
| 91920 | Telehealth attendance by a general practitioner, lasting at least 60 minutes and including any of the following that are clinically relevant:(a) taking an extensive patient history;(b) arranging any necessary investigation;(c) implementing a management plan;(d) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $286.80 |
| 91923 | Telehealth attendance by a medical practitioner (not including a general practitioner), of more than 60 minutes in duration and including any of the following that are clinically relevant:(a) taking an extensive patient history;(b) arranging any necessary investigation;(c) implementing a management plan;(d) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $147.60 |
| 91926 | Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of more than 60 minutes in duration and including any of the following that are clinically relevant:(a) taking an extensive patient history;(b) arranging any necessary investigation;(c) implementing a management plan;(d) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $229.40 |
| **General practice phone services** | | |
| 91890 | Phone attendance by a general practitioner lasting less than 6 minutes for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited management | $35.30 |
| 91891 | Phone attendance by a general practitioner lasting at least 6 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care | $77.10 |
| 91892 | Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician) lasting less than 6 minutes for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited management | $22.20 |
| 91893 | Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician) lasting at least 6 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventative health care | $42.40 |
| **Focussed Psychological Strategies telehealth services** | | |
| 91818 | Telehealth attendance by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 30 minutes, but less than 40 minutes. | $175.20 |
| 91819 | Telehealth attendance by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 40 minutes. | $250.60 |
| 91820 | Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 30 minutes, but less than 40 minutes | $140.10 |
| 91821 | Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 40 minutes | $200.50 |
| 91859 | Telehealth attendance by a general practitioner (not including a specialist or a consultant physician), registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 30 minutes but less than 40 minutes | $161.60 |
| 91861 | Telehealth attendance by a general practitioner (not including a specialist or a consultant physician), registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 40 minutes | $231.20 |
| 91862 | Telehealth attendance by a medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 30 minutes but less than 40 minutes | $129.30 |
| 91863 | Telehealth attendance by a medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 40 minutes | $184.90 |
| **Specialist attendances telehealth services** | | |
| 91822 | Telehealth attendance for a person by a specialist in the practice of the specialist s specialty if: (a) the attendance follows referral of the patient to the specialist; and (b) the attendance was of more than 5 minutes in duration. Where the attendance was other than a second or subsequent attendance as part of a single course of treatment. | $205.00 |
| 91823 | Telehealth attendance for a person by a specialist in the practice of the specialist s specialty if: (a) the attendance follows referral of the patient to the specialist; and (b) the attendance was of more than 5 minutes in duration. Where the attendance is after the first attendance as part of a single course of treatment. | $110.00 |
| **Consultant physician telehealth services** | | |
| 91824 | Telehealth attendance for a person by a consultant physician in the practice of the consultant physician s specialty (other than psychiatry) if: (a) the attendance follows referral of the patient to the specialist; and (b) the attendance was of more than 5 minutes in duration. Where the attendance was other than a second or subsequent attendance as part of a single course of treatment. | $390.00 |
| 91825 | Telehealth attendance for a person by a consultant physician in the practice of the consultant physician s specialty (other than psychiatry) if: (a) the attendance follows referral of the patient to the specialist; and (b) the attendance was of more than 5 minutes in duration. Where the attendance is not a minor attendance after the first as part of a single course of treatment. | $180.00 |
| 91826 | Telehealth attendance for a person by a consultant physician in the practice of the consultant physician s specialty (other than psychiatry) if: (a) the attendance follows referral of the patient to the specialist; and (b) the attendance was of more than 5 minutes in duration. Where the attendance is a minor attendance after the first as part of a single course of treatment. | $180.00 |
| 92422 | Telehealth 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, 119 of the general medical services table or item 91824, 91825, 91826 or 91836 applies did not take place on the same day by the same consultant physician; and (d) this item, or item 132 of the general medical services table, has not applied to an attendance on the patient in the preceding 12 months by the same consultant physician | $680.00 |
| 92423 | Telehealth 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, 119 of the general medical services table or 91824, 91825, 91826 or 91836 applies did not take place on the same day by the same consultant physician; and (d) item 132 of the general medical services table or item 92422 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 of the general medical services table or 92422; and (f) this item, or item 133 of the general medical services table has not applied more than twice in any 12 month period | $340.00 |
| **Consultant psychiatrist telehealth services** | | |
| 91827 | Telehealth attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was not more than 15 minutes in duration; if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306, 308, 91828 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year | $108.00 |
| 91828 | Telehealth attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was at least 15 minutes, but not more than 30 minutes in duration; if that attendance and another attendance to which item 296, 297, 299, or any of items 300, 302, 304, 306 to 308, 91827, 91829 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year | $215.00 |
| 91829 | Telehealth attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was at least 30 minutes, but not more than 45 minutes in duration; if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827, 91828, 91830, 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year | $325.00 |
| 91830 | Telehealth attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was at least 45 minutes, but not more than 75 minutes in duration; if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91829, 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year | $490.00 |
| 91831 | Telehealth attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was at least 75 minutes in duration; if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91830, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year. | $545.00 |
| 91868 | Telehealth 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 and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91869, 91870, 91871, 91872, 91873 or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient | $36.20 |
| 91869 | Telehealth 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 and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91870, 91871, 91872, 91873 or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient | $72.60 |
| 91870 | Telehealth 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 and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91869, 91871, 91872, 91873 or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient | $111.80 |
| 91871 | Telehealth 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 and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91869, 91870, 91872, 91873 or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient | $154.10 |
| 91872 | Telehealth 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 and another attendance to which item 296, 297, 299, 92437 or any of items 300, 302, 304, 306, 308, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91869, 91870, 91871, 91873, or 91879 to 91881 applies exceed 50 attendances in a calendar year for the patient | $178.70 |
| 91873 | Telehealth attendance lasting at least 45 minutes by a consultant physician in the practice of the consultant physician s specialty of psychiatry, following referral of the patient to the psychiatrist by a referring practitioner, where the formulation of the patient s clinical presentation indicates intensive psychotherapy is a clinically appropriate and indicated treatment, if that attendance and another attendance to which any of items 296, 297, 299 or any of items 300, 302, 304, 306, 308, 319, 92437, 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 91868, 91869, 91870, 91871, 91872 or 91879 to 91881 applies has not exceeded 160 attendances in a calendar year for the patient | $307.80 |
| 91874 | Telehealth attendance involving an interview, lasting not more than 15 minutes, of a person other than the patient when the patient is not in 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 for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91875, 91876, 91877, 91878, 91882, 91883 or 91884 applies have not exceeded 15 in a calendar year for the patient | $72.60 |
| 91875 | Telehealth attendance involving an interview, lasting more than 15 minutes but not more than 30 minutes, of a person other than the patient when the patient is not in 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 for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874, 91876, 91877, 91878, 91882, 91883 or 91884 applies have not exceeded 15 in a calendar year for the patient | $144.90 |
| 91876 | Telehealth attendance involving an interview, lasting more than 30 minutes but not more than 45 minutes, of a person other than the patient when the patient is not in 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 for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874, 91875, 91877, 91878, 91882, 91883 or 91884 applies have not exceeded 15 in a calendar year for the patient | $223.10 |
| 91877 | Telehealth attendance involving an interview, lasting more than 45 minutes but not more than 75 minutes, of a person other than the patient when the patient is not in 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 for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874, 91875, 91876 91878, 91882, 91883 or 91884 applies have not exceeded 15 in a calendar year for the patient | $307.80 |
| 91878 | Telehealth attendance involving an interview, lasting more than 75 minutes, of a person other than the patient, when the patient is not in 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 for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874, 91875, 91876, 91877, 91882, 91883 or 91884 applies have not exceeded 15 in a calendar year for the patient | $357.20 |
| 92434 | Telehealth attendance lasting at least 45 minutes by a consultant physician in the practice of the consultant physician s specialty of psychiatry, following referral of the patient to the consultant psychiatrist by a referring practitioner, for a patient aged under 25, if the consultant psychiatrist: (a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of a complex neurodevelopmental disorder (such as autism spectrum disorder) is made (if appropriate, using information provided by an eligible allied health provider); and (b) develops a treatment and management plan, which must include: (i) documentation of the confirmed diagnosis; and (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and (iii) a risk assessment; and (iv) treatment options (which may include biopsychosocial recommendations); and (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 135, 137, 139, 289, 92140, 92141 or 92142) Applicable only once per lifetime | $680.00 |
| 92435 | Telehealth attendance lasting more than 45 minutes 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, by a medical practitioner in general practice (including a general practitioner, but not a specialist or consultant physician) or a participating nurse practitioner for an assessment or management; and (b) during the attendance, the consultant: (i) if it is clinically appropriate to do so uses an appropriate outcome tool; and (ii) carries out a mental state examination; and (iii) undertakes a comprehensive diagnostic assessment; and (c) the consultant decides that it is clinically appropriate for the patient to be managed by the referring practitioner without ongoing management by the consultant and (d) within 2 weeks after the attendance, the consultant prepares and gives the referring practitioner a written report, which includes: (i) a comprehensive diagnostic assessment of the patient; and (ii) a management plan for the patient for the next 12 months for the patient that comprehensively evaluates the patient s biopsychosocial factors and makes recommendations to the referring practitioner to manage the patient s ongoing care in a biopsychosocial model; and (e) if clinically appropriate, the consultant explains the diagnostic assessment and management plan, and a gives a copy, to: (i) the patient; and (ii) the patient s carer (if any), if the patient agrees; and (f) in the preceding 12 months, a service to which this item or item 291 of the general medical services table applies has not been provided | $890.00 |
| 92436 | Telehealth attendance lasting more than 30 minutes, but not more than 45 minutes, 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 accordance with a management plan prepared by the consultant in accordance with item 291 or 92435; and (b) the attendance follows referral of the patient to the consultant, by the medical practitioner or participating nurse practitioner managing the patient, for review of the management plan and the associated comprehensive diagnostic assessment; and (c) during the attendance, the consultant: (i) if it is clinically appropriate to do so uses an appropriate outcome tool; and (ii) carries out a mental state examination; and (iii) reviews the comprehensive diagnostic assessment and undertakes additional assessment as required; and (iv) reviews the management plan; and (d) within 2 weeks after the attendance, the consultant prepares and gives to the referring practitioner a written report, which includes: (i) a revised comprehensive diagnostic assessment of the patient; and (ii) a revised management plan including updated recommendations to the referring practitioner to manage the patient s ongoing care in a biopsychosocial model; and (e) if clinically appropriate, the consultant explains the diagnostic assessment and the management plan, and gives a copy, to: (i) the patient; and (ii) the patient s carer (if any), if the patient agrees; and (f) in the preceding 12 months, a service to which item 291 of the general medical services table or item 92435 applies has been provided; and (g) in the preceding 12 months, a service to which this item or item 293 of the general medical services table applies has not been provided | $595.00 |
| 92437 | Telehealth 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 the consultant physician by a referring practitioner: (a) if the patient: (i) is a new patient for this consultant physician; or (ii) has not received an attendance from this consultant physician in the preceding 24 months; and (b) the patient has not received an attendance under this item, or item 91827 to 91831, 91837 to 91839, 92455 to 92457, 91868 to 91873, 91879 to 91881 or item 296, 297, 299, 300, 302, 304, 306 to 308, 310, 312, 314, 316, 318, 319, 320, 322, 324, 326, 328, 330, 332, 334, 336, 338, 342, 344 or 346 of the general medical services table, in the preceding 24 months | $485.00 |
| 92455 | Telehealth attendance for 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): (a) of not less than 1 hour in duration; and (b) given under the continuous direct supervision of a consultant physician in the practice of the consultant physician s specialty of psychiatry; and (c) 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 | $134.00 |
| 92456 | Telehealth attendance for 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): (a) of not less than 1 hour in duration; and (b) given under the continuous direct supervision of a consultant physician in the practice of the consultant physician s specialty of psychiatry; and (c) involving a family group of 3 patients, each of whom is referred to the consultant physician by a referring practitioner; each patient | $174.00 |
| 92457 | Telehealth attendance for 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): (a) of not less than 1 hour in duration; and (b) given under the continuous direct supervision of a consultant physician in the practice of the consultant physician s specialty of psychiatry; and (c) involving a family group of 2 patients, each of whom is referred to the consultant physician by a referring practitioner; each patient | $260.00 |
| **Specialist attendances phone services** | | |
| 91833 | Phone attendance for a person by a specialist in the practice of the specialist s specialty if: (a) the attendance follows referral of the patient to the specialist; and (b) the attendance was of more than 5 minutes in duration. Where the attendance is after the first attendance as part of a single course of treatment. | $110.00 |
| **Consultant physician phone services** | | |
| 91836 | Phone attendance for a person by a consultant physician in the practice of the consultant physician s specialty (other than psychiatry) if: (a) the attendance follows referral of the patient to the specialist; and (b) the attendance was of more than 5 minutes in duration. Where the attendance is a minor attendance after the first as part of a single course of treatment. | $180.00 |
| **Consultant psychiatrist phone services** | | |
| 91837 | Phone attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was not more than 15 minutes duration; Where the attendance is after the first attendance as part of a single course of treatment, if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91831, 91838, 91839 and 92437 applies have not exceeded 50 attendances in a calendar year | $108.00 |
| 91838 | Phone attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner and (b) the attendance was at least 15 minutes, but not more than 30 minutes in duration; Where the attendance is after the first attendance as part of a single course of treatment, if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91831, 91837, 91839 and 92437 applies have not exceeded 50 attendances in a calendar year | $215.00 |
| 91839 | Phone attendance for a person by a consultant psychiatrist; if: (a) the attendance follows a referral of the patient to the consultant psychiatrist by a referring practitioner; and (b) the attendance was at least 30 minutes, but not more than 45 minutes in duration Where the attendance is after the first attendance as part of a single course of treatment, if that attendance and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306 to 308, 91827 to 91831, 91837, 91838 and 92437 applies have not exceeded 50 attendances in a calendar year | $325.00 |
| 91879 | Phone 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 and another attendance to which 296, 297, 299 or any of items 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 91868 to 91873, 91880, 91881 or 92437 applies exceed 50 attendances in a calendar year for the patient | $36.20 |
| 91880 | Phone 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 and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 91868 to 91873, 91879, 91881 or 92437 applies exceed 50 attendances in a calendar year for the patient | $72.60 |
| 91881 | Phone 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 and another attendance to which item 296, 297, 299 or any of items 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 91868 to 91873, 91879, 91880 or 92437 applies exceed 50 attendances in a calendar year for the patient | $111.80 |
| 91882 | Phone attendance involving an interview, lasting not more than 15 minutes, of a person other than the patient when the patient is not in 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 for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874 to 91878, 91883 or 91884 applies have not exceeded 15 in a calendar year for the patient | $72.60 |
| 91883 | Phone attendance involving an interview, lasting more than 15 minutes but not more than 30 minutes, of a person other than the patient when the patient is not in 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 for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874 to 91878, 91882 or 91884 applies have not exceeded 15 in a calendar year for the patient | $144.90 |
| 91884 | Phone attendance involving an interview, lasting more than 30 minutes but not more than 45 minutes, of a person other than the patient when the patient is not in 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 for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that attendance and another attendance to which any of items 341, 343, 345, 347, 349, 91874 to 91878, 91882 or 91883 applies have not exceeded 15 in a calendar year for the patient | $223.10 |
| **Focussed Psychological Strategies phone services** | | |
| 91842 | Phone attendance by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 30 minutes, but less than 40 minutes. | $175.20 |
| 91843 | Phone attendance by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 40 minutes. | $250.60 |
| 91844 | Phone attendance by a medical practitioner (not including a General Practitioner, Specialist or Consultant Physician), for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 30 minutes, but less than 40 minutes | $140.10 |
| 91845 | Phone attendance by a medical practitioner (not including a General Practitioner, Specialist or Consultant Physician), for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 40 minutes | $200.50 |
| 91864 | Phone attendance by a general practitioner (not including a specialist or a consultant physician), registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 30 minutes but less than 40 minutes | $161.60 |
| 91865 | Phone attendance by a general practitioner (not including a specialist or a consultant physician), registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 40 minutes | $231.20 |
| 91866 | Phone attendance by a medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 30 minutes but less than 40 minutes | $129.30 |
| 91867 | Phone attendance by a medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient s treatment; and (b) lasting at least 40 minutes | $184.90 |
| **COVID-19 Health Assessment for Aboriginal and Torres Strait Islander People—Telehealth Service** | | |
| 92004 | Telehealth attendance by a general practitioner for a health assessment of a patient—this item or items 93470 or 93479 not more than once in a 9 month period. NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $335.80 |
| 92011 | Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), for a health assessment—this item or items 93470 or 93479 not more than once in a 9 month period. NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $327.80 |
| **COVID-19 Chronic Disease Management (CDM) Service—Telehealth Service** | | |
| 92024 | Telehealth 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 235 to 240 or 735 to 758 of the general medical services table apply) NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $228.70 |
| 92025 | Telehealth 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 235 to 240 or 735 to 758 of the general medical services table apply) NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $180.70 |
| 92028 | Telehealth 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 items 229 or 721 of the general medical services table, or item 92024, 92055, 92068 or 92099 applies;(b) team care arrangements which have been coordinated by the general practitioner (or an associated general practitioner) to which items 230 or 723 of the general medical services table, or item 92025 or 92069 applies NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $114.30 |
| 92055 | Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 235 to 240 or 735 to 758 of the general medical services table apply) NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $222.80 |
| 92056 | Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 235 to 240 or 735 to 758 of the general medical services table apply) NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $176.60 |
| 92057 | Contribution by a medical practitioner (not including a general practitioner, specialist or consultant physician) by telehealth 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 235 to 240 or 735 to 758 of the general medical services table apply) NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $108.70 |
| 92058 | Contribution by a medical practitioner (not including a general practitioner, specialist or consultant physician) by telehealth 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 235 to 240 or 735 to 758 of the general medical services table apply) NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $108.70 |
| 92059 | Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician) 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 of the general medical services table or item 92024, 92055, 92068 or 92099 applies; or(b) team care arrangements which have been coordinated by the medical practitioner (or an associated medical practitioner) to which items 230 or 723 of the general medical services table or item 92025, 92056, 92069 or 92100 applies NOTE: It is a legislative requirement that this service must be performed by the patient s usual medical practitioner (please see Note AN.1.1 for the definition of patient’s usual medical practitioner as some exemptions do apply). | $111.30 |
| **COVID-19 GP Mental Health Treatment Plan—Telehealth Service** | | |
| 92112 | Telehealth attendance, by a general practitioner who has not undertaken mental health skills training (and not including a specialist or consultant physician), 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. | $157.10 |
| 92113 | Telehealth attendance, by a general practitioner who has not undertaken mental health skills training (and not including a specialist or consultant physician), of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient. | $231.10 |
| 92114 | Telehealth attendance by a general practitioner to review a GP mental health treatment plan which the general practitioner, or an associated general practitioner has prepared, or to review a Psychiatrist Assessment and Management Plan. | $179.10 |
| 92115 | Telehealth 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. | $158.30 |
| 92116 | Telehealth attendance, by 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. | $199.60 |
| 92117 | Telehealth attendance, by 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. | $293.70 |
| 92118 | Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), 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 | $110.70 |
| 92119 | Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), 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 | $163.00 |
| 92120 | Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), 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 | $110.70 |
| 92121 | Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), 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 | $110.70 |
| 92122 | Telehealth attendance by a medical practitioner, (not including a general practitioner, specialist or consultant physician),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 | $140.80 |
| 92123 | Telehealth attendance by a medical practitioner, (not including a general practitioner, specialist or consultant physician),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 | $207.10 |
| **COVID-19 GP Mental Health Treatment Plan—Phone Service** | | |
| 92126 | Phone attendance by a general practitioner to review a GP mental health treatment plan which the general practitioner, or an associated general practitioner has prepared, or to review a Psychiatrist Assessment and Management Plan. | $179.10 |
| 92127 | Phone 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. | $158.30 |
| 92132 | Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), 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 | $110.70 |
| 92133 | Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician) 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 | $110.70 |
| **COVID-19 GP and Other Medical Practitioner—Urgent Hours Service in Unsociable Hours—Telehealth Service** | | |
| 92210 | Telehealth 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. | $560.00 |
| 92211 | Telehealth 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. | $267.30 |
| **COVID-19 Public health physician—Telehealth Services** | | |
| 92513 | Telehealth attendance by a public health physician in the practice of the public health physician s specialty of public health medicine attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited management. | $47.00 |
| 92514 | Telehealth attendance by a public health physician in the practice of the public health physician s specialty of public health medicine, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation | $95.00 |
| 92515 | Telehealth attendance by a public health physician in the practice of the public health physician s specialty of public health medicine, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation. | $174.00 |
| 92516 | Telehealth attendance by a public health physician in the practice of the public health physician s specialty of public health medicine, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation. | $265.00 |
| **COVID-19 Public health physician—Phone Services** | | |
| 92521 | Phone attendance by a public health physician in the practice of the public health physician s specialty of public health medicine attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited management; Where the attendance is not the first attendance for that particular clinical indication | $47.00 |
| 92522 | Phone attendance by a public health physician in the practice of the public health physician s specialty of public health medicine, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care; for one or more health related issues, where the attendance is not the first attendance for those particular health related issues, with appropriate documentation | $95.00 |
| **COVID-19 Neurosurgery attendances—Telehealth Services** | | |
| 92610 | Telehealth attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist (other than a second or subsequent attendance in a single course of treatment). | $315.00 |
| 92611 | Telehealth 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. | $112.00 |
| 92612 | Telehealth 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 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. | $220.00 |
| 92613 | Telehealth 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 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. | $305.00 |
| 92614 | Telehealth 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 arranging any necessary investigations in relation to one or more complex problems and of more than 45 minutes in duration. | $390.00 |
| **COVID-19 Neurosurgery attendances—Phone Services** | | |
| 92618 | Phone 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. | $112.00 |
| **COVID-19 Specialist, anaesthesia—Telehealth Services** | | |
| 92701 | Telehealth 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 the formulation of a written patient management plan documented in the patient notes, and lasting more than 15 minutes (other than a service associated with a service to which any of items 2801 to 3000 of the general medical services table apply) | $180.00 |
| **A46—COVID-19 MANAGEMENT SUPPORT SERVICE** | | |
| 93716 | Phone attendance by a general practitioner lasting at least 20 minutes for the assessment and management of a person with COVID 19 infection of recent onset, for the purposes of determining the patient s eligibility for receiving a COVID-19 oral antiviral treatment, where the service includes any of the following that are clinically relevant: (a) taking a detailed patient history;(b) arranging any necessary investigation;(c) implementing a management plan, including follow up arrangements;(d) providing any necessary treatment, including prescribing a COVID-19 oral antiviral treatment;(e) providing appropriate preventive health care for one or more related issues; with appropriate documentation | $160.10 |
| 93717 | Phone attendance by a medical practitioner (other than a general practitioner) lasting at least 25 minutes for the assessment and management of a person with COVID 19 infection of recent onset, for the purposes of determining the patient s eligibility for receiving a COVID-19 oral antiviral treatment, where the service includes any of the following that are clinically relevant: (a) taking a detailed patient history;(b) arranging any necessary investigation;(c) implementing a management plan, including follow up arrangements;(d) providing any necessary treatment, including prescribing a COVID-19 oral antiviral treatment;(e)providing appropriate preventive health care for one or more related issues; with appropriate documentation | $79.10 |
| **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 | $269.50 |
| 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 | $269.50 |
| 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 | $269.50 |
| 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 | $262.70 |
| 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) | $269.50 |
| 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 | $269.50 |
| 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 | $269.50 |
| 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 | $269.50 |
| 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 | $269.50 |
| 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 | $269.50 |
| **GROUP D1—MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS** | | |
| **Neurology** | | |
| 11000 | ELECTROENCEPHALOGRAPHY, not being a service: (a)associated with a service to which item 11003 or 11009 applies; or (b)involving quantitative topographic mapping using neurometrics or similar devices (Anaes.) | $253.40 |
| 11003 | Electroencephalography, prolonged recording lasting at least 3 hours, that requires multi channel recording using: (a) for a service not associated with a service to which an item in Group T8 applies standard 10 20 electrode placement; or (b) for a service associated with a service to which an item in Group T8 applies either standard 10 20 electrode placement or a different electrode placement and number of recorded channels; other than a service: (c) associated with a service to which item 11000, 11004 or 11005 applies; or (d) involving quantitative topographic mapping using neurometrics or similar devices. | $679.80 |
| 11004 | Electroencephalography, ambulatory or video, prolonged recording lasting at least 3 hours and up to 24 hours, that requires multi channel recording using standard 10-20 electrode placement, first day, other than a service:(a) associated with a service to which item 11000, 11003 or 11005 applies; or(b) involving quantitative topographic mapping using neurometrics or similar devices. | $706.50 |
| 11005 | Electroencephalography, ambulatory or video, prolonged recording lasting at least 3 hours and up to 24 hours, that requires multi channel recording using standard 10-20 electrode placement, each day after the first day, other than a service:(a) associated with a service to which item 11000, 11003 or 11004 applies; or(b) involving quantitative topographic mapping using neurometrics or similar devices. | $661.00 |
| 11009 | Electrocorticography | $470.20 |
| 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) | $227.30 |
| 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) | $311.30 |
| 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) | $484.90 |
| 11021 | NEUROMUSCULAR ELECTRODIAGNOSIS repetitive stimulation for study of neuromuscular conduction OR electromyography with quantitative computerised analysis OR both of these examinations | $307.90 |
| 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 | $235.90 |
| 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 | $348.40 |
| **Ophthalmology** | | |
| 11200 | Provocative test or tests for open angle glaucoma, including water drinking | $83.60 |
| 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. | $218.30 |
| 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. | $218.30 |
| 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 | $218.30 |
| 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 | $218.30 |
| 11215 | Retinal angiography, multiple exposures of 1 eye with intravenous dye injection | $253.00 |
| 11218 | Retinal angiography, multiple exposures of both eyes with intravenous dye injection | $312.90 |
| 11219 | Optical coherence tomography for diagnosis of an ocular condition for the treatment of which there is a medication that is: (a) listed on the pharmaceutical benefits scheme; and (b) indicated for intraocular administration Applicable only once in any 12 month period | $78.50 |
| 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. | $78.50 |
| 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 | $155.70 |
| 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 | $86.80 |
| 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 | $253.10 |
| 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 | $168.40 |
| 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. | $168.40 |
| 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 | $212.90 |
| 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 | $165.60 |
| 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 | $161.60 |
| 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. | $166.40 |
| **Otolaryngology** | | |
| 11300 | Brain stem evoked response audiometry if: (a) the service is not for the purposes of programming either an auditory implant or the sound processor of an auditory implant; and(b) a service to which item 82300 applies has not been performed on the patient on the same day other than a service associated with a service to which item 11340, 11341 or 11343 applies (Anaes.) | $409.70 |
| 11302 | Programming an auditory implant or the sound processor of an auditory implant, unilateral, performed by or on behalf of a medical practitioner, if a service to which item 82301, 82302 or 82304 applies has not been performed on the patient on the same day Applicable up to a total of 4 services to which this item, item 11342 or item 11345 applies on the same day | $335.30 |
| 11303 | Electrocochleography, extratympanic method, 1 or both ears | $409.70 |
| 11304 | ELECTROCOCHLEOGRAPHY, transtympanic membrane insertion technique, 1 or both ears | $667.50 |
| 11306 | Non determinate audiometry, if a service to which item 82306 applies has not been performed on the patient on the same day. | $46.00 |
| 11309 | Audiogram, air conduction, if a service to which item 82309 applies has not been performed on the patient on the same day. | $53.80 |
| 11312 | Audiogram, air and bone conduction or air conduction and speech discrimination, if a service to which item 82312 applies has not been performed on the patient on the same day. | $77.90 |
| 11315 | Audiogram, air and bone conduction and speech, if a service to which item 82315 applies has not been performed on the patient on the same day | $101.80 |
| 11318 | Audiogram, air and bone conduction and speech, with other cochlear tests, if a service to which item 82318 applies has not been performed on the patient on the same day | $124.50 |
| 11324 | Impedance audiogram involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a medical practitioner, if a service to which item 82324 applies has not been performed on the patient on the same day | $65.00 |
| 11332 | Oto-acoustic emission audiometry for the detection of outer hair cell functioning in the cochlea, performed by or on behalf of a specialist or consultant physician, when middle ear pathology has been excluded, if:(a) the service is performed:(i) on an infant or child who is at risk of permanent hearing impairment; or(ii) on an individual who is at risk of oto-toxicity due to medications or medical intervention; or(iii) on an individual at risk of noise induced hearing loss; or(iv) to assist in the diagnosis of auditory neuropathy; and(b) a service to which item 82332 applies has not been performed on the patient on the same day | $118.30 |
| 11340 | Investigation of the vestibular function to assist in the diagnosis, treatment or management of a vestibular or related disorder, performed by or on behalf of a medical practitioner: (a) to assess one or more of the following: (i) the organs of the peripheral vestibular system (utricle, saccule, lateral, superior and posterior semicircular canals, and vestibular nerve); (ii) muscular or eye movement responses elicited by vestibular stimulation; (iii) static signs of vestibular dysfunction; (iv) the central ocular motor function; and (b) using up to 2 clinically recognised tests; other than a service associated with a service to which item 11015, 11021, 11024, 11027, 11205 or 11300 applies | $324.20 |
| 11341 | Investigation of the vestibular function to assist in the diagnosis, treatment or management of a vestibular or related disorder, performed by or on behalf of a medical practitioner: (a) to assess one or more of the following: (i) the organs of the peripheral vestibular system (utricle, saccule, lateral, superior and posterior semicircular canals, and vestibular nerve); (ii) muscular or eye movement responses elicited by vestibular stimulation; (iii) static signs of vestibular dysfunction; (iv) the central ocular motor function; and (b) using 3 or 4 clinically recognised tests; other than a service associated with a service to which item 11015, 11021, 11024, 11027, 11205 or 11300 applies | $650.00 |
| 11342 | Programming by telehealth of an auditory implant, or the sound processor of an auditory implant, unilateral, performed by or on behalf of a medical practitioner, if a service to which items 82301, 82302 or 82304 applies has not been performed on the patient on the same day Applicable up to a total of 4 services to which this item, item 11302 or item 11345 applies on the same day | $283.20 |
| 11343 | Investigation of the vestibular function to assist in the diagnosis, treatment or management of a vestibular or related disorder, performed by or on behalf of a medical practitioner: (a) to assess one or more of the following: (i) the organs of the peripheral vestibular system (utricle, saccule, lateral, superior and posterior semicircular canals, and vestibular nerve); (ii) muscular or eye movement responses elicited by vestibular stimulation; (iii) static signs of vestibular dysfunction; (iv) the central ocular motor function; and (b) using 5 or more clinically recognised tests; other than a service associated with a service to which item 11015, 11021, 11024, 11027, 11205 or 11300 applies | $972.40 |
| 11345 | Programming by phone of an auditory implant, or the sound processor of an auditory implant, unilateral, performed by or on behalf of a medical practitioner, if a service to which items 82301, 82302 or 82304 applies has not been performed on the patient on the same day Applicable up to a total of 4 services to which this item, item 11302 or item 11342 applies on the same day | $283.20 |
| **Respiratory** | | |
| 11503 | 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 specialist or consultant 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 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 | $282.50 |
| 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 | $77.60 |
| 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 | $43.50 |
| 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 | $189.20 |
| 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 specialist or consultant physician who is also responsible for the supervision of technical staff and quality assurance | $549.00 |
| 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 specialist or consultant physician 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 | $127.50 |
| **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) | $136.00 |
| 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 | $120.00 |
| 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 | $120.00 |
| 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 | $120.00 |
| 11607 | Continuous ambulatory blood pressure recording for 24 hours or more for a patient if: (a) the patient has a clinic blood pressure measurement (using a sphygmomanometer or a validated oscillometric blood pressure monitoring device) of either or both of the following measurements: (i) systolic blood pressure greater than or equal to 140 mmHg and less than or equal to 180 mmHg; (ii) diastolic blood pressure greater than or equal to 90 mmHg and less than or equal to 110 mmHg; and (b) the patient has not commenced anti hypertensive therapy; and (c) the recording includes the patient s resting blood pressure; and (d) the recording is conducted using microprocessor based analysis equipment; and (e) the recording is interpreted by a medical practitioner and a report is prepared by the same medical practitioner; and (f) a treatment plan is provided for the patient; and (g) the service: (i) is not provided in association with ambulatory electrocardiogram recording, and (ii) is not associated with a service to which any of the following items apply: (A) 177; (B) 224 to 228; (C) 229 to 244; (D) 699; (E) 701 to 707; (F) 715; (G) 721 to 732; (H) 735 to 758. Applicable only once in any 12 month period | $197.40 |
| 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. | $120.00 |
| 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. | $120.00 |
| 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. | $188.50 |
| 11614 | Transcranial doppler, examination of the intracranial arterial circulation using CW Doppler or pulsed Doppler with hard copy recording of waveforms, examination and report, other than a service associated with a service to which item 55280 of the diagnostic imaging services table applies | $120.00 |
| 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. | $164.40 |
| 11627 | PULMONARY ARTERY pressure monitoring during open heart surgery, in a patient under 12 years of age | $461.70 |
| **Cardiovascular** | | |
| 11704 | Twelve lead electrocardiography, trace and formal report, by a specialist or a consultant physician, if the service: (a) is requested by a requesting practitioner; and (b) is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies. Note: the following are also requirements of the service: a formal report is completed; and a copy of the formal report is provided to the requesting practitioner; and the service is not provided to the patient as part of an episode of hospital treatment or hospital-substitute treatment; and is not provided in association with an attendance item (Part 2 of the schedule); and the specialist or consultant physician who renders the service does not have a financial relationship with the requesting practitioner. | $59.40 |
| 11705 | Twelve lead electrocardiography, formal report only, by a specialist or a consultant physician, if the service: (a) is requested by a requesting practitioner; and (b) is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than twice on the same day Note: the following are also requirements of the service: a formal report is completed; and a copy of the formal report is provided to the requesting practitioner; and the specialist or consultant physician who renders the service does not have a financial relationship with the requesting practitioner. | $35.00 |
| 11707 | Twelve lead electrocardiography, trace only, by a medical practitioner, if: (a) the trace: (i) is required to inform clinical decision making; and (ii) is reviewed in a clinically appropriate timeframe to identify potentially serious or life threatening abnormalities; and (iii) does not need to be fully interpreted or reported on; and (b) the service is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than twice on the same day Note: the service is not provided to the patient as part of an episode of: hospital treatment; or hospital-substitute treatment. | $35.00 |
| 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 | $143.90 |
| 11714 | Twelve lead electrocardiography, trace and clinical note, by a specialist or consultant physician, if the service is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than twice on the same day Note: the service is not provided to the patient as part of an episode of: hospital treatment; or hospital-substitute treatment. | $46.00 |
| 11716 | Note: the service only applies if the patient meets one or more of the following and the requirements in Note: DR.1.1 Continuous ambulatory electrocardiogram recording for 12 or more hours, by a specialist or consultant physician, if the service: (a) is indicated for the evaluation of any of the following: (i) syncope; (ii) pre syncopal episodes; (iii) palpitations where episodes are occurring more than once a week; (iv) another asymptomatic arrhythmia is suspected with an expected frequency of greater than once a week; (v) surveillance following cardiac surgical procedures that have an established risk of causing dysrhythmia; and (b) utilises a system capable of superimposition and full disclosure printout of at least 12 hours of recorded electrocardiogram data (including resting electrocardiogram and the recording of parameters) and microprocessor based scanning analysis; and (c) includes interpretation and report; and (d) is not provided in association with ambulatory blood pressure monitoring; and (e) is not associated with a service to which item 11704, 11705, 11707, 11714, 11717, 11723, 11735, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable only once in any 4 week period Note: this services does not apply if the patient is being provided with the service as part of an episode of: hospital treatment; or hospital substitute treatment. | $317.90 |
| 11717 | Note: the service only applies if the patient meets one or more of the following and the requirements in Note: DR.1.1 Ambulatory electrocardiogram monitoring, by a specialist or consultant physician, if the service: (a) utilises a patient activated, single or multiple event memory recording device that: (i) is connected continuously to the patient for between 7 and 30 days; and (ii) is capable of recording for at least 20 seconds prior to each activation and for 15 seconds after each activation; and (b) includes transmission, analysis, interpretation and reporting (including the indication for the investigation); and (c) is for the investigation of recurrent episodes of: unexplained syncope; or palpitation; or other symptoms where a cardiac rhythm disturbance is suspected and where infrequent episodes have occurred; and (d) is not associated with a service to which item 11716, 11723, 11735, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable only once in any 3 month period Note: the service does not apply if the patient is being provided with the service as part of an episode of: hospital treatment; or hospital substitute treatment. | $186.80 |
| 11719 | IMPLANTED PACEMAKER (including cardiac resynchronisation pacemaker) REMOTE MONITORING involving reviews (without patient attendance) of 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 | $133.80 |
| 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 11721 applies. | $133.80 |
| 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 11704, 11719, 11720, 11725 or 11726 applies | $149.60 |
| 11723 | Note: the service only applies if the patient meets one or more of the following and the requirements in Note: DR.1.1 Ambulatory electrocardiogram monitoring, by a specialist or consultant physician, if the service: (a) utilises a patient activated, single or multiple event recording, on a memory recording device that: (i) is connected continuously to the patient for up to 7 days; and (ii) is capable of recording for at least 20 seconds prior to each activation and for 15 seconds after each activation; and (b) includes transmission, analysis, interpretation and formal report (including the indication for the investigation); and (c) is for the investigation of recurrent episodes of: (i) unexplained syncope; or (ii) palpitation; or (iii) other symptoms where a cardiac rhythm disturbance is suspected and where infrequent episodes have occurred; and (d) is not associated with a service to which item 11716, 11717, 11735, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable only once in any 3 month period Note: The service does not apply if the patient is an admitted patient. | $98.50 |
| 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 | $360.10 |
| 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 | $379.60 |
| 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. | $189.70 |
| 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 11719, 11720, 11721, 11725 or 11726 applies | $194.50 |
| 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 | $67.10 |
| 11729 | Multi channel electrocardiogram monitoring and recording during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts) or pharmacological stress, if: (a) the patient is 17 years or more; and (b) the patient: (i) has symptoms consistent with cardiac ischemia; or (ii) has other cardiac disease which may be exacerbated by exercise; or (iii) has a first degree relative with suspected heritable arrhythmia; and (c) the monitoring and recording: (i) is not less than 20 minutes; and (ii) includes resting electrocardiogram; and (d) a written report is produced by a medical practitioner that includes interpretation of the monitoring and recording data, commenting on the significance of the data, and the relationship of the data to clinical decision making for the patient in the clinical context; and (e) the service is not a service: (i) provided on the same occasion as a service to which item 11704, 11705, 11707 or 11714 applies; or (ii) performed within 24 months of a service to which item 55141, 55143, 55145, 55146, 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 or 61414 applies Applicable only once in any 24 month period | $289.00 |
| 11730 | Multi channel electrocardiogram monitoring and recording during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts), if: (a) the patient is less than 17 years; and (b) the patient: (i) has symptoms consistent with cardiac ischemia; or (ii) has other cardiac disease which may be exacerbated by exercise; or (iii) has a first degree relative with suspected heritable arrhythmia; and (c) the monitoring and recording: (i) is not less than 20 minutes in duration; and (ii) includes resting electrocardiogram; and (d) a written report is produced by a medical practitioner that includes interpretation of the monitoring and recording data, commenting on the significance of the data, and the relationship of the data to clinical decision making for the patient in the clinical context; and (e) the service is not a service: (i) provided on the same occasion as a service to which item 11704, 11705, 11707 or 11714 applies; or (ii) performed within 24 months of a service to which item 55141, 55143, 55145, 55146, 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 or 61414 applies Applicable only once in any 24 month period | $289.00 |
| 11731 | Implanted electrocardiogram loop recording, by a medical practitioner, including reprogramming (if required), retrieval of stored data, analysis, interpretation and report, if the service is: (a) an investigation for a patient with: (i) cryptogenic stroke; or (ii) recurrent unexplained syncope; and (b) not a service to which item 38285 applies Applicable only once in any 4 week period | $66.00 |
| 11732 | Multi channel electrocardiogram monitoring and recording during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts), performed by a cardiologist with relevant expertise in genetic heart disease, if: (a) the patient is: (i) under investigation or treatment for long QT syndrome, catecholaminergic polymorphic ventricular tachycardia or arrhythmogenic cardiomyopathy; or (ii) a first degree relative of a person with confirmed long QT syndrome, catecholaminergic polymorphic ventricular tachycardia, arrhythmogenic cardiomyopathy or unexplained sudden cardiac death at 40 years of age or younger; and (b) the monitoring and recording: (i) is for at least 20 minutes; and (ii) includes resting electrocardiogram; and (c) the cardiologist produces a report that includes interpretation of the monitoring and recording data (commenting on the significance of the data) and discussion of the relationship of the data to clinical decision making for the patient in the clinical context; and (d) the service is not provided on the same occasion as a service to which item 11704, 11705, 11707, 11714, 11729 or 11730 applies Applicable once per day | $251.30 |
| 11735 | Note: the service only applies if the patient meets one or more of the following and the requirements in Note: DR.1.1 Continuous ambulatory electrocardiogram recording for 7 days, by a specialist or consultant physician, if the service: (a) utilises intelligent microprocessor based monitoring, with patient triggered recording and symptom reporting capability, real time analysis of electrocardiograms and alerts and daily or live data uploads; and (b) is for the investigation of: (i) episodes of suspected intermittent cardiac arrhythmia or episodes of syncope; or (ii) suspected intermittent cardiac arrhythmia in a patient who has had a previous cerebrovascular accident, is at risk of cerebrovascular accident or has had one or more previous transient ischemic attacks; and (c) includes interpretation and report; and (d) is not a service: (i) provided in association with ambulatory blood pressure monitoring; or (ii) associated with a service to which item 11716, 11717, 11723, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than 4 times in any 12 month period Note: The service does not apply if the patient is an admitted patient. | $242.80 |
| 11736 | Implanted loop recording via remote monitoring (including reprogramming (if required), retrieval of stored data, analysis, interpretation and report), for the investigation of atrial fibrillation, if the service: (a) is provided to a patient who has been diagnosed as having had an embolic stroke of undetermined source; and (b) is not a service to which item 38288 applies Applicable not more than 4 times in any 12 month period | $64.90 |
| 11737 | Implanted electrocardiogram loop recording via remote monitoring (including reprogramming (if required), retrieval of stored data, analysis, interpretation and report), by a medical practitioner, if the service is: (a) an investigation for a patient with: (i) cryptogenic stroke; or (ii) recurrent unexplained syncope; and (b) not a service to which item 38285 applies Applicable only once in any 4 week period | $64.90 |
| **Gastroenterology and colorectal** | | |
| 11800 | Oesophageal motility test, manometric | $371.20 |
| 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-monitoring: (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.) | $526.70 |
| 11810 | CLINICAL ASSESSMENT of GASTRO-OESOPHAGEAL REFLUX DISEASE involving 24 hour pH monitoring, including analysis, interpretation and report and including any associated consultation | $383.60 |
| 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 | $2618.90 |
| 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. | $3610.10 |
| 11830 | DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR involving anal manometry or measurement of anorectal sensation or measurement of the rectosphincteric reflex | $316.30 |
| 11833 | Diagnosis of abnormalities of the pelvic floor and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency | $540.30 |
| **Gentio/urinary physiological investigations** | | |
| 11900 | Urine flow study, including peak urine flow measurement, not being a service associated with a service to which item 11912, 11917 or 11919 applies | $59.50 |
| 11912 | Cystometrography:(a) with measurement of any one or more of the following: (i) urine flow rate; (ii) urethral pressure profile; (iii) urethral sphincter electromyography; and(b) with simultaneous measurement of: (i) rectal pressure; or (ii) stomal or vaginal pressure if rectal pressure is not possible; not being a service associated with a service to which any of items 11012 to 11027, 11900, 11917, 11919 and 36800 or an item in Group I3 of the diagnostic imaging services table applies (Anaes.) | $376.20 |
| 11917 | Cystometrography, in conjunction with real time ultrasound of one or more components of the urinary tract:(a) with measurement of any one or more of the following: (i) urine flow rate; (ii) urethral pressure profile; (iii) urethral sphincter electromyography; and(b) with simultaneous measurement of: (i) rectal pressure; or (ii) stomal or vaginal pressure if rectal pressure is not possible; including all imaging associated with cystometrography, not being a service associated with a service to which any of items 11012 to 11027, 11900, 11912, 11919 and 36800 or an item in Group I3 of the diagnostic imaging services table applies (Anaes.) | $885.70 |
| 11919 | CYSTOMETROGRAPHY IN CONJUNCTION WITH CONTRAST MICTURATING CYSTOURETHROGRAPHY, with measurement of any one or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography, being a service associated with a service to which items 60506 or 60509 applies; other than a service associated with a service to which items 11012-11027, 11900-11917 and 36800 apply (Anaes.) | $885.70 |
| **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 | $80.10 |
| 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 | $73.60 |
| 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 | $73.60 |
| 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 | $106.00 |
| 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 | $111.10 |
| 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 | $149.60 |
| 12012 | Epicutaneous patch testing in the investigation of allergic dermatitis using not more than 25 allergens | $43.10 |
| 12017 | Epicutaneous patch testing in the investigation of allergic dermatitis using more than 25 allergens but not more than 50 allergens | $137.90 |
| 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 | $248.00 |
| 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 | $266.30 |
| 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 | $303.00 |
| **Other diagnostic procedures and investigations** | | |
| 12200 | Collection of specimen of sweat by iontophoresis | $79.30 |
| 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 | $3790.00 |
| 12203 | Overnight diagnostic assessment of sleep, for at least 8 hours, 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 adult 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 of3 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 adult sleep medicine practitioner or a consultant respiratory physician, the qualified adult 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 adult 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 a report; and (f) interpretation and preparation of a permanent report is provided by a qualified adult 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 described in any of items 11000, 11003, 11004, 11005, 11503, 11704, 11705,11707, 11713, 11714, 11716, 11717, 11723, 11735or 12250 is provided to the patient Applicable only once in any 12 month period | $1190.50 |
| 12204 | Overnight assessment of positive airway pressure, for at least 8 hours, for a patient aged 18 years or more, if: (a) the necessity for an intervention sleep study is determined by a qualified adult 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 adult sleep medicine practitioner or a consultant respiratory physician (either face to face or by video conference), the qualified adult 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 adult 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 adult 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, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716,11717, 11723, 11735or 12250 is provided to the patient Applicable only once in any 12 month period | $1110.20 |
| 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 adult 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 adult 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 a report; and (e) interpretation and preparation of a permanent report is provided by a qualified adult 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, 11003, 11004,11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735or 12250 is provided to the patient Applicable only once in any 12 month period | $1110.20 |
| 12207 | Overnight investigation, for a patient aged 18 years or more, for a sleep related breathing disorder, following professional attendance by a qualified adult 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 adult 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 adult 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 a report; and (f) interpretation and preparation of a permanent report is provided by a qualified adult 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, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 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 any 12 month period | $1190.50 |
| 12208 | Overnight investigation, for sleep apnoea for at least 8 hours, for a patient aged 18 years or more, if: (a) a qualified adult 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 adult 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 a report; and (e) interpretation and preparation of a permanent report is provided by a qualified adult 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, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient Applicable only once in any 12 month period | $1110.20 |
| 12210 | Overnight paediatric investigation, for at least 8 hours, 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 paediatric 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 paediatric 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 a report; and (f) interpretation and report are provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct 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 to which item 11704, 11705, 11707, 11714, 11716, 11717, 11723 or 11735 applies is provided to 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 | $1416.90 |
| 12213 | Overnight paediatric investigation, for at least 8 hours, 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 a 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) the investigation is not provided to the patient on the same occasion that a service to which item 11704, 11705, 11707, 11714, 11716, 11717, 11723 or 11735 applies is provided to 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 | $1276.50 |
| 12215 | Overnight paediatric investigation, for at least 8 hours, 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 paediatric 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 paediatric 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 a report; and (f) interpretation and report are provided by a qualified paediatric 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; and (h) the investigation is not provided to the patient on the same occasion that a service to which item 11704, 11705, 11707, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient Applicable only once in the same 12 month period to which item 12210 applies | $1416.90 |
| 12217 | Overnight paediatric investigation, for at least 8 hours, 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 a 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; and (h) the investigation is not provided to the patient on the same occasion that a service to which item 11704, 11705, 11707, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient Applicable only once in the same 12 month period to which item 12213 applies | $1276.50 |
| 12250 | Overnight investigation of sleep for 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 adult 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 of3 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 adult sleep medicine practitioner or a consultant respiratory physician, the qualified adult 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 adult 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 a report; and (f) interpretation and preparation of a permanent report is provided by a qualified adult 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, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11714, 11716, 11717, 11723, 11735 and 12203 is provided to the patient Applicable only once in any 12 month period | $680.40 |
| 12254 | Multiple sleep latency test for the assessment of unexplained hypersomnolence in a patient aged 18 years or more, if: (a) a qualified adult 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 under the pharmaceutical benefits scheme for drugs relevant to treat that condition are met; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, 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 adult 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 a report; and (f) interpretation and preparation of a permanent report is provided by a qualified adult 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 described in item 11003, 12203, 12204, 12205, 12208, 12250 or 12258 is provided to the patient Applicable only once in a 12 month period | $1725.30 |
| 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 adult 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 is performed for at least 8 hours, 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 adult 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 a report; and (f)interpretation and preparation of a permanent report is provided by a qualified adult 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 described in item 11003, 12203, 12204, 12205, 12208, 12250 or 12254 is provided to the patient Applicable only once in a 12 month period | $1725.30 |
| 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 under the pharmaceutical benefits scheme for drugs relevant to treat that condition are met; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following, 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 a 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 described in item 11003, 12213, 12217 or 12265 is provided to the patient Applicable only once in a 12 month period | $1808.80 |
| 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 is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following, 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 a 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 described in item 11003, 12213, 12217 or 12261 is provided to the patient Applicable only once in a 12 month period | $1808.80 |
| 12268 | Multiple sleep latency test for the assessment of unexplained hypersomnolence for a patient less than 12 years of age, if: (a) a qualified paediatric 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 under the pharmaceutical benefits scheme for drugs relevant to treat that condition are met; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following, 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 paediatric 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 a report; and (f)interpretation and preparation of a permanent report is provided by a qualified paediatric 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 described in item 11003, 12210, 12215 or 12272 is provided to the patient Applicable only once in a 12 month period | $1940.10 |
| 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 paediatric sleep medicine practitioner determines that testing to objectively confirm the ability to maintain wakefulness is necessary; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following, 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 paediatric 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 a report; and (f)interpretation and preparation of a permanent report is provided by a qualified paediatric 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 described in item 11003, 12210, 12215 or 12268 is provided to the patient Applicable only once in a 12 month period | $1940.10 |
| 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 | $210.40 |
| 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 | $210.40 |
| 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 | $210.40 |
| 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 | $197.80 |
| 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 | $210.40 |
| 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 | $197.80 |
| 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 | $91.00 |
| 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 | $91.00 |
| **GROUP D2—NUCLEAR MEDICINE (NON-IMAGING)** | | |
| 12500 | Blood volume estimation | $450.00 |
| 12524 | Renal function test (without imaging procedure) | $321.10 |
| 12527 | Renal function test (with imaging and at least 2 blood samples) | $172.30 |
| 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 | $171.60 |
| **GROUP T1—MISCELLANEOUS THERAPEUTIC PROCEDURES** | | |
| **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. | $514.30 |
| 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 | $525.70 |
| 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) | $238.30 |
| 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) | $331.50 |
| **Dialysis** | | |
| 13100 | SUPERVISION IN HOSPITAL by a medical specialist ofhaemodialysis, 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 | $282.80 |
| 13103 | SUPERVISION IN HOSPITAL by a medical specialist ofhaemodialysis, 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 | $147.40 |
| 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 | $300.40 |
| 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 | $1117.70 |
| 13106 | Declotting of an arteriovenous shunt | $244.30 |
| 13109 | INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSISINSERTION AND FIXATION OF (Anaes.) | $468.40 |
| 13110 | INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS , removal of (including catheter cuffs) (Anaes.) | $461.30 |
| **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, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, transfer of frozen embryos or donated embryos or ova or a service to which item 13201, 13202, 13203 or 13218 applies, being services rendered during one treatment cycle initial cycle in a single calendar year | $6335.00 |
| 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, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, transfer of frozen embryos or donated embryos or ova or a service to which item 13200, 13202, 13203 or 13218 applies, being services rendered during one treatment cycle each cycle after the first in a single calendar year | $5930.00 |
| 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 and ultrasound examinations, but excluding artificial insemination, transfer of frozen embryos or donated embryos or ova or a service to which item 13200, 13201, 13203 or 13218 applies, being services rendered during one treatment cycle | $950.00 |
| 13203 | Ovulation monitoring services for artificial insemination or gonadotrophin, stimulated ovulation induction, including quantitative estimation of hormones and ultrasound examinations, being services rendered during one treatment cycle but excluding a service to which item 13200, 13201, 13202, 13212, 13215 or 13218 applies | $1038.30 |
| 13209 | Planning and management of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies or for artificial insemination applicable once during a treatment cycle | $192.00 |
| 13212 | Oocyte retrieval for the purpose of assisted reproductive technologies only if rendered in connection with a service to which item 13200 or 13201 applies (Anaes.) | $735.40 |
| 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 or 13218 applies, being services rendered in one treatment cycle (Anaes.) | $229.10 |
| 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 one treatment cycle and excluding a service to which item 13200, 13201, 13202, 13203 or 13212 applies (Anaes.) | $1729.70 |
| 13221 | Preparation of semen for the purpose of artificial insemination only if rendered in connection with a service to which item 13203 applies | $107.20 |
| 13241 | Open surgical testicular sperm retrieval, unilateral, using operating microscope, including the exploration of scrotal contents, with biopsy, for the purposes of intracytoplasmic sperm injection, for male factor infertility, not being a service associated with a service to which item 13218 or 37604 applies (H) (Anaes.) | $1563.80 |
| 13251 | Intracytoplasmic sperm injection for the purpose of assisted reproductive technologies, for male factor infertility, excluding a service to which item 13203 or 13218 applies | $892.20 |
| 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. | $783.60 |
| 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 | $412.30 |
| **Paediatric and neonatal** | | |
| 13300 | UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate | $115.00 |
| 13303 | Umbilical artery catheterisation with or without infusion | $170.50 |
| 13306 | BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor | $674.20 |
| 13309 | BLOOD TRANSFUSION with venesection and complete replacement of blood, using blood already collected | $575.00 |
| 13312 | BLOOD for pathology test, collection of, BY FEMORAL OR EXTERNAL JUGULAR VEIN PUNCTURE IN INFANTS | $57.40 |
| 13318 | CENTRAL VEIN CATHETERISATION—by open exposure in a patient under 12 years of age (Anaes.) | $459.10 |
| 13319 | Central vein catheterisation in a neonate via peripheral vein (Anaes.) | $459.10 |
| **Cardiovascular** | | |
| 13400 | Restoration of cardiac rhythm by electrical stimulation (cardioversion), other than in the course of cardiac surgery (H) (Anaes.) | $211.70 |
| **Gastroenterology** | | |
| 13506 | Gastro-oesophageal balloon intubation, for control of bleeding from gastric oesophageal varices | $373.00 |
| **Haematology** | | |
| 13700 | HARVESTING OF HOMOLOGOUS (including allogeneic) or AUTOLOGOUS bone marrow for the purpose of transplantation (Anaes.) | $690.60 |
| 13703 | Transfusion of blood including collection from donor, when used for intra-operative normovolaemic haemodilution, other than a service associated with a service to which item 22052 applies | $251.90 |
| 13706 | Transfusion of blood or bone marrow already collected | $172.00 |
| 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 | $281.60 |
| 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 | $281.60 |
| 13757 | THERAPEUTIC VENESECTION for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda | $136.30 |
| 13760 | In vitro processing with cryopreservation of bone marrow or peripheral blood, for autologous stem cell transplantation for a patient receiving high dose chemotherapy for management of: (a) aggressive malignancy; or (b) malignancy that has proven refractory to prior treatment | $1586.60 |
| **Procedures associated with intensive care and cardiopulmonary support** | | |
| 13815 | Central vein catheterisation, including under ultrasound guidance where clinically appropriate, by percutaneous or open exposure other than a service to which item 13318 applies (Anaes.) No separate ultrasound item is payable with this item. (Anaes.) | $179.90 |
| 13818 | Right heart balloon catheter, insertion of, including pulmonary wedge pressure and cardiac output measurement (Anaes.) | $242.50 |
| 13830 | INTRACRANIAL PRESSURE, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician—each day | $156.70 |
| 13832 | Peripheral cannulation, including under ultrasound guidance where clinically appropriate, for veno-arterial cardiopulmonary extracorporeal life support No separate ultrasound item is payable with this item | $1648.90 |
| 13834 | Veno arterial cardiopulmonary extracorporeal life support, management of the first day | $923.10 |
| 13835 | Veno arterial cardiopulmonary extracorporeal life support, management of each day after the first | $214.90 |
| 13837 | Veno-venous pulmonary extracorporeal life support, management of the first day | $923.10 |
| 13838 | Veno-venous pulmonary extracorporeal life support, management of each day after the first | $214.90 |
| 13839 | Arterial puncture and collection of blood for diagnostic purposes | $46.70 |
| 13840 | Peripheral cannulation, including under ultrasound guidance where clinically appropriate, for veno-venous pulmonary extracorporeal life support No separate ultrasound item is payable with this item | $1104.70 |
| 13842 | Intra-arterial cannulation, including under ultrasound guidance where clinically appropriate, for the purpose of intra-arterial pressure monitoring or arterial blood sampling (or both) No separate ultrasound item is payable with this item | $142.20 |
| 13848 | Counterpulsation by intra-aortic balloon-management including associated consultations and monitoring of parameters by means of full haemodynamic assessment and management on several occasions on a day each day | $288.40 |
| 13851 | Ventricular assist device, management of, for a patient admitted to an intensive care unit for implantation of the device or for complications arising from implantation or management of the device—first day | $1020.40 |
| 13854 | Ventricular assist device, management of, for a patient admitted to an intensive care unit, including management ofcomplications arising from implantation or management of the device—each day after the first day | $236.40 |
| 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 | $321.10 |
| **Management and procedures undertaken in an intensive care unit** | | |
| 13870 | (Note: See para T1.8 of Explanatory Notes to this Category for definition of an Intensive Care Unit) MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician 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) | $700.50 |
| 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) | $513.30 |
| 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) | $144.10 |
| 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) | $302.60 |
| 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) | $238.30 |
| 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) | $317.40 |
| 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) | $163.60 |
| 13899 | Preparation of Goals of Care is provided outside of an intensive care unit. Refer to explanatory note TN.1.11 for further information about Goals of Care attendance Professional attendance, outside an intensive care unit, for at least 60 minutes spent in preparation of goals of care for a gravely ill patient lacking current goals of care, by a specialist in the specialty of intensive care who takes overall responsibility for the preparation of the goals of care for the patient Item 13899 cannot be co-claimed with item 13870 or item 13873 on the same day | $500.80 |
| **Chemotherapeutic procedures** | | |
| 13950 | Parenteral administration of one or more antineoplastic agents, including agents used in cytotoxic chemotherapy or monoclonal antibody therapy but not agents used in anti-resorptive bone therapy or hormonal therapy, by or on behalf of a specialist or consultant physician attendance for one or more episodes of administration Note: The fee for item 13950 contains a component which covers the accessing of a long-term drug delivery device. TN.1.27 refers | $205.20 |
| **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 | $107.10 |
| 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.) | $405.40 |
| 14106 | Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, caf 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 cm2 (Anaes.) | $405.40 |
| 14115 | Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, caf 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 cm2 to 300 cm2 (Anaes.) | $596.00 |
| 14118 | Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, caf 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 cm2 (Anaes.) | $835.20 |
| 14124 | Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, caf 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.) | $322.00 |
| **Other therapeutic procedures** | | |
| 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 | $519.10 |
| 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 | $262.60 |
| 14203 | HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes.) | $109.50 |
| 14206 | HORMONE OR LIVING TISSUE IMPLANTATION by cannula | $70.20 |
| 14212 | Intussusception, management of fluid or gas reduction for (Anaes.) | $376.20 |
| 14216 | Professional attendance on a patient by a psychiatrist, who has undertaken training in Repetitive Transcranial Magnetic Stimulation (rTMS), for treatment mapping for rTMS, if the patient: (a) has not previously received any prior transcranial magnetic stimulation therapy in a public or private setting; and (b) is at least 18 years old; and (c) is diagnosed with a major depressive episode; and (d) has failed to receive satisfactory improvement for the major depressive episode despite the adequate trialling of at least 2 different classes of antidepressant medications, unless contraindicated, and all of the following apply: (i) the patient s adherence to antidepressant treatment has been formally assessed; (ii) the trialling of each antidepressant medication has been at the recommended therapeutic dose for a minimum of 3 weeks; (iii) where clinically appropriate, the treatment has been titrated to the maximum tolerated therapeutic dose; and (e) has undertaken psychological therapy, if clinically appropriate | $343.10 |
| 14217 | Repetitive Transcranial Magnetic Stimulation (rTMS) treatment of up to 35 services provided by, or on behalf of, a psychiatrist who has undertaken training in rTMS, if the patient has previously received a service under item 14216 each service up to 35 services | $294.40 |
| 14218 | Implanted infusion pump, refilling of reservoir with a therapeutic agent or agents for infusion to the subarachnoid space or accessing the side port to assess catheter patency, with or without pump reprogramming, for the management of chronic pain, including cancer pain | $211.70 |
| 14219 | Professional attendance on a patient by a psychiatrist, who has undertaken training in Repetitive Transcranial Magnetic Stimulation (rTMS), for treatment mapping for rTMS, if the patient: (a) is at least 18 years old; and (b) is diagnosed with a major depressive episode; and (c) has failed to receive satisfactory improvement for the major depressive episode despite the adequate trialling of at least 2 different classes of antidepressant medications, unless contraindicated, and all of the following apply: (i) the patient s adherence to antidepressant treatment has been formally assessed; (ii) the trialling of each antidepressant medication has been at the recommended therapeutic dose for a minimum of 3 weeks; (iii) where clinically appropriate, the treatment has been titrated to the maximum tolerated therapeutic dose; and (d) has undertaken psychological therapy, if clinically appropriate; and (e) has previously received an initial service under item 14217 and the patient: (i) has relapsed after a remission following the initial service; and (ii) has had a satisfactory clinical response to the service under item 14217 (which has been assessed by a validated major depressive disorder tool at least 4 months after receiving that service) | $343.10 |
| 14220 | Repetitive Transcranial Magnetic Stimulation (rTMS) treatment of up to 15 services provided by, or on behalf of, a psychiatrist who has undertaken training in rTMS, if the patient has previously received: (a) a service under item 14217 (which was not provided in the previous 4 months); and (b) a service under item 14219 Each service up to 15 services | $294.40 |
| 14221 | LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessing of, not being a service associated with a service to which item 13950 applies | $108.60 |
| 14224 | Electroconvulsive therapy, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (H) (Anaes.) | $253.90 |
| 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 | $197.80 |
| 14234 | Infusion pump or components of an infusion pump, removal 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.) | $687.00 |
| 14237 | Infusion pump or components of an 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.) | $1252.70 |
| 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 | $197.80 |
| 14247 | Extracorporeal photopheresis for the treatment of erythrodermic stage III-IVa T4 M0 cutaneous T-cell lymphoma; if the service is provided in the initial six months of treatment; and the service is delivered using an integrated, closed extracorporeal photopheresis system; and the patient is 18 years old or over; and the patient has received prior systemic treatment for this condition and experienced either disease progression or unacceptable toxicity while on this treatment; and the service is provided in combination with the use of Pharmaceutical Benefits Scheme-subsidised methoxsalen; and the service is supervised by a specialist or consultant physician in the speciality of haematology. Applicable once per treatment cycle | $3512.60 |
| 14249 | Extracorporeal photopheresis for the continuing treatment of erythrodermic stage III-IVa T4 M0 cutaneous T-cell lymphoma; if in the preceding 6 months:(i) a service to which item 14247 applies has been provided; and(ii) the patient has demonstrated a response to this service; and(iii)the patient requires further treatment; and the service is delivered using an integrated, closed extracorporeal photopheresis system; and the patient is 18 years old or over; and the service is provided in combination with the use of Pharmaceutical Benefits Scheme-subsidised methoxsalen; and the service is supervised by a specialist or consultant physician in the speciality of haematology. Applicable once per treatment cycle | $3512.60 |
| **Management and procedures undertaken in an emergency department** | | |
| 14255 | Resuscitation of a patient provided for at least 30 minutes but less than 1 hour, by a specialist in the practice of the specialist s specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.) | $277.50 |
| 14256 | Resuscitation of a patient provided for at least 1 hour but less than 2 hours, by a specialist in the practice of the specialist s specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.) | $533.60 |
| 14257 | Resuscitation of a patient provided for at least 2 hours, by a specialist in the practice of the specialist s specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.) | $1062.70 |
| 14258 | Resuscitation of a patient provided for at least 30 minutes but less than 1 hour, by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.) | $208.30 |
| 14259 | Resuscitation of a patient provided for at least 1 hour but less than 2 hours, by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.) | $400.30 |
| 14260 | Resuscitation of a patient provided for at least 2 hours, by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.) | $797.00 |
| 14263 | Minor procedure on a patient by a specialist in the practice of the specialist s specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.) | $97.70 |
| 14264 | Procedure (except a minor procedure) on a patient by a specialist in the practice of the specialist s specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.) | $219.90 |
| 14265 | Minor procedure on a patient by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.) | $73.30 |
| 14266 | Procedure (except a minor procedure) on a patient by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.) | $165.00 |
| 14270 | Management, without aftercare, of all fractures and dislocations suffered by a patient that: (a) is provided by a specialist in the practice of the specialist’s specialty of emergency medicine in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019; and (b) occurs at a recognised emergency department of a private hospital (Anaes.) | $246.50 |
| 14272 | Management, without aftercare, of all fractures and dislocations suffered by a patient that: (a) is provided by a medical practitioner (except a specialist in the practice of the specialist’s specialty of emergency medicine) in conjunction with an attendance on the patient by thepractitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (b) occurs at a recognised emergency department of a private hospital (Anaes.) | $185.10 |
| 14277 | Application of chemical or physical restraint of a patient by a specialist in the practice of the specialist s specialty of emergency medicine at a recognised emergency department of a private hospital | $277.50 |
| 14278 | Application of chemical or physical restraint of a patient by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) at a recognised emergency department of a private hospital | $208.30 |
| 14280 | Anaesthesia (whether general anaesthesia or not) of a patient that: (a) is managed by a specialist in the practice of the specialist s specialty of emergency medicine at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies | $277.50 |
| 14283 | Anaesthesia (whether general anaesthesia or not) of a patient that: (a) is managed by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies | $208.30 |
| 14285 | Emergent intubation, airway management or both of a patient that: (a) is managed by a specialist in the practice of the specialist s specialty of emergency medicine at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies | $277.50 |
| 14288 | Emergent intubation, airway management or both of a patient that: (a) is managed by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies | $208.30 |
| **GROUP T2—RADIATION ONCOLOGY** | | |
| **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 | $86.50 |
| 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 | $144.10 |
| 15006 | RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technique is applied—1 field | $208.50 |
| 15009 | Radiotherapy, superficial attendance at which a single dose technique is applied—2 or more fields up to a maximum of 5 additional fields | $285.30 |
| 15012 | RADIOTHERAPY, SUPERFICIAL each attendance at which treatment is given to an eye | $110.10 |
| **Orthovoltage** | | |
| 15100 | RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 3 or more treatments per week—1 field | $96.90 |
| 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) | $159.80 |
| 15106 | RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 2 treatments per week or less frequently—1 field | $114.40 |
| 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) | $190.40 |
| 15112 | RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field | $244.10 |
| 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) | $402.60 |
| **Megavoltage** | | |
| 15211 | RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy unit each attendance at which treatment is given—1 field | $118.40 |
| 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 | $184.70 |
| 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) | $120.90 |
| 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) | $120.90 |
| 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) | $120.90 |
| 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 | $123.40 |
| 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 | $123.40 |
| 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) | $212.70 |
| 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) | $212.70 |
| 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) | $212.70 |
| 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 | $215.40 |
| 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 | $215.40 |
| 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) | $123.40 |
| 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) | $120.90 |
| 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) | $123.40 |
| 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 | $123.40 |
| 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 | $123.40 |
| 15260 | 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 (lung)ncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of 10mv photons or greater, with electron facilities—each attendance at which treatment is given—2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)—treatment delivered to primary site (lung) | $215.40 |
| 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) | $212.70 |
| 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) | $215.40 |
| 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 | $215.40 |
| 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 | $215.40 |
| 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. | $350.00 |
| **Brachytherapy** | | |
| 15303 | INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual after loading techniques (Anaes.) | $724.40 |
| 15304 | INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic after loading techniques (Anaes.) | $724.40 |
| 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 after loading techniques (Anaes.) | $1373.40 |
| 15308 | INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic after loading techniques (Anaes.) | $1373.40 |
| 15311 | INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual after loading techniques (Anaes.) | $676.20 |
| 15312 | INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic after loading techniques (Anaes.) | $671.10 |
| 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 after loading techniques (Anaes.) | $1327.60 |
| 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 after loading techniques (Anaes.) | $1340.80 |
| 15319 | COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using manual after loading techniques (Anaes.) | $823.80 |
| 15320 | COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using automatic after loading techniques (Anaes.) | $823.80 |
| 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 after loading techniques (Anaes.) | $1465.10 |
| 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 after loading techniques (Anaes.) | $1493.70 |
| 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 after loading techniques (Anaes.) | $1593.90 |
| 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 after loading techniques (Anaes.) | $1625.00 |
| 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 after loading techniques (Anaes.) | $1513.20 |
| 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 after loading techniques (Anaes.) | $1603.00 |
| 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 after loading techniques (Anaes.) | $1373.40 |
| 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 after loading techniques (Anaes.) | $1373.40 |
| 15338 | Prostate, radioactive seed implantation of, radiation oncology component, using transrectal ultrasound guidance: (a) for a patient with: (i) localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate); and (ii) a Gleason score of less than or equal to 7 (Grade Group 1 to Grade Group 3); and (iii) a prostate specific antigen (PSA) of not more than 10ng/ml at the time of diagnosis; and (b) performed by an oncologist at an approved site in association with a urologist; and (c) being a service associated with: (i) services to which items 37220 and 55603 apply; and (ii) a service to which item 60506or 60509 applies | $1928.70 |
| 15339 | REMOVAL OF A SEALED RADIOACTIVE SOURCE under general anaesthesia, or under epidural or spinal nerve block (Anaes.) | $164.70 |
| 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 | $386.20 |
| 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 | $1047.30 |
| 15348 | SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15342 or 15345each attendance | $120.00 |
| 15351 | CONSTRUCTION WITH OR WITHOUT INITIAL APPLICATION OF RADIOACTIVE MOULD not exceeding 5 cm. diameter to an external surface | $254.60 |
| 15354 | CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD 5 cm. or more in diameter to an external surface | $287.00 |
| 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 | $87.30 |
| **Computerised planning** | | |
| 15500 | RADIOTHERAPY PLANNINGRADIATION 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) | $490.50 |
| 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) | $670.30 |
| 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) | $956.40 |
| 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) | $425.10 |
| 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) | $437.70 |
| 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 | $630.10 |
| 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) | $770.00 |
| 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 | $159.80 |
| 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 | $698.50 |
| 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 | $1313.90 |
| 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 | $160.60 |
| 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 | $690.60 |
| 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 | $1359.90 |
| 15536 | Brachytherapy planning, computerised radiation dosimetry | $560.40 |
| 15539 | BRACHYTHERAPY PLANNING, computerised radiation dosimetry for I125 seed implantation of localised prostate cancer, in association with item 15338 | $1490.00 |
| 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 | $1121.20 |
| 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 | $1146.50 |
| 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. | $1420.00 |
| 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 | $1102.00 |
| 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 | $1472.10 |
| 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 | $2038.50 |
| 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 gantry position (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 (c)the final IMRT dosimetry plan is approved by the radiation oncologist prior to delivery. | $6636.60 |
| **Stereotactic radiosurgery** | | |
| 15600 | STEREOTACTIC RADIOSURGERY, including all radiation oncology consultations, planning, simulation, dosimetry and treatment | $3655.00 |
| **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). | $94.20 |
| 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). | $157.20 |
| 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) | $157.90 |
| 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 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. | $153.30 |
| **Brachytherapy planning and verification** | | |
| 15800 | Brachytherapy treatment verification—maximum of one only for each attendance. | $206.70 |
| 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. | $440.00 |
| **GROUP T3—THERAPEUTIC NUCLEAR MEDICINE** | | |
| 16003 | Intra-cavitary administration of a therapeutic dose of Yttrium 90 (not including preliminary paracentesis and other than a service to which item 35404, 35406 or 35408 applies or a service associated with selective internal radiation therapy) (Anaes.) | $1397.90 |
| 16006 | ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique | $1071.70 |
| 16009 | ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique | $760.20 |
| 16012 | Intravenous administration of a therapeutic dose of Phosphorous 32 | $657.90 |
| 16015 | Administration of Strontium 89 for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan), if systemic antineoplastic therapy is unavailable or has failed to control the patient s disease and either: a) the disease is poorly controlled by conventional radiotherapy; or b) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain. | $8021.10 |
| 16018 | Administration of153 Sm-lexidronam for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan), if systemic antineoplastic therapy is unavailable or has failed to control the patient s disease, and: a) the disease is poorly controlled by conventional radiotherapy; or b) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain. | $4275.70 |
| **GROUP T2—TARGETED INTRAOPERATIVE RADIOTHERAPY** | | |
| **Intraoperative radiotherapy** | | |
| 15900 | BREAST, MALIGNANT TUMOUR, targeted intraoperative radiation therapy, using an Intrabeam or Xoft Axxent 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 Applicable only once per breast per lifetime (H) | $500.70 |
| **GROUP T4—OBSTETRICS** | | |
| 16400 | Antenatal service provided by a practice midwife, nurse or an Aboriginal and Torres Strait Islander health practitioner, applicable 10 times for a pregnancy, if: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the service is provided at, or from, a practice location in a regional, rural or remote area; and (c) the service is not performed in conjunction with another antenatal attendance item in Group T4 for the same patient on the same day by the same practitioner; and (d) the service is not provided for an admitted patient of a hospital or approved day facility | $55.00 |
| 16401 | Professional attendance at consulting rooms or a hospital by a specialist in the practice of the specialist s specialty of obstetrics after referral of the patient to the specialist initial attendance in a single course of treatment | $187.10 |
| 16404 | Professional attendance at consulting rooms or a hospital by a specialist in the practice of the specialist s specialty of obstetrics after referral of the patient to the specialist an attendance after the initial attendance in a single course of treatment | $88.40 |
| 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 Applicable once for a pregnancy | $293.30 |
| 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 | $138.40 |
| 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 | $103.00 |
| 16500 | Antenatal attendance | $100.50 |
| 16501 | External cephalic version for breech presentation, after 36 weeks, if no contraindication exists, in a unit with facilities for caesarean section, including pre and post version CTG, with or without tocolysis, other than 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 ECVs per pregnancy | $283.70 |
| 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 a professional attendance that is not a routine antenatal attendance, applicable once per day | $103.10 |
| 16505 | Threatened abortion, threatened miscarriage or hyperemesis gravidarum, requiring admission to hospital, treatment of an attendance that is not a routine antenatal attendance | $96.80 |
| 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 professional attendance (other than a service to which item 16533 applies) that is not a routine antenatal attendance, applicable once per day | $103.00 |
| 16509 | Pre eclampsia, eclampsia or antepartum haemorrhage, treatment of professional attendance (other than a service to which item 16534 applies) that is not a routine antenatal attendance | $97.00 |
| 16511 | Cervix, purse string ligation of (Anaes.) | $453.70 |
| 16512 | Cervix, removal of purse string ligature of (Anaes.) | $130.70 |
| 16514 | ANTENATAL CARDIOTOCOGRAPHY in the management of high risk pregnancy (not during the course of the confinement) | $74.20 |
| 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.) | $1341.90 |
| 16518 | Management of labour, incomplete, if the patient s care has been transferred to another medical practitioner for completion of the birth (Anaes.) | $1040.80 |
| 16519 | Management of labour and birth by any means (including Caesarean section) including post partum care for 5 days (Anaes.) | $1788.60 |
| 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.) | $1933.50 |
| 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 109/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.) | $3475.80 |
| 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 Applicable once for a pregnancy (Anaes.) | $987.40 |
| 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 Applicable once for a pregnancy (Anaes.) | $1380.80 |
| 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.) | $742.00 |
| 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.) | $1484.10 |
| 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 routine antenatal attendance, to a maximum of 3 services per pregnancy | $203.80 |
| 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 | $203.80 |
| 16564 | 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.) | $448.10 |
| 16567 | MANAGEMENT OF POSTPARTUM HAEMORRHAGE by special measures such as packing of uterus, as an independent procedure (Anaes.) | $658.90 |
| 16570 | ACUTE INVERSION OF THE UTERUS, vaginal correction of, as an independent procedure (Anaes.) | $889.80 |
| 16571 | Cervix, repair of extensive laceration or lacerations (Anaes.) | $656.80 |
| 16573 | THIRD DEGREE TEAR, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.) | $557.70 |
| 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 Applicable once for a pregnancy | $455.00 |
| 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 Applicable once for a pregnancy | $235.00 |
| 16600 | Amniocentesis, diagnostic | $153.00 |
| 16603 | Chorionic villus sampling, by any route | $250.40 |
| 16606 | Fetal blood sampling, using interventional techniques from umbilical cord or fetus, including fetal neuromuscular blockade and amniocentesis (Anaes.) | $491.10 |
| 16609 | Fetal intravascular blood transfusion, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling (Anaes.) | $1001.30 |
| 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.) | $787.70 |
| 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.) | $419.90 |
| 16618 | Amniocentesis, therapeutic, when indicated because of polyhydramnios with at least 500 ml being aspirated | $425.60 |
| 16621 | AMNIOINFUSION, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios | $419.90 |
| 16624 | Fetal fluid filled cavity, drainage of | $603.90 |
| 16627 | Feto amniotic shunt, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis | $1229.30 |
| **GROUP T6—ANAESTHETICS** | | |
| **Anaesthesia consultations** | | |
| 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 | $90.50 |
| 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 | $180.00 |
| 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 | $258.10 |
| 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 | $316.60 |
| 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 | $93.60 |
| 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. | $186.30 |
| 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 | $260.40 |
| 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. | $326.40 |
| 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. | $185.80 |
| 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. | $88.10 |
| **GROUP T7—REGIONAL OR FIELD NERVE BLOCKS** | | |
| 18213 | Intravenous regional anaesthesia of limb by retrograde perfusion of local anaesthetic agent | $181.40 |
| 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.) | $235.70 |
| 18219 | Intrathecal or epidural infusion of a therapeutic substance, initial injection or commencement of, where continuous attendance by the medical practitioner extends beyond the first hour (Anaes.) | $500.10 |
| 18222 | Continuous infusion or injection by catheter of a therapeutic substance (not contrast agent) to maintain regional anaesthesia or analgesia, subsequent injection or revision of, if the period of continuous medical practitioner attendance is 15 minutes or less | $91.10 |
| 18225 | Continuous infusion or injection by catheter of a therapeutic substance (not contrast agent) to maintain regional anaesthesia or analgesia, subsequent injection or revision of, if the period of continuous medical practitioner attendance is more than 15 minutes | $127.50 |
| 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 | $574.50 |
| 18227 | Intrathecal 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. | $754.80 |
| 18228 | Interpleural block, initial injection or commencement of infusion of a therapeutic substance, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach | $155.20 |
| 18230 | Intrathecal or epidural injection of neurolytic substance (not contrast agent) by any route, including transforaminal route (Anaes.) | $491.70 |
| 18232 | Intrathecal or epidural injection (including translaminar and transforaminal approaches) of therapeutic substance or substances (anaesthetic, steroid or chemotherapeutic agents):(a) other than a service to which another item in this Group applies; and (b) not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (Anaes.) | $389.00 |
| 18233 | Epidural injection of blood for blood patch (Anaes.) | $394.10 |
| 18234 | Trigeminal nerve, primary branch (ophthalmic, maxillary or mandibular branches, excluding infraorbital nerve), injection of an anaesthetic agent or steroid, but not in association with a service to which an item in Group T8 applies, unless a targeted percutaneous technique is used (Anaes.) | $268.90 |
| 18236 | Trigeminal nerve, peripheral branch (including infraorbital nerve), injection of an anaesthetic agent, but not in association with a service to which an item in Group T8 applies, unless a targeted percutaneous technique is used (Anaes.) | $128.60 |
| 18238 | Facial nerve, injection of an anaesthetic agent, other than a service associated with a service to which item 18240 applies, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach | $76.60 |
| 18240 | Retrobulbar or peribulbar injection of an anaesthetic agent | $201.30 |
| 18242 | Greater occipital nerve, injection of an anaesthetic agent (Anaes.) | $80.10 |
| 18244 | Vagus nerve, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach | $241.40 |
| 18248 | Phrenic nerve, injection of an anaesthetic agent | $190.30 |
| 18250 | Spinal accessory nerve, injection of an anaesthetic agent | $162.40 |
| 18252 | Cervical plexus, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach | $207.80 |
| 18254 | Brachial plexus, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach | $248.50 |
| 18256 | Suprascapular nerve, injection of an anaesthetic agent | $130.10 |
| 18258 | Intercostal nerve (single), injection of an anaesthetic agent | $129.30 |
| 18260 | Intercostal nerves (multiple), injection of an anaesthetic agent | $185.70 |
| 18262 | Ilio inguinal, iliohypogastric or genitofemoral nerves, one or more of, injections of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (Anaes.) | $163.10 |
| 18264 | Pudendal nerve or dorsal nerve (or both), injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach | $222.90 |
| 18266 | Ulnar, radial or median nerve, main trunk of, one or more of, injections of an anaesthetic agent, not being associated with a brachial plexus block, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach | $144.70 |
| 18268 | Obturator nerve, injection of an anaesthetic agent | $194.30 |
| 18270 | Femoral nerve, injection of an anaesthetic agent | $319.80 |
| 18272 | SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent | $183.30 |
| 18276 | Paravertebral nerves, injection of an anaesthetic agent, (multiple levels) | $273.90 |
| 18278 | Sciatic nerve, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach | $192.30 |
| 18280 | Sphenopalatine ganglion, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (Anaes.) | $258.10 |
| 18282 | CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure | $292.90 |
| 18284 | Cervical or thoracic sympathetic chain, injection of an anaesthetic agent (Anaes.) | $321.70 |
| 18286 | Lumbar or pelvic sympathetic chain, injection of an anaesthetic agent (Anaes.) | $321.70 |
| 18288 | Coeliac plexus or splanchnic nerves, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (Anaes.) | $316.30 |
| 18290 | Cranial nerve other than trigeminal, destruction by a neurolytic agent under image guidance, other than a service associated with the injection of botulinum toxin (Anaes.) | $506.90 |
| 18292 | Nerve branch, destruction by a neurolytic agent under image guidance, other than a service to which another item in this Group applies or a service associated with the injection of botulinum toxin except a service to which item 18354 applies (Anaes.) | $269.40 |
| 18294 | Coeliac plexus or splanchnic nerves, destruction by a neurolytic agent under image guidance (Anaes.) | $363.10 |
| 18296 | Lumbar or pelvic sympathetic chain, destruction by a neurolytic agent under image guidance (Anaes.) | $318.00 |
| 18297 | Assistance at the administration of an epidural blood patch (a service to which item 18233 applies) by another medical practitioner | $113.90 |
| 18298 | CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.) | $357.00 |
| **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 | $255.00 |
| 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 | $258.20 |
| 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 | $506.90 |
| 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 of 2 sets of injections for each lower limb), including all injections per set (Anaes.) | $257.60 |
| 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 | $253.40 |
| 18361 | Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or 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) 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.) | $273.50 |
| 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.) | $544.70 |
| 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 an acute event, 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 | $254.40 |
| 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.) | $333.30 |
| 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 | $541.90 |
| 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.) | $92.00 |
| 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.) | $92.40 |
| 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.) | $252.00 |
| 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.) | $252.00 |
| 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.) | $485.50 |
| 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) | $263.60 |
| 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.) | $470.90 |
| **GROUP T10—RELATIVE VALUE GUIDE FOR ANAESTHESIA—WORKCOVER BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE** | | |
| **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) | $264.50 |
| 20102 | INITIATION OF MANAGEMENT OF ANAESTHESIA for plastic repair of cleft lip (6 basic units) | $317.40 |
| 20104 | INITIATION OF MANAGEMENT OF ANAESTHESIA for electroconvulsive therapy (4 basic units) | $211.60 |
| 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) | $264.50 |
| 20124 | INITIATION OF MANAGEMENT OF ANAESTHESIA for otoscopy (4 basic units) | $211.60 |
| 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) | $264.50 |
| 20142 | INITIATION OF MANAGEMENT OF ANAESTHESIA for lens surgery (5 basic units) | $317.40 |
| 20143 | INITIATION OF MANAGEMENT OF ANAESTHESIA for retinal surgery (6 basic units) | $317.40 |
| 20144 | INITIATION OF MANAGEMENT OF ANAESTHESIA for corneal transplant (7 basic units) | $423.20 |
| 20145 | INITIATION OF MANAGEMENT OF ANAESTHESIA for vitrectomy (7 basic units) | $423.20 |
| 20146 | INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of conjunctiva (5 basic units) | $264.50 |
| 20147 | INITIATION OF MANAGEMENT OF ANAESTHESIA for squint repair (6 basic units) | $317.40 |
| 20148 | INITIATION OF MANAGEMENT OF ANAESTHESIA for ophthalmoscopy (4 basic units) | $211.60 |
| 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) | $317.40 |
| 20162 | Initiation of the management of anaesthesia for intranasal surgery for malignancy or for intranasal ablation (7 basic units) | $370.30 |
| 20164 | INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of soft tissue of the nose and accessory sinuses (4 basic units) | $211.60 |
| 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) | $317.40 |
| 20172 | INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of cleft palate (7 basic units) | $370.30 |
| 20174 | INITIATION OF MANAGEMENT OF ANAESTHESIA for excision of retropharyngeal tumour (9 basic units) | $476.10 |
| 20176 | INITIATION OF MANAGEMENT OF ANAESTHESIA for radical intraoral surgery (10 basic units) | $529.00 |
| 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) | $264.50 |
| 20192 | INITIATION OF MANAGEMENT OF ANAESTHESIA for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction) (10 basic units) | $529.00 |
| 20210 | INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial procedures, not being a service to which another item in this Subgroup applies (15 basic units) | $793.50 |
| 20212 | INITIATION OF MANAGEMENT OF ANAESTHESIA for subdural taps (5 basic units) | $264.50 |
| 20214 | INITIATION OF MANAGEMENT OF ANAESTHESIA for burr holes of the cranium (9 basic units) | $476.10 |
| 20216 | INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial vascular procedures including those for aneurysms or arterio-venous abnormalities (20 basic units) | $1058.00 |
| 20220 | INITIATION OF MANAGEMENT OF ANAESTHESIA for spinal fluid shunt procedures (10 basic units) | $529.00 |
| 20222 | INITIATION OF MANAGEMENT OF ANAESTHESIA for ablation of an intracranial nerve (6 basic units) | $317.40 |
| 20225 | INITIATION OF MANAGEMENT OF ANAESTHESIA for all cranial bone procedures (12 basic units) | $634.80 |
| 20230 | INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the head or face (12 basic units) | $634.80 |
| **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) | $264.50 |
| 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) | $793.50 |
| 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) | $317.40 |
| 20321 | INITIATION OF MANAGEMENT OF ANAESTHESIA for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy (10 basic units) | $529.00 |
| 20330 | INITIATION OF MANAGEMENT OF ANAESTHESIA for laser surgery to the airway (excluding nose and mouth) (8 basic units) | $423.20 |
| 20350 | INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major vessels of neck, not being a service to which another item in this Subgroup applies (10 basic units) | $529.00 |
| 20352 | INITIATION OF MANAGEMENT OF ANAESTHESIA for simple ligation of major vessels of neck (5 basic units) | $264.50 |
| 20355 | INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the neck (12 basic units) | $634.80 |
| **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) | $158.70 |
| 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) | $211.60 |
| 20402 | Initiation of management of anaesthesia for reconstructive procedures on breast including implant reconstruction and exchange (5 basic units) | $264.50 |
| 20403 | Initiation of management of anaesthesia for axillary dissection or sentinel node biopsy (5 basic units) | $264.50 |
| 20404 | INITIATION OF MANAGEMENT OF ANAESTHESIA for mastectomy (6 basic units) | $317.40 |
| 20405 | INITIATION OF MANAGEMENT OF ANAESTHESIA for reconstructive procedures on the breast using myocutaneous flaps (8 basic units) | $423.20 |
| 20406 | INITIATION OF MANAGEMENT OF ANAESTHESIA for radical or modified radical procedures on breast with internal mammary node dissection (13 basic units) | $687.70 |
| 20410 | INITIATION OF MANAGEMENT OF ANAESTHESIA for electrical conversion of arrhythmias (4 basic units) | $264.50 |
| 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) | $264.50 |
| 20440 | INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the sternum (4 basic units) | $211.60 |
| 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) | $264.50 |
| 20452 | INITIATION OF MANAGEMENT OF ANAESTHESIA for radical surgery on clavicle, scapula or sternum (6 basic units) | $317.40 |
| 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) | $317.40 |
| 20472 | INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracoplasty (10 basic units) | $529.00 |
| 20474 | INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures on chest wall (13 basic units) | $687.70 |
| 20475 | INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior thorax (10 basic units) | $529.00 |
| **Intrathoracic** | | |
| 20500 | INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the oesophagus (15 basic units) | $793.50 |
| 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) | $317.40 |
| 20522 | INITIATION OF MANAGEMENT OF ANAESTHESIA for needle biopsy of pleura (4 basic units) | $211.60 |
| 20524 | INITIATION OF MANAGEMENT OF ANAESTHESIA for pneumocentesis (4 basic units) | $211.60 |
| 20526 | INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracoscopy (10 basic units) | $529.00 |
| 20528 | INITIATION OF MANAGEMENT OF ANAESTHESIA for mediastinoscopy (8 basic units) | $423.20 |
| 20540 | INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracotomy procedures involving lungs, pleura, diaphragm, or mediastinum, not being a service to which another item in this Subgroup applies (13 basic units) | $687.70 |
| 20542 | INITIATION OF MANAGEMENT OF ANAESTHESIA for pulmonary decortication (15 basic units) | $793.50 |
| 20546 | INITIATION OF MANAGEMENT OF ANAESTHESIA for pulmonary resection with thoracoplasty (15 basic units) | $793.50 |
| 20548 | INITIATION OF MANAGEMENT OF ANAESTHESIA for intrathoracic repair of trauma to trachea and bronchi (15 basic units) | $793.50 |
| 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) | $1058.00 |
| **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) | $529.00 |
| 20604 | INITIATION OF MANAGEMENT OF ANAESTHESIA for posterior cervical laminectomy with the patient in the sitting position (13 basic units) | $687.70 |
| 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) | $529.00 |
| 20622 | INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracolumbar sympathectomy (13 basic units) | $687.70 |
| 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) | $423.20 |
| 20632 | INITIATION OF MANAGEMENT OF ANAESTHESIA for lumbar sympathectomy (7 basic units) | $370.30 |
| 20634 | INITIATION OF MANAGEMENT OF ANAESTHESIA for chemonucleolysis (10 basic units) | $529.00 |
| 20670 | INITIATION OF MANAGEMENT OF ANAESTHESIA for extensive spine and/or spinal cord procedures (13 basic units) | $687.70 |
| 20680 | INITIATION OF MANAGEMENT OF ANAESTHESIA for manipulation of spine when performed in the operating theatre of a hospital (3 basic units) | $158.70 |
| 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) | $264.50 |
| **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) | $158.70 |
| 20702 | INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units) | $211.60 |
| 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) | $211.60 |
| 20704 | INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior upper abdomen (10 basic units) | $529.00 |
| 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) | $370.30 |
| 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) | $264.50 |
| 20740 | INITIATION OF MANAGEMENT OF ANAESTHESIA for upper gastrointestinal endoscopic procedures (5 basic units) | $264.50 |
| 20745 | Initiation of the management of anaesthesia for any of the following:(a) upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage;(b) endoscopic retrograde cholangiopancreatography;(c) upper gastrointestinal endoscopic ultrasound;(d) percutaneous endoscopic gastrostomy;(e) upper gastrointestinal endoscopic mucosal resection of tumour. (7 basic units) | $317.40 |
| 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) | $211.60 |
| 20752 | INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional hernia and/or wound dehiscence (6 basic units) | $317.40 |
| 20754 | INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on an omphalocele (7 basic units) | $370.30 |
| 20756 | INITIATION OF MANAGEMENT OF ANAESTHESIA for transabdominal repair of diaphragmatic hernia (9 basic units) | $476.10 |
| 20770 | INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major upper abdominal blood vessels (15 basic units) | $793.50 |
| 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) | $423.20 |
| 20791 | Initiation of the management of anaesthesia for bariatric surgery in a patient with clinically severe obesity (10 basic units) | $529.00 |
| 20792 | INITIATION OF MANAGEMENT OF ANAESTHESIA for partial hepatectomy (excluding liver biopsy) (13 basic units) | $687.70 |
| 20793 | INITIATION OF MANAGEMENT OF ANAESTHESIA for extended or trisegmental hepatectomy (15 basic units) | $793.50 |
| 20794 | INITIATION OF MANAGEMENT OF ANAESTHESIA for pancreatectomy, partial or total (12 basic units) | $634.80 |
| 20798 | INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the upper abdomen (10 basic units) | $529.00 |
| 20799 | INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra-abdominal organ in the upper abdomen (6 basic units) | $317.40 |
| **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) | $158.70 |
| 20802 | INITIATION OF MANAGEMENT OF ANAESTHESIA for lipectomy of the lower abdomen (5 basic units) | $264.50 |
| 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) | $211.60 |
| 20804 | INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen (10 basic units) | $529.00 |
| 20806 | INITIATION OF MANAGEMENT OF ANAESTHESIA for laparoscopic procedures in the lower abdomen (7 basic units) | $370.30 |
| 20810 | INITIATION OF MANAGEMENT OF ANAESTHESIA for lowerintestinal endoscopic procedures (4 basic units) | $211.60 |
| 20815 | INITIATION OF MANAGEMENT OF ANAESTHESIA for extracorporeal shock wave lithotripsy to urinary tract (6 basic units) | $317.40 |
| 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) | $264.50 |
| 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) | $211.60 |
| 20832 | INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional herniae and/or wound dehiscence of the lower abdomen (6 basic units) | $317.40 |
| 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) | $317.40 |
| 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) | $423.20 |
| 20842 | INITIATION OF MANAGEMENT OF ANAESTHESIA for amniocentesis (4 basic units) | $211.60 |
| 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) | $529.00 |
| 20845 | INITIATION OF MANAGEMENT OF ANAESTHESIA for radical prostatectomy (10 basic units) | $529.00 |
| 20846 | INITIATION OF MANAGEMENT OF ANAESTHESIA for radical hysterectomy (10 basic units) | $529.00 |
| 20847 | INITIATION OF MANAGEMENT OF ANAESTHESIA for ovarian malignancy (10 basic units) | $529.00 |
| 20848 | INITIATION OF MANAGEMENT OF ANAESTHESIA for pelvic exenteration (10 basic units) | $529.00 |
| 20850 | INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean section (12 basic units) | $634.80 |
| 20855 | INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean hysterectomy or hysterectomy within 24 hours of birth (15 basic units) | $793.50 |
| 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) | $317.40 |
| 20862 | INITIATION OF MANAGEMENT OF ANAESTHESIA for renal procedures, including upper 1/3 of ureter (7 basic units) | $370.30 |
| 20863 | INITIATION OF MANAGEMENT OF ANAESTHESIA for nephrectomy (10 basic units) | $529.00 |
| 20864 | INITIATION OF MANAGEMENT OF ANAESTHESIA for total cystectomy (10 basic units) | $529.00 |
| 20866 | INITIATION OF MANAGEMENT OF ANAESTHESIA for adrenalectomy (10 basic units) | $529.00 |
| 20867 | INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the lower abdomen (10 basic units) | $529.00 |
| 20868 | INITIATION OF MANAGEMENT OF ANAESTHESIA for renal transplantation (donor or recipient) (10 basic units) | $529.00 |
| 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) | $793.50 |
| 20882 | INITIATION OF MANAGEMENT OF ANAESTHESIA for inferior vena cava ligation (10 basic units) | $529.00 |
| 20884 | INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous umbrella insertion (5 basic units) | $264.50 |
| 20886 | INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra-abdominal organ in the lower abdomen (6 basic units) | $317.40 |
| **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) | $158.70 |
| 20902 | Initiation of the management of anaesthesia for anorectal procedures (including surgical haemorrhoidectomy, but not banding of haemorrhoids) (4 basic units) | $211.60 |
| 20904 | INITIATION OF MANAGEMENT OF ANAESTHESIA for radical perineal procedures including radical perineal prostatectomy or radical vulvectomy (7 basic units) | $370.30 |
| 20905 | INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the perineum (10 basic units) | $529.00 |
| 20906 | INITIATION OF MANAGEMENT OF ANAESTHESIA for vulvectomy (4 basic units) | $211.60 |
| 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) | $211.60 |
| 20911 | INITIATION OF MANAGEMENT OF ANAESTHESIA for endoscopic ureteroscopic surgery including laser procedures (5 basic units) | $264.50 |
| 20912 | INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral resection of bladder tumour(s) (5 basic units) | $264.50 |
| 20914 | INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral resection of prostate (7 basic units) | $370.30 |
| 20916 | INITIATION OF MANAGEMENT OF ANAESTHESIA for bleeding post-transurethral resection (7 basic units) | $370.30 |
| 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) | $211.60 |
| 20924 | INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on undescended testis, unilateral or bilateral (4 basic units) | $211.60 |
| 20926 | INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, inguinal approach (4 basic units) | $211.60 |
| 20928 | INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, abdominal approach (6 basic units) | $317.40 |
| 20930 | INITIATION OF MANAGEMENT OF ANAESTHESIA for orchiopexy, unilateral or bilateral (4 basic units) | $211.60 |
| 20932 | INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis (4 basic units) | $211.60 |
| 20934 | INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal lymphadenectomy (6 basic units) | $317.40 |
| 20936 | INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy (8 basic units) | $423.20 |
| 20938 | INITIATION OF MANAGEMENT OF ANAESTHESIA for insertion of penile prosthesis (4 basic units) | $211.60 |
| 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) | $211.60 |
| 20942 | INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal procedures including repair operations and urinary incontinence procedures (perineal) (5 basic units) | $264.50 |
| 20943 | INITIATION OF MANAGEMENT OF ANAESTHESIA for transvaginal assisted reproductive services (4 basic units) | $211.60 |
| 20944 | INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal hysterectomy (6 basic units) | $317.40 |
| 20946 | INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal birth (8 basic units) | $423.20 |
| 20948 | INITIATION OF MANAGEMENT OF ANAESTHESIA for purse string ligation of cervix, or removal of purse string ligature (4 basic units) | $211.60 |
| 20950 | INITIATION OF MANAGEMENT OF ANAESTHESIA for culdoscopy (5 basic units) | $264.50 |
| 20952 | INITIATION OF MANAGEMENT OF ANAESTHESIA for hysteroscopy (4 basic units) | $211.60 |
| 20954 | INITIATION OF MANAGEMENT OF ANAESTHESIA for correction of inverted uterus (10 basic units) | $529.00 |
| 20956 | INITIATION OF MANAGEMENT OF ANAESTHESIA for evacuation of retained products of conception, as a complication of confinement (4 basic units) | $211.60 |
| 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) | $264.50 |
| 20960 | INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of post partum haemorrhage (blood loss &gt; 500mls) (7 basic units) | $370.30 |
| **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) | $158.70 |
| 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) | $264.50 |
| 21112 | INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units) | $211.60 |
| 21114 | INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units) | $264.50 |
| 21116 | INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow harvesting from the pelvis (6 basic units) | $317.40 |
| 21120 | INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the bony pelvis (6 basic units) | $317.40 |
| 21130 | INITIATION OF MANAGEMENT OF ANAESTHESIA for body cast application or revision when performed in the operating theatre of a hospital (3 basic units) | $158.70 |
| 21140 | INITIATION OF MANAGEMENT OF ANAESTHESIA for interpelviabdominal (hind-quarter) amputation (15 basic units) | $793.50 |
| 21150 | INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures for tumour of the pelvis, except hind-quarter amputation (10 basic units) | $529.00 |
| 21155 | INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior pelvis (10 basic units) | $529.00 |
| 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) | $211.60 |
| 21170 | INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving symphysis pubis or sacroiliac joint (8 basic units) | $423.20 |
| **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) | $158.70 |
| 21199 | INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg (4 basic units) | $211.60 |
| 21200 | INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving hip joint when performed in the operating theatre of a hospital (4 basic units) | $211.60 |
| 21202 | INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the hip joint (4 basic units) | $211.60 |
| 21210 | INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving hip joint, not being a service to which another item in this Subgroup applies (6 basic units) | $317.40 |
| 21212 | INITIATION OF MANAGEMENT OF ANAESTHESIA for hip disarticulation (10 basic units) | $529.00 |
| 21214 | Initiation of management of anaesthesia for primary total hip replacement. (10 basic units) | $529.00 |
| 21215 | Initiation of management of anaesthesia for revision total hip replacement (15 basic units) | $546.40 |
| 21216 | INITIATION OF MANAGEMENT OF ANAESTHESIA for bilateral total hip replacement (14 basic units) | $740.60 |
| 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) | $211.60 |
| 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) | $317.40 |
| 21232 | INITIATION OF MANAGEMENT OF ANAESTHESIA for above knee amputation (5 basic units) | $264.50 |
| 21234 | INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection of the upper 2/3 of femur (8 basic units) | $423.20 |
| 21260 | INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures involving veins of upper leg, including exploration (4 basic units) | $211.60 |
| 21270 | INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures involving arteries of upper leg, including bypass graft, not being a service to which another item in this Subgroup applies (8 basic units) | $423.20 |
| 21272 | INITIATION OF MANAGEMENT OF ANAESTHESIA for femoral artery ligation (4 basic units) | $211.60 |
| 21274 | INITIATION OF MANAGEMENT OF ANAESTHESIA for femoral artery embolectomy (6 basic units) | $317.40 |
| 21275 | INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the upper leg (10 basic units) | $529.00 |
| 21280 | INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper leg (15 basic units) | $793.50 |
| **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) | $158.70 |
| 21321 | INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of knee and/or popliteal area (4 basic units) | $211.60 |
| 21340 | INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on lower 1/3 of femur when performed in the operating theatre of a hospital (4 basic units) | $211.60 |
| 21360 | INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on lower 1/3 of femur (5 basic units) | $264.50 |
| 21380 | INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on knee joint when performed in the operating theatre of a hospital (3 basic units) | $158.70 |
| 21382 | INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of knee joint (4 basic units) | $211.60 |
| 21390 | INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on upper ends of tibia, fibula, and/or patella when performed in the operating theatre of a hospital (3 basic units) | $158.70 |
| 21392 | INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on upper ends of tibia, fibula, and/or patella (4 basic units) | $211.60 |
| 21400 | INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on knee joint, not being a service to which another item in this Subgroup applies (4 basic units) | $211.60 |
| 21402 | INITIATION OF MANAGEMENT OF ANAESTHESIA for knee replacement (7 basic units) | $370.30 |
| 21403 | INITIATION OF MANAGEMENT OF ANAESTHESIA for bilateral knee replacement (10 basic units) | $529.00 |
| 21404 | INITIATION OF MANAGEMENT OF ANAESTHESIA for disarticulation of knee (5 basic units) | $264.50 |
| 21420 | INITIATION OF MANAGEMENT OF ANAESTHESIA for cast application, removal, or repair involving knee joint, undertaken in a hospital (3 basic units) | $158.70 |
| 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) | $211.60 |
| 21432 | INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of arteriovenous fistula of knee or popliteal area (5 basic units) | $264.50 |
| 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) | $423.20 |
| 21445 | INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the knee and/or popliteal area (10 basic units) | $529.00 |
| **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) | $158.70 |
| 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) | $211.60 |
| 21462 | INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on lower leg, ankle, or foot (3 basic units) | $158.70 |
| 21464 | INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedure of ankle joint (4 basic units) | $211.60 |
| 21472 | INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of Achilles tendon (5 basic units) | $264.50 |
| 21474 | INITIATION OF MANAGEMENT OF ANAESTHESIA for gastrocnemius recession (5 basic units) | $264.50 |
| 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) | $211.60 |
| 21482 | INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection of bone involving lower leg, ankle or foot (5 basic units) | $264.50 |
| 21484 | INITIATION OF MANAGEMENT OF ANAESTHESIA for osteotomy or osteoplasty of tibia or fibula (5 basic units) | $264.50 |
| 21486 | INITIATION OF MANAGEMENT OF ANAESTHESIA for total ankle replacement (7 basic units) | $370.30 |
| 21490 | INITIATION OF MANAGEMENT OF ANAESTHESIA for lower leg cast application, removal or repair, undertaken in a hospital (3 basic units) | $158.70 |
| 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) | $423.20 |
| 21502 | INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of the lower leg (6 basic units) | $317.40 |
| 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) | $211.60 |
| 21522 | INITIATION OF MANAGEMENT OF ANAESTHESIA for venous thrombectomy of the lower leg (5 basic units) | $264.50 |
| 21530 | INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of lower leg, ankle or foot (15 basic units) | $793.50 |
| 21532 | INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of toe (8 basic units) | $423.20 |
| 21535 | INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the lower leg (10 basic units) | $529.00 |
| **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) | $158.70 |
| 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) | $264.50 |
| 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) | $211.60 |
| 21622 | INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of shoulder joint (5 basic units) | $264.50 |
| 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) | $264.50 |
| 21632 | INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection involving humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint (6 basic units) | $317.40 |
| 21634 | INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder disarticulation (9 basic units) | $476.10 |
| 21636 | INITIATION OF MANAGEMENT OF ANAESTHESIA for interthoracoscapular (forequarter) amputation (15 basic units) | $793.50 |
| 21638 | INITIATION OF MANAGEMENT OF ANAESTHESIA for total shoulder replacement (10 basic units) | $529.00 |
| 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) | $423.20 |
| 21652 | INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures for axillary-brachial aneurysm (10 basic units) | $529.00 |
| 21654 | INITIATION OF MANAGEMENT OF ANAESTHESIA for bypass graft of arteries of shoulder or axilla (8 basic units) | $423.20 |
| 21656 | INITIATION OF MANAGEMENT OF ANAESTHESIA for axillary-femoral bypass graft (10 basic units) | $529.00 |
| 21670 | INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of shoulder or axilla (4 basic units) | $211.60 |
| 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) | $158.70 |
| 21682 | INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder spica application when undertaken in a hospital (4 basic units) | $211.60 |
| 21685 | INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the shoulder or the axilla (10 basic units) | $529.00 |
| **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) | $158.70 |
| 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) | $211.60 |
| 21712 | INITIATION OF MANAGEMENT OF ANAESTHESIA for open tenotomy of the upper arm or elbow (5 basic units) | $264.50 |
| 21714 | INITIATION OF MANAGEMENT OF ANAESTHESIA for tenoplasty of the upper arm or elbow (5 basic units) | $264.50 |
| 21716 | INITIATION OF MANAGEMENT OF ANAESTHESIA for tenodesis for rupture of long tendon of biceps (5 basic units) | $264.50 |
| 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) | $158.70 |
| 21732 | INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of elbow joint (4 basic units) | $211.60 |
| 21740 | INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the upper arm or elbow, not being a service to which another item in this Subgroup applies (5 basic units) | $264.50 |
| 21756 | INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures on the upper arm or elbow (6 basic units) | $317.40 |
| 21760 | INITIATION OF MANAGEMENT OF ANAESTHESIA for total elbow replacement (7 basic units) | $370.30 |
| 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) | $423.20 |
| 21772 | INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of arteries of the upper arm (6 basic units) | $317.40 |
| 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) | $211.60 |
| 21785 | INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the upper arm or elbow (10 basic units) | $529.00 |
| 21790 | INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper arm (15 basic units) | $793.50 |
| **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) | $158.70 |
| 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) | $211.60 |
| 21820 | INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on the radius, ulna, wrist, or hand bones when performed in the operating theatre of a hospital (3 basic units) | $158.70 |
| 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) | $211.60 |
| 21832 | INITIATION OF MANAGEMENT OF ANAESTHESIA for total wrist replacement (7 basic units) | $370.30 |
| 21834 | INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the wrist joint (4 basic units) | $211.60 |
| 21840 | INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the arteries of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (8 basic units) | $423.20 |
| 21842 | INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of artery of forearm, wrist or hand (6 basic units) | $317.40 |
| 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) | $211.60 |
| 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) | $158.70 |
| 21865 | INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the forearm, wrist or hand (10 basic units) | $529.00 |
| 21870 | INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of forearm, wrist or hand (15 basic units) | $793.50 |
| 21872 | INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of a finger (8 basic units) | $423.20 |
| **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) | $158.70 |
| 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) | $264.50 |
| 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) | $370.30 |
| 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) | $476.10 |
| 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) | $581.90 |
| 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) | $687.70 |
| 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) | $793.50 |
| 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) | $899.30 |
| 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) | $1005.10 |
| 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) | $1110.90 |
| **Anaesthesia for radiological or other diagnostic or therapeutic procedures** | | |
| 21900 | INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for hysterosalpingography (3 basic units) | $158.70 |
| 21906 | INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: lumbar or thoracic (5 basic units) | $264.50 |
| 21908 | INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: cervical (6 basic units) | $317.40 |
| 21910 | INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: posterior fossa (9 basic units) | $476.10 |
| 21912 | INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography: lumbar or thoracic (5 basic units) | $264.50 |
| 21914 | INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography: cervical (6 basic units) | $317.40 |
| 21915 | INITIATION OF MANAGEMENT OF ANAESTHESIA for peripheral arteriogram (5 basic units) | $264.50 |
| 21916 | INITIATION OF MANAGEMENT OF ANAESTHESIA for arteriograms: cerebral, carotid or vertebral (5 basic units) | $264.50 |
| 21918 | INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde arteriogram: brachial or femoral (5 basic units) | $264.50 |
| 21922 | INITIATION OF MANAGEMENT OF ANAESTHESIA for computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning (6 basic units) | $370.30 |
| 21925 | INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde cystography, retrograde urethrography or retrograde cystourethrography (4 basic units) | $211.60 |
| 21926 | INITIATION OF MANAGEMENT OF ANAESTHESIA for fluoroscopy (4 basic units) | $264.50 |
| 21930 | INITIATION OF MANAGEMENT OF ANAESTHESIA for bronchography (6 basic units) | $317.40 |
| 21935 | INITIATION OF MANAGEMENT OF ANAESTHESIA for phlebography (5 basic units) | $264.50 |
| 21936 | INITIATION OF MANAGEMENT OF ANAESTHESIA for heart, 2 dimensional real time transoesophageal examination (5 basic units) | $317.40 |
| 21939 | INITIATION OF MANAGEMENT OF ANAESTHESIA for peripheral venous cannulation (3 basic units) | $158.70 |
| 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) | $370.30 |
| 21942 | INITIATION OF MANAGEMENT OF ANAESTHESIA for cardiac electrophysiological procedures including radio frequency ablation (10 basic units) | $529.00 |
| 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) | $264.50 |
| 21945 | INITIATION OF MANAGEMENT OF ANAESTHESIA for lumbar puncture, cisternal puncture, or epidural injection (5 basic units) | $264.50 |
| 21949 | INITIATION OF MANAGEMENT OF ANAESTHESIA for harvesting of bone marrow for the purpose of transplantation (5 basic units) | $264.50 |
| 21952 | Initiation of the management of anaesthesia for diagnostic muscle biopsy to assess for malignant hyperpyrexia (4 basic units) | $529.00 |
| 21955 | INITIATION OF MANAGEMENT OF ANAESTHESIA for electroencephalography (5 basic units) | $264.50 |
| 21959 | INITIATION OF MANAGEMENT OF ANAESTHESIA for brain stem evoked response audiometry (5 basic units) | $264.50 |
| 21962 | INITIATION OF MANAGEMENT OF ANAESTHESIA for electrocochleography by extratympanic method or transtympanic membrane insertion method (5 basic units) | $264.50 |
| 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) | $264.50 |
| 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) | $423.20 |
| 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) | $793.50 |
| 21973 | INITIATION OF MANAGEMENT OF ANAESTHESIA for brachytherapy using radioactive sealed sources (5 basic units) | $264.50 |
| 21976 | INITIATION OF MANAGEMENT OF ANAESTHESIA for therapeutic nuclear medicine (5 basic units) | $264.50 |
| 21980 | INITIATION OF MANAGEMENT OF ANAESTHESIA for radiotherapy (5 basic units) | $264.50 |
| **Miscellaneous** | | |
| 21990 | INITIATION OF MANAGEMENT OF ANAESTHESIA when no procedure ensues (3 basic units) | $158.70 |
| 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) | $211.60 |
| 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) | $211.60 |
| **Therapeutic and diagnostic services** | | |
| 22002 | Administration of homologous blood or bone marrow already collected, when performed in association with the management of anaesthesia (4 basic units) | $211.60 |
| 22007 | ENDOTRACHEAL INTUBATION with flexible fibreoptic scope associated with difficult airway when performed in association with the administration of anaesthesia (4 basic units) | $211.60 |
| 22008 | DOUBLE LUMEN ENDOBRONCHIAL TUBE OR BRONCHIAL BLOCKER, insertion of when performed in association with the administration of anaesthesia (4 basic units) | $211.60 |
| 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) | $158.70 |
| 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) | $158.70 |
| 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) | $317.40 |
| 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) | $211.60 |
| 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) | $211.60 |
| 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) | $264.50 |
| 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) | $158.70 |
| 22041 | Perioperative introduction of a plexus or nerve block proximal to the lower leg or forearm for post operative pain management (2 basic units) | $105.80 |
| 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) | $52.90 |
| 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) | $476.10 |
| 22052 | Transfusion of blood by an anaesthetist, including collection from donor, when used for intra-operative normovolaemic haemodilution, where the service is provided on the same occasion as the administration of anaesthesia by the same anaesthetist, other than a service associated with a service to which item 13703 applies (6 basic units) | $196.20 |
| 22053 | Insertion of lumbar cerebrospinal fluid drain, by an anaesthetist at the request of the treating specialist, where the service is provided on the same occasion as the administration of anaesthesia by the same anaesthetist, other than a service associated with a service to which item 40018 applies (6 basic units) | $196.20 |
| 22054 | Intraoperative two-dimensional or three-dimensional real time transoesophageal echocardiography by an anaesthetist, where the service: (a) is provided on the same day as a service to which item 38477, 38484, 38499, 38516 or 38517 applies; and (b) includes Doppler techniques with colour flow mapping and recordings on digital media; and (c) is performed during cardiac valve surgery (replacement or repair); and (d) incorporates sequential assessment of cardiac function and valve competence before and after the surgical procedure; and (e) is not associated with a service to which item 21936, 22051, 55118, 55130 or 55135 applies; and (f) is provided on the same occasion as the administration of anaesthesia by the same anaesthetist (18 basic units) | $588.60 |
| 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) | $634.80 |
| 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 (Anaes.) (30 basic units) | $1298.30 |
| 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) | $264.50 |
| 22075 | DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22&#176;c, including 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) | $793.50 |
| **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) | $317.40 |
| 22905 | INITIATION OF MANAGEMENT OF ANAESTHESIA for restorative dental work (6 basic units) | $317.40 |
| **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) | $52.90 |
| 23025 | 16 MINUTES TO 30 MINUTES (2 basic units) | $105.80 |
| 23035 | 31 MINUTES to 45 MINUTES (3 basic units) | $158.70 |
| 23045 | 46 MINUTES to 1:00 HOUR (4 basic units) | $211.60 |
| 23055 | 1:01 HOURS to 1:15 HOURS (5 basic units) | $264.50 |
| 23065 | 1:16 HOURS to 1:30 HOURS (6 basic units) | $317.40 |
| 23075 | 1:31 HOURS to 1:45 HOURS (7 basic units) | $370.30 |
| 23085 | 1:46 HOURS to 2:00 HOURS (8 basic units) | $423.20 |
| 23091 | 2:01 HOURS TO 2:10 HOURS (9 basic units) | $476.10 |
| 23101 | 2:11 HOURS TO 2:20 HOURS (10 basic units) | $529.00 |
| 23111 | 2:21 HOURS TO 2:30 HOURS (11 basic units) | $581.90 |
| 23112 | 2:31 HOURS TO 2:40 HOURS (12 basic units) | $634.80 |
| 23113 | 2:41 HOURS TO 2:50 HOURS (13 basic units) | $687.70 |
| 23114 | 2:51 HOURS TO 3:00 HOURS (14 basic units) | $740.60 |
| 23115 | 3:01 HOURS TO 3:10 HOURS (15 basic units) | $793.50 |
| 23116 | 3:11 HOURS TO 3:20 HOURS (16 basic units) | $846.40 |
| 23117 | 3:21 HOURS TO 3:30 HOURS (17 basic units) | $899.30 |
| 23118 | 3:31 HOURS TO 3:40 HOURS (18 basic units) | $952.20 |
| 23119 | 3:41 HOURS TO 3:50 HOURS (19 basic units) | $1005.10 |
| 23121 | 3:51 HOURS TO 4:00 HOURS (20 basic units) | $1058.00 |
| 23170 | 4:01 HOURS TO 4:10 HOURS (21 basic units) | $1110.90 |
| 23180 | 4:11 HOURS TO 4:20 HOURS (22 basic units) | $1163.80 |
| 23190 | 4:21 HOURS TO 4:30 HOURS (23 basic units) | $1216.70 |
| 23200 | 4:31 HOURS TO 4:40 HOURS (24 basic units) | $1269.60 |
| 23210 | 4:41 HOURS TO 4:50 HOURS (25 basic units) | $1322.50 |
| 23220 | 4:51 HOURS TO 5:00 HOURS (26 basic units) | $1375.40 |
| 23230 | 5:01 HOURS TO 5:10 HOURS (27 basic units) | $1428.30 |
| 23240 | 5:11 HOURS TO 5:20 HOURS (28 basic units) | $1481.20 |
| 23250 | 5:21 HOURS TO 5:30 HOURS (29 basic units) | $1534.10 |
| 23260 | 5:31 HOURS TO 5:40 HOURS (30 basic units) | $1587.00 |
| 23270 | 5:41 HOURS TO 5:50 HOURS (31 basic units) | $1639.90 |
| 23280 | (5:51 HOURS TO 6:00 HOURS (32 basic units) | $1692.80 |
| 23290 | 6:01 HOURS TO 6:10 HOURS (33 basic units) | $1745.70 |
| 23300 | 6:11 HOURS TO 6:20 HOURS (34 basic units) | $1798.60 |
| 23310 | 6:21 HOURS TO 6:30 HOURS (35 basic units) | $1851.50 |
| 23320 | 6:31 HOURS TO 6:40 HOURS (36 basic units) | $1904.40 |
| 23330 | 6:41 HOURS TO 6:50 HOURS (37 basic units) | $1957.30 |
| 23340 | 6:51 HOURS TO 7:00 HOURS (38 basic units) | $2010.20 |
| 23350 | 7:01 HOURS TO 7:10 HOURS (39 basic units) | $2063.10 |
| 23360 | 7:11 HOURS TO 7:20 HOURS (40 basic units) | $2116.00 |
| 23370 | 7:21 HOURS TO 7:30 HOURS (41 basic units) | $2168.90 |
| 23380 | 7:31 HOURS TO 7:40 HOURS (42 basic units) | $2221.80 |
| 23390 | 7:41 HOURS TO 7:50 HOURS (43 basic units) | $2274.70 |
| 23400 | 7:51 HOURS TO 8:00 HOURS (44 basic units) | $2327.60 |
| 23410 | 8:01 HOURS TO 8:10 HOURS (45 basic units) | $2380.50 |
| 23420 | 8:11 HOURS TO 8:20 HOURS (46 basic units) | $2433.40 |
| 23430 | 8:21 HOURS TO 8:30 HOURS (47 basic units) | $2486.30 |
| 23440 | 8:31 HOURS TO 8:40 HOURS (48 basic units) | $2539.20 |
| 23450 | 8:41 HOURS TO 8:50 HOURS (49 basic units) | $2592.10 |
| 23460 | 8:51 HOURS TO 9:00 HOURS (50 basic units) | $2645.00 |
| 23470 | 9:01 HOURS TO 9:10 HOURS (51 basic units) | $2697.90 |
| 23480 | 9:11 HOURS TO 9:20 HOURS (52 basic units) | $2750.80 |
| 23490 | 9:21 HOURS TO 9:30 HOURS (53 basic units) | $2803.70 |
| 23500 | 9:31 HOURS TO 9:40 HOURS (54 basic units) | $2856.60 |
| 23510 | 9:41 HOURS TO 9:50 HOURS (55 basic units) | $2909.50 |
| 23520 | 9:51 HOURS TO 10:00 HOURS (56 basic units) | $2962.40 |
| 23530 | 10:01 HOURS TO 10:10 HOURS (57 basic units) | $3015.30 |
| 23540 | 10:11 HOURS TO 10:20 HOURS (58 basic units) | $3068.20 |
| 23550 | 10:21 HOURS TO 10:30 HOURS (59 basic units) | $3121.10 |
| 23560 | 10:31 HOURS TO 10:40 HOURS (60 basic units) | $3174.00 |
| 23570 | 10:41 HOURS TO 10:50 HOURS (61 basic units) | $3226.90 |
| 23580 | 10:51 HOURS TO 11:00 HOURS (62 basic units) | $3279.80 |
| 23590 | 11:01 HOURS TO 11:10 HOURS (63 basic units) | $3332.70 |
| 23600 | 11:11 HOURS TO 11:20 HOURS (64 basic units) | $3385.60 |
| 23610 | 11:21 HOURS TO 11:30 HOURS (65 basic units) | $3438.50 |
| 23620 | 11:31 HOURS TO 11:40 HOURS (66 basic units) | $3491.40 |
| 23630 | 11:41 HOURS TO 11:50 HOURS (67 basic units) | $3544.30 |
| 23640 | 11:51 HOURS TO 12:00 HOURS (68 basic units) | $3597.20 |
| 23650 | 12:01 HOURS TO 12:10 HOURS (69 basic units) | $3650.10 |
| 23660 | 12:11 HOURS TO 12:20 HOURS (70 basic units) | $3703.00 |
| 23670 | 12:21 HOURS TO 12:30 HOURS (71 basic units) | $3755.90 |
| 23680 | 12:31 HOURS TO 12:40 HOURS (72 basic units) | $3808.80 |
| 23690 | 12:41 HOURS TO 12:50 HOURS (73 basic units) | $3861.70 |
| 23700 | 12:51 HOURS TO 13:00 HOURS (74 basic units) | $3914.60 |
| 23710 | 13:01 HOURS TO 13:10 HOURS (75 basic units) | $3967.50 |
| 23720 | 13:11 HOURS TO 13:20 HOURS (76 basic units) | $4020.40 |
| 23730 | 13:21 HOURS TO 13:30 HOURS (77 basic units) | $4073.30 |
| 23740 | 13:31 HOURS TO 13:40 HOURS (78 basic units) | $4126.20 |
| 23750 | 13:41 HOURS TO 13:50 HOURS (79 basic units) | $4179.10 |
| 23760 | 13:51 HOURS TO 14:00 HOURS (80 basic units) | $4232.00 |
| 23770 | 14:01 HOURS TO 14:10 HOURS (81 basic units) | $4284.90 |
| 23780 | 14:11 HOURS TO 14:20 HOURS (82 basic units) | $4337.80 |
| 23790 | 14:21 HOURS TO 14:30 HOURS (83 basic units) | $4390.70 |
| 23800 | 14:31 HOURS TO 14:40 HOURS (84 basic units) | $4443.60 |
| 23810 | 14:41 HOURS TO 14:50 HOURS (85 basic units) | $4496.50 |
| 23820 | 14:51 HOURS TO 15:00 HOURS (86 basic units) | $4549.40 |
| 23830 | 15:01 HOURS TO 15:10 HOURS (87 basic units) | $4602.30 |
| 23840 | 15:11 HOURS TO 15:20 HOURS (88 basic units) | $4655.20 |
| 23850 | 15:21 HOURS TO 15:30 HOURS (89 basic units) | $4708.10 |
| 23860 | 15:31 HOURS TO 15:40 HOURS (90 basic units) | $4761.00 |
| 23870 | 15:41 HOURS TO 15:50 HOURS (91 basic units) | $4813.90 |
| 23880 | 15:51 HOURS TO 16:00 HOURS (92 basic units) | $4866.80 |
| 23890 | 16:01 HOURS TO 16:10 HOURS (93 basic units) | $4919.70 |
| 23900 | 16:11 HOURS TO 16:20 HOURS (94 basic units) | $4972.60 |
| 23910 | 16:21 HOURS TO 16:30 HOURS (95 basic units) | $5025.50 |
| 23920 | 16:31 HOURS TO 16:40 HOURS (96 basic units) | $5078.40 |
| 23930 | 16:41 HOURS TO 16:50 HOURS (97 basic units) | $5131.30 |
| 23940 | 16:51 HOURS TO 17:00 HOURS (98 basic units) | $5184.20 |
| 23950 | 17:01 HOURS TO 17:10 HOURS (99 basic units) | $5237.10 |
| 23960 | 17:11 HOURS TO 17:20 HOURS (100 basic units) | $5290.00 |
| 23970 | 17:21 HOURS TO 17:30 HOURS (101 basic units) | $5342.90 |
| 23980 | 17:31 HOURS TO 17:40 HOURS (102 basic units) | $5395.80 |
| 23990 | 17:41 HOURS TO 17:50 HOURS (103 basic units) | $5448.70 |
| 24100 | 17:51 HOURS TO 18:00 HOURS (104 basic units) | $5501.60 |
| 24101 | 18:01 HOURS TO 18:10 HOURS (105 basic units) | $5554.50 |
| 24102 | 18:11 HOURS TO 18:20 HOURS (106 basic units) | $5607.40 |
| 24103 | 18:21 HOURS TO 18:30 HOURS (107 basic units) | $5660.30 |
| 24104 | 18:31 HOURS TO 18:40 HOURS (108 basic units) | $5713.20 |
| 24105 | 18:41 HOURS TO 18:50 HOURS (109 basic units) | $5766.10 |
| 24106 | 18:51 HOURS TO 19:00 HOURS (110 basic units) | $5819.00 |
| 24107 | 19:01 HOURS TO 19:10 HOURS (111 basic units) | $5871.90 |
| 24108 | 19:11 HOURS TO 19:20 HOURS (112 basic units) | $5924.80 |
| 24109 | 19:21 HOURS TO 19:30 HOURS (113 basic units) | $5977.70 |
| 24110 | 19:31 HOURS TO 19:40 HOURS (114 basic units) | $6030.60 |
| 24111 | 19:41 HOURS TO 19:50 HOURS (115 basic units) | $6083.50 |
| 24112 | 19:51 HOURS TO 20:00 HOURS (116 basic units) | $6136.40 |
| 24113 | 20:01 HOURS TO 20:10 HOURS (117 basic units) | $6189.30 |
| 24114 | 20:11 HOURS TO 20:20 HOURS (118 basic units) | $6242.20 |
| 24115 | 20:21 HOURS TO 20:30 HOURS (119 basic units) | $6295.10 |
| 24116 | 20:31 HOURS TO 20:40 HOURS (120 basic units) | $6348.00 |
| 24117 | 20:41 HOURS TO 20:50 HOURS (121 basic units) | $6400.90 |
| 24118 | 20:51 HOURS TO 21:00 HOURS (122 basic units) | $6453.80 |
| 24119 | 21:01 HOURS TO 21:10 HOURS (123 basic units) | $6506.70 |
| 24120 | 21:11 HOURS TO 21:20 HOURS (124 basic units) | $6559.60 |
| 24121 | 21:21 HOURS TO 21:30 HOURS (125 basic units) | $6612.50 |
| 24122 | 21:31 HOURS TO 21:40 HOURS (126 basic units) | $6665.40 |
| 24123 | 21:41 HOURS TO 21:50 HOURS (127 basic units) | $6718.30 |
| 24124 | 21:51 HOURS TO 22:00 HOURS (128 basic units) | $6771.20 |
| 24125 | 22:01 HOURS TO 22:10 HOURS (129 basic units) | $6824.10 |
| 24126 | 22:11 HOURS TO 22:20 HOURS (130 basic units) | $6877.00 |
| 24127 | 22:21 HOURS TO 22:30 HOURS (131 basic units) | $6929.90 |
| 24128 | 22:31 HOURS TO 22:40 HOURS (132 basic units) | $6982.80 |
| 24129 | 22:41 HOURS TO 22:50 HOURS (133 basic units) | $7035.70 |
| 24130 | 22:51 HOURS TO 23:00 HOURS (134 basic units) | $7088.60 |
| 24131 | 23:01 HOURS TO 23:10 HOURS (135 basic units) | $7141.50 |
| 24132 | 23:11 HOURS TO 23:20 HOURS (136 basic units) | $7194.40 |
| 24133 | 23:21 HOURS TO 23:30 HOURS (137 basic units) | $7247.30 |
| 24134 | 23:31 HOURS TO 23:40 HOURS (138 basic units) | $7300.20 |
| 24135 | 23:41 HOURS TO 23:50 HOURS (139 basic units) | $7353.10 |
| 24136 | 23:51 HOURS TO 24:00 HOURS (140 basic units) | $7406.00 |
| **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) | $52.90 |
| 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) | $105.80 |
| 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) | $158.70 |
| **Anaesthesia/perfusion modifying units—other** | | |
| 25014 | Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is aged 75 years or more (Anaes.) (1 basic units) | $52.90 |
| 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) | $105.80 |
| **Anaesthesia after hours emergency modifier** | | |
| 25025 | Anaesthesia, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday (0 basic units) Derived fee: An additional amount of 50% of fee for the anaesthetic service. That is:(a) an anaesthesia item/s range 20100—21997 or 22900, plus (b) an item range 23010—24136, plus(c) if applicable, an item range 25000-25014, plus(d) where performed, any assoc therapeutic or diagnostic service range 22002-22051 | DF |
| 25030 | Assistance in the management of anaesthesia, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday (0 basic units) Derived fee: 50% of the fee for assistance at anaesthesia. That is: (a) an assistant anaesthesia item in the range 25200—25205, plus (b) an item range 23010-24136, plus (c) where applicable, an item range 25000-25014, plus (d) where performed, any associated therapeutic or diagnostic service 22002 -22051 | DF |
| **Perfusion after hours emergency modifier** | | |
| 25050 | Perfusion, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday. (0 basic units) Derived fee: An additional amount of 50% of the fee for the perfusion service. That is: (a) item 22060, plus (b) an item range 23010—24136, plus (c) where applicable, an item range 25000—25014, plus (d) where performed, any associated therapeutic or diagnostic service in the range 22002-22051 or 22065-22075 | DF |
| **Assistance at anaesthesia** | | |
| 25200 | Assistance in the administration of anaesthesia requiring continuous anaesthesia on a patient in imminent danger of death requiring continuous life saving emergency treatment, to the exclusion of all other patients (005) (basic units) Derived fee: An amount of $264.50 (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 | DF |
| 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 (005) (basic units) Derived fee: An amount of $264.50 (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 | DF |
| **GROUP T8—SURGICAL OPERATIONS** | | |
| **General** | | |
| 30001 | Operative procedure, not being a service to which any other item i n this Group applies, being a service to which an item in this Group would have applied had the procedure not been discontinued on medical grounds Derived fee : 50% of the fee which would have applied had the procedure not been discontinued. | DF |
| 30003 | Burns, involving 1% or more but less than 3% of total body surface, dressing of (including redressing of any related donor site, if required), without anaesthesia, if medical practitioner is present each attendance at which the procedure is performed Not applicable for skin reactions secondary to radiotherapy | $69.70 |
| 30006 | Burns, involving 3% or more but less than 10% of total body surface, dressing of (including redressing of any related donor site, if required), without anaesthesia, if medical practitioner is present each attendance at which the procedure is performed Not applicable for skin reactions secondary to radiotherapy | $94.50 |
| 30007 | Burns, involving 10% or more of total body surface, dressing of (including redressing of any related donor site, if required), without anaesthesia, if medical practitioner is present each attendance at which the procedure is performed Not applicable for skin reactions secondary to radiotherapy | $280.40 |
| 30010 | Burns, involving not more than 3% of total body surface, dressing of (including redressing of any related donor site, if required), in an operating theatre under general anaesthesia or intravenous sedation, if medical practitioner is present (H) (Anaes.) | $152.50 |
| 30014 | Burns, involving 3% or more but less than 20% of total body surface, dressing of (including redressing of any related donor site, if required), in an operating theatre under general anaesthesia or intravenous sedation, if medical practitioner is present (H) (Anaes.) | $320.10 |
| 30015 | Burns, involving 20% or more but less than 50% of total body surface, or burns of less than 20% of total body surface involving 1% or more of total body surface within the hands or face, dressing of (including redressing of any related donor site, if required), in an operating theatre under general anaesthesia or intravenous sedation, if medical practitioner is present (H) (Anaes.) (Assist.) | $420.60 |
| 30016 | Burns, involving 50% or more of total body surface, dressing of (including redressing of any related donor site, if required), in an operating theatre under general anaesthesia or intravenous sedation, if medical practitioner is present (H) (Anaes.) (Assist.) | $630.80 |
| 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.) | $677.00 |
| 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.) | $673.80 |
| 30026 | SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OFWOUND 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.) | $106.00 |
| 30029 | SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OFWOUND 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.) | $182.60 |
| 30032 | SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OFWOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes.) | $167.20 |
| 30035 | SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OFWOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) | $238.70 |
| 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.) | $182.60 |
| 30042 | SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OFWOUND 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.) | $385.40 |
| 30045 | SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OFWOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes.) | $238.70 |
| 30049 | SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OFWOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) | $381.80 |
| 30052 | FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.) | $519.60 |
| 30055 | Wounds, dressing of, under general, regional or intravenous sedation, with or without removal of sutures, other than a service associated with a service to which another item in this Group applies (Anaes.) | $152.50 |
| 30058 | POSTOPERATIVE HAEMORRHAGE, control of, under general anaesthesia, as an independent procedure (Anaes.) | $307.70 |
| 30061 | SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea or sclera), as an independent procedure (Anaes.) | $50.20 |
| 30062 | Etonogestrel subcutaneous implant, removal of, as an independent procedure (Anaes.) | $122.80 |
| 30064 | SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.) | $223.10 |
| 30068 | FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.) | $570.00 |
| 30071 | Diagnostic biopsy of skin, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.) | $107.80 |
| 30072 | Diagnostic biopsy of mucous membrane, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.) | $102.50 |
| 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.) | $318.80 |
| 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.) | $100.60 |
| 30081 | DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using open approach, where the biopsy specimen is sent for pathological examination (Anaes.) | $224.00 |
| 30084 | Diagnostic biopsy of bone marrow by trephine using percutaneous approach where the biopsy is sent for pathological examination (Anaes.) | $121.20 |
| 30087 | DIAGNOSTIC BIOPSY OF BONE MARROW by aspiration or PUNCH BIOPSY OF SYNOVIAL MEMBRANE, where the biopsy is sent for pathological examination (Anaes.) | $60.90 |
| 30090 | DIAGNOSTIC BIOPSY OF PLEURA, PERCUTANEOUS 1 or more biopsies on any 1 occasion, where the biopsy is sent for pathological examination (Anaes.) | $264.80 |
| 30093 | DIAGNOSTIC NEEDLE BIOPSY OF VERTEBRA, where the biopsy is sent for pathological examination (Anaes.) | $345.70 |
| 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.) | $389.80 |
| 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. | $200.20 |
| 30099 | Sinus, excision of, involving superficial tissue only (Anaes.) | $191.50 |
| 30103 | Sinus, excision of, involving muscle and deep tissue (Anaes.) | $377.90 |
| 30104 | Pre-auricular sinus, excision of, on a patient 10 years of age or over (Anaes.) | $263.20 |
| 30107 | Excision of ganglion, other than a service associated with a service to which another item in this Group applies (Anaes.) | $467.90 |
| 30166 | Removal of redundant abdominal skin and lipectomy, as a wedge excision, for functional problems following significant weight loss equivalent to at least 5 body mass index points and if there has been a stable weight for a period of at least 6 months prior to surgery, other than a service associated with a service to which item 30175, 30176, 30177, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070, 46072, 46080, 46082, 46084, 46086, 46088 or 46090 applies (H) (Anaes.) (Assist.) | $1353.30 |
| 30169 | Removal of redundant non-abdominal skin and lipectomy for functional problems following significant weight loss equivalent to at least 5 body mass index points and if there has been a stable weight for a period of at least 6 months prior to surgery, one or 2 non-abdominal areas, other than a service associated with a service to which item 30175, 30176, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070, 46072, 46080, 46082, 46084, 46086, 46088 or 46090 applies (H) (Anaes.) (Assist.) | $1082.60 |
| 30176 | Radical abdominoplasty, 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 30166, 30169, 30175, 30177, 30179, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies, if the patient has previously had a massive intra-abdominal or pelvic tumour surgically removed (H) (Anaes.) (Assist.) | $1974.30 |
| 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, with or without repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30166, 30175, 30176, 30179, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070, 46072, 46080, 46082, 46084, 46086, 46088 or 46090applies, 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.) | $2090.00 |
| 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, not being a service associated with a service to which item 30175, 30176, 30177, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070, 46072, 46080, 46082, 46084, 46086, 46088 or 46090 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.) | $2429.60 |
| 30180 | Axillary hyperhidrosis, partial excision for (Anaes.) | $280.00 |
| 30183 | Axillary hyperhidrosis, total excision of sweat gland bearing area (Anaes.) | $558.20 |
| 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.) | $481.40 |
| 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.) | $318.50 |
| 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.) | $818.90 |
| 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. | $120.00 |
| 30192 | PREMALIGNANT SKIN LESIONS (including solar keratoses), treatment of, by ablative technique (10 or more lesions) (Anaes.) | $80.90 |
| 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 or plastic surgerywhere 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.) | $255.10 |
| 30202 | Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by the opinion of a specialist in the specialty of dermatology or plastic surgery removal of, by liquid nitrogen cryotherapy using repeat freeze thaw cycles | $97.50 |
| 30207 | Skin lesions, multiple injections with glucocorticoid preparations (Anaes.) | $91.90 |
| 30210 | Keloid and other skin lesions, extensive, multiple injections of glucocorticoid preparations, if undertaken in the operating theatre of a hospital (H) (Anaes.) | $335.50 |
| 30216 | Haematoma, aspiration of (Anaes.) | $59.30 |
| 30219 | HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital—INCISION WITH DRAINAGE OF (excluding aftercare) | $59.30 |
| 30223 | LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.) | $335.90 |
| 30224 | PERCUTANEOUS DRAINAGE OF DEEP ABSCESS using interventional imaging techniques—but not including imaging (Anaes.) | $492.80 |
| 30225 | ABSCESS DRAINAGE TUBE, exchange of using interventional imaging techniques—but not including imaging (Anaes.) | $550.60 |
| 30226 | MUSCLE, excision of (LIMITED), or fasciotomy (Anaes.) | $308.50 |
| 30229 | MUSCLE, excision of (EXTENSIVE) (Anaes.) (Assist.) | $563.20 |
| 30232 | MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.) | $460.60 |
| 30235 | MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.) | $610.30 |
| 30238 | Fascia, deep, repair of, for herniated muscle (Anaes.) | $308.40 |
| 30241 | BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in this Group applies (Anaes.) (Assist.) | $758.50 |
| 30244 | STYLOID PROCESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.) | $730.00 |
| 30246 | PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.) | $1423.60 |
| 30247 | Parotid gland, total extirpation of, including removal of tumour, other than a service associated with a service to which item 39321, 39324, 39327 or 39330 applies (H) (Anaes.) (Assist.) | $1530.00 |
| 30250 | Parotid gland, total extirpation of, with preservation of facial nerve, including: (a) removal of tumour; and (b) exposure or mobilisation of facial nerve; other than a service associated with a service to which item 39321, 39324, 39327 or 39330 applies (H) (Anaes.) (Assist.) | $2562.20 |
| 30251 | Recurrent parotid tumour, excision of, with preservation of facial nerve, including: (a) removal of tumour; and (b) exposure or mobilisation of facial nerve; other than a service associated with a service to which item 39321, 39324, 39327 or 39330 applies (H) (Anaes.) (Assist.) | $3960.80 |
| 30253 | Parotid gland, superficial lobectomy of, with exposure of facial nerve, including: (a) removal of tumour; and (b) exposure or mobilisation of facial nerve; other than a service associated with a service to which item 39321, 39324, 39327 or 39330 applies (H) (Anaes.) (Assist.) | $1784.60 |
| 30255 | SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.) | $2495.00 |
| 30256 | Submandibular gland, extirpation of, other than a service associated with a service to which item 31423, 31426, 31429, 31432, 31435 or 31438 applies on the same side (H) (Anaes.) (Assist.) | $949.30 |
| 30257 | Sialendoscopy, of submandibular or parotid duct, with or without removal of calculus or treatment of stricture (Anaes.) | $870.70 |
| 30259 | Sublingual gland, extirpation of (Anaes.) | $412.50 |
| 30262 | Salivary gland, dilatation or diathermy of duct (Anaes.) | $121.50 |
| 30266 | Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, 1 or more such procedures. (Anaes.) | $318.70 |
| 30269 | Salivary gland, repair of cutaneous fistula of (Anaes.) | $345.00 |
| 30272 | TONGUE, partial excision of (Anaes.) (Assist.) | $629.90 |
| 30275 | Radical excision of intra oral tumour, with or without resection of mandible, including dissection of lymph glands of neck, unilateral, other than a service associated with a service to which item 31423, 31426, 31429, 31432, 31435 or 31438 applies on the same side (H) (Anaes.) (Assist.) | $3753.00 |
| 30278 | Tongue tie, repair of, other than: (a) a service to which another item in this Subgroup applies; or (b) a service associated with a service to which item 45009 applies (Anaes.) | $95.30 |
| 30281 | Tongue tie, mandibular frenulum or maxillary frenulum, repair of, in a person aged 2 years and over, under general anaesthesia, other than a service associated with a service to which item 45009 applies (Anaes.) | $265.00 |
| 30283 | Ranula or mucous cyst of mouth, removal of (Anaes.) | $436.30 |
| 30286 | Branchial cyst, removal of, on a patient 10 years of age or over (Anaes.) (Assist.) | $851.80 |
| 30289 | Branchial fistula, removal of, on a patient 10 years of age or over (Anaes.) (Assist.) | $1110.30 |
| 30293 | CERVICAL OESOPHAGOSTOMY or CLOSURE OF CERVICAL OESOPHAGOSTOMY with or without plastic repair (Anaes.) (Assist.) | $917.70 |
| 30294 | CERVICAL OESOPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction (Anaes.) (Assist.) | $3558.50 |
| 30296 | THYROIDECTOMY, total (Anaes.) (Assist.) | $2101.60 |
| 30297 | THYROIDECTOMY following previous thyroid surgery (Anaes.) (Assist.) | $2179.10 |
| 30299 | Sentinel lymph node biopsy or biopsies for breast cancer, involving dissection in an axilla, using preoperative lymphoscintigraphy and/or lymphotropic dye injection (H) (Anaes.) (Assist.) | $1444.50 |
| 30306 | TOTAL HEMITHYROIDECTOMY (Anaes.) (Assist.) | $1730.50 |
| 30310 | Partial or subtotal thyroidectomy (Anaes.) (Assist.) | $1106.40 |
| 30311 | Sentinel lymph node biopsy or biopsies for cutaneous melanoma, using preoperative lymphoscintigraphy and/or lymphotropic dye injection, if: (a) the primary lesion is greater than 1.0 mm in depth (or at least 0.8 mm in depth in the presence of ulceration); and (b) appropriate excision of the primary melanoma has occurred; and (c) the service is not associated with a service to which item 30075, 30078, 30299, 30305, 30329, 30332, 30618, 30820, 31423, 52025 or 52027 applies Applicable to only one lesion per occasion on which the service is provided (H) (Anaes.) (Assist.) | $1192.10 |
| 30314 | Thyroglossal cyst or fistula or both, radical removal of, including thyroglossal duct and portion of hyoid bone, on a patient 10 years of age or over (Anaes.) (Assist.) | $1054.50 |
| 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.) | $2428.00 |
| 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.) | $2810.80 |
| 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.) | $2188.50 |
| 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.) | $2810.80 |
| 30323 | Excision of phaeochromocytoma or extraadrenal paraganglioma via endoscopic or open approach. (Anaes.) (Assist.) | $2810.80 |
| 30324 | Excision of an adrenocortical tumour or hyperplasia via endoscopic or open approach. (Anaes.) (Assist.) | $2817.20 |
| 30329 | LYMPH NODES of GROIN, limited excision of (Anaes.) | $530.40 |
| 30330 | LYMPH NODES of GROIN, radical excision of (Anaes.) (Assist.) | $1481.80 |
| 30332 | Lymph nodes of axilla, limited excision of (H) (Anaes.) (Assist.) | $744.50 |
| 30336 | Lymph nodes of axilla, complete excision of (H) (Anaes.) (Assist.) | $2218.20 |
| 30382 | Enterocutaneous fistula, repair of, if dissection and resection of bowel is performed, with or without anastomosis or formation of a stoma (H) (Anaes.) (Assist.) | $2692.70 |
| 30384 | Open or minimally invasive excision of a retroperitoneal mass, 4 cm or greater in largest dimension, lasting more than 3 hours, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.) | $2582.80 |
| 30385 | Unplanned return to theatre for laparotomy or laparoscopy for control or drainage of intra-abdominal haemorrhage following abdominal surgery (H) (Anaes.) (Assist.) | $1160.90 |
| 30387 | Laparoscopy or laparotomy when an operation is performed on abdominal, retroperitoneal or pelvic viscera, excluding lymph node biopsy, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.) | $1400.40 |
| 30388 | Laparotomy for abdominal trauma, including control of haemorrhage (with or without packing) and containment of contamination (H) (Anaes.) (Assist.) | $3065.10 |
| 30390 | Laparoscopy, diagnostic, with or without aspiration of fluid, on a patient 10 years of age or over, if no other intra-abdominal procedure is performed (H) (Anaes.) (Assist.) | $453.70 |
| 30392 | RADICAL OR DEBULKING OPERATION for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (Anaes.) (Assist.) | $1390.70 |
| 30396 | Laparotomy or laparoscopy for generalised intra-peritoneal sepsis(also known asperitonitis), with or without removal of foreign material or enteric contents, with lavage of the entire peritoneal cavity, with or without closure of the abdomen when performed by laparotomy (H) (Anaes.) (Assist.) | $2095.60 |
| 30397 | Laparostomy, via wound previously made and left open or closed, including change of dressings or packs, with or without drainage of loculated collections (H) (Anaes.) | $478.90 |
| 30399 | Laparostomy, final closure of wound made at previous operation, after removal of dressings or packs (Anaes.) (Assist.) | $657.00 |
| 30400 | LAPAROTOMY WITH INSERTION OF PORTACATH for administration of cytotoxic therapy including placement of reservoir (Anaes.) (Assist.) | $1304.30 |
| 30406 | Paracentesis abdominis (Anaes.) | $107.40 |
| 30408 | PERITONEOVENOUS shunt, insertion of (Anaes.) (Assist.) | $807.60 |
| 30409 | Liver biopsy, percutaneous (Anaes.) | $361.90 |
| 30411 | LIVER BIOPSY by wedge excision when performed in conjunction with another intraabdominal procedure (Anaes.) | $200.00 |
| 30412 | LIVER BIOPSY by core needle, when performed in conjunction with another intra-abdominal procedure (Anaes.) | $107.70 |
| 30414 | LIVER, subsegmental resection of, (local excision), other than for trauma (Anaes.) (Assist.) | $1422.20 |
| 30415 | LIVER, segmental resection of, other than for trauma (Anaes.) (Assist.) | $2835.10 |
| 30416 | Liver cysts, greater than 5 cm in diameter, marsupialisation of 4 or less (Anaes.) (Assist.) | $1540.70 |
| 30417 | Liver cysts, greater than 5 cm in diameter, marsupialisation of 5 or more (Anaes.) (Assist.) | $2310.70 |
| 30418 | LIVER, lobectomy of, other than for trauma (Anaes.) (Assist.) | $3289.80 |
| 30419 | Liver tumour, other than a hepatocellular carcinoma, destruction of one or more, by local ablation, other than a service associated with a service to which item 50950 or 50952 applies (Anaes.) (Assist.) | $1755.00 |
| 30421 | Liver, extended lobectomy of, or central resections of segments 4, 5 and 8, other than for trauma (Anaes.) (Assist.) | $4106.80 |
| 30422 | LIVER, repair of superficial laceration of, for trauma (Anaes.) (Assist.) | $1388.30 |
| 30425 | LIVER, repair of deep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.) | $2692.70 |
| 30427 | LIVER, segmental resection of, for trauma (Anaes.) (Assist.) | $3167.30 |
| 30428 | LIVER, lobectomy of, for trauma (Anaes.) (Assist.) | $3388.60 |
| 30430 | Liver, extended lobectomy of, or central resections of segments 4, 5 and 8, for trauma (Anaes.) (Assist.) | $4780.00 |
| 30431 | Liver abscess, single, open or minimally invasive abdominal drainage of, excluding aftercare (Anaes.) (Assist.) | $1071.80 |
| 30433 | Liver abscess, multiple, open or minimally invasive abdominal drainage of, excluding aftercare (Anaes.) (Assist.) | $1558.70 |
| 30439 | Intraoperative ultrasound of biliary tract, or operative cholangiography, if the service: (a) is performed in association with an intra-abdominal procedure; and (b) is not associated with a service to which item 30442 or 30445 applies (Anaes.) (Assist.) | $382.80 |
| 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.) | $1085.60 |
| 30441 | Intraoperative ultrasound for staging of intra-abdominal tumours (Anaes.) | $280.60 |
| 30442 | Choledochoscopy in conjunction with another procedure (Anaes.) | $385.40 |
| 30443 | Cholecystectomy, by any approach, without cholangiogram (Anaes.) (Assist.) | $1418.80 |
| 30445 | Cholecystectomy, by any approach, with attempted or completed cholangiogram or intraoperative ultrasound of the biliary system, when performed via laparoscopic or open approach or when conversion from laparoscopic to open approach is required (Anaes.) (Assist.) | $1758.40 |
| 30448 | Cholecystectomy, by any approach, involving removal of common duct calculi via the cystic duct, with or without stent insertion (Anaes.) (Assist.) | $2003.30 |
| 30449 | Cholecystectomy with removal of common duct calculi via choledochotomy, by any approach, with or without insertion of a stent (Anaes.) (Assist.) | $2229.80 |
| 30450 | Calculus of biliary tract, extraction of, using interventional imaging techniques (Anaes.) (Assist.) | $1079.30 |
| 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.) | $550.80 |
| 30452 | CHOLEDOCHOSCOPY with balloon dilation of a stricture or passage of stent or extraction of calculi (Anaes.) (Assist.) | $804.00 |
| 30454 | Choledochotomy without cholecystectomy, with or without removal of calculi (Anaes.) (Assist.) | $2052.30 |
| 30455 | Choledochotomy with cholecystectomy, with removal of calculi, including biliary intestinal anastomosis (Anaes.) (Assist.) | $2383.70 |
| 30457 | CHOLEDOCHOTOMY, intrahepatic, involving removal of intrahepatic bile duct calculi (Anaes.) (Assist.) | $2844.80 |
| 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.) | $2092.60 |
| 30460 | CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (Anaes.) (Assist.) | $1775.20 |
| 30461 | Radical resection of porta hepatis (including associated neuro-lymphatic tissue), for cancer, suspected cancer or choledochal cyst, including bile duct excision and biliary-enteric anastomoses, other than a service associated with a service to which item 30440, 30451 or 31454 applies (Anaes.) (Assist.) | $3147.60 |
| 30463 | Radical resection of common hepatic duct and right and left hepatic ducts, with 2 duct anastomoses, for cancer, suspected cancer or choledochal cyst (Anaes.) (Assist.) | $3999.40 |
| 30464 | Radical resection of common hepatic duct and right and left hepatic ducts, for cancer, suspected cancer or choledochal cyst, involving either or both of the following:(a) more than 2 anastomoses;(b) resection of segment (or major portion of segment) of liver; (Anaes.) (Assist.) | $4485.80 |
| 30469 | BILIARY STRICTURE, repair of, after 1 or more operations on the biliary tree (Anaes.) (Assist.) | $3542.10 |
| 30472 | Repair of bile duct injury, including immediate reconstruction, other than a service associated with a service to which item 30584 applies (Anaes.) (Assist.) | $2198.40 |
| 30473 | Oesophagoscopy (not being a service associated with a service to which item 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.) | $364.30 |
| 30475 | Endoscopic dilatation of stricture of upper gastrointestinal tract (including the use of imaging intensification where clinically indicated) (Anaes.) | $719.10 |
| 30478 | Oesophagoscopy (other than a service associated with a service to which item 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.) | $507.30 |
| 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.) | $981.00 |
| 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.) | $760.40 |
| 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.) | $545.30 |
| 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 patient 10 years of age or over, excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.) | $376.80 |
| 30484 | Endoscopic retrogradecholangiopancreatography, other than a service to which item 30664 or 30665 applies (Anaes.) | $783.90 |
| 30485 | ENDOSCOPIC SPHINCTEROTOMY with or without extraction of stones from common bile duct (Anaes.) | $1160.90 |
| 30488 | SMALL BOWEL INTUBATIONas an independent procedure (Anaes.) | $191.60 |
| 30490 | OESOPHAGEAL PROSTHESIS, insertion of, including endoscopy and dilatation (Anaes.) | $1120.60 |
| 30491 | Bile duct, endoscopic stenting of (including endoscopy and dilatation) (Anaes.) | $1181.10 |
| 30492 | BILE DUCT, PERCUTANEOUS STENTING OF (including dilatation when performed), using interventional imaging techniques—but not including imaging (Anaes.) | $1674.70 |
| 30494 | Endoscopic biliary dilatation (Anaes.) | $867.30 |
| 30495 | PERCUTANEOUS BILIARY DILATATION for biliary stricture, using interventional imaging techniques—but not including imaging (Anaes.) | $1674.70 |
| 30515 | Gastroenterostomy (including gastroduodenostomy), enterocolostomy or enteroenterostomy, as an independent procedure or in combination with another procedure, only if required for irresectable obstruction, other than a service to which any of items 31569 to 31581 apply (Anaes.) (Assist.) | $1453.80 |
| 30517 | Revision of gastroenterostomy, pyloroplasty or gastroduodenostomy (Anaes.) (Assist.) | $1910.80 |
| 30518 | Partial gastrectomy, not being a service associated with a service to which any of items 31569 to 31581 apply (Anaes.) (Assist.) | $2240.00 |
| 30520 | Gastric tumour, 2 cm or greater in diameter, removal of, by local excision, by laparoscopic or open approach, including any associated anastomosis, excluding polypectomy, other than a service to which item 30518 applies (Anaes.) (Assist.) | $1587.20 |
| 30521 | GASTRECTOMY, TOTAL, for benign disease (Anaes.) (Assist.) | $2921.70 |
| 30526 | Gastrectomy, total, and removal of lower oesophagus, performed by open or minimally invasive approach, with anastomosis in the mediastinum, including any of the following (if performed):(a) distal pancreatectomy;(b) nodal dissection;(c) splenectomy (Anaes.) (Assist.) | $4433.80 |
| 30529 | ANTIREFLUX operation by fundoplasty, with OESOPHAGOPLASTY for stricture or short oesophagus (Anaes.) (Assist.) | $2692.70 |
| 30530 | ANTIREFLUX operation by cardiopexy, with or without fundoplasty (Anaes.) (Assist.) | $1612.30 |
| 30532 | Oesophagogastric myotomy (Heller s operation) by endoscopic, abdominal or thoracic approach, whether performed by open or minimally invasive approach, including fundoplication when performed laparoscopically (Anaes.) (Assist.) | $1853.40 |
| 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.) | $2204.30 |
| 30559 | OESOPHAGUS, local excision for tumour of (Anaes.) (Assist.) | $1750.70 |
| 30560 | Oesophageal perforation, repair of, by abdominal or thoracic approach, including thoracic drainage (Anaes.) (Assist.) | $1943.30 |
| 30562 | Enterostomy or colostomy, closure of (not involving resection of bowel), on a patient 10 years of age or over (Anaes.) (Assist.) | $1228.10 |
| 30563 | Colostomy or ileostomy, refashioning of, on a person 10 years of age or over (Anaes.) (Assist.) | $1228.10 |
| 30565 | SMALL INTESTINE, resection of, without anastomosis (including formation of stoma) (Anaes.) (Assist.) | $1793.10 |
| 30574 | NOTE: Multiple Operation and Multiple Anaesthetic rules apply to this item Appendicectomy, when performed in conjunction with another intra-abdominal procedure and during which a specimen is collected and sent for pathological testing (Anaes.) | $188.00 |
| 30577 | Initial pancreatic necrosectomy by open, laparoscopic or endoscopic approach, excluding aftercare (Anaes.) (Assist.) | $2237.70 |
| 30583 | Distal pancreatectomy with splenic preservation, by open or minimally invasive approach (Anaes.) (Assist.) | $2843.80 |
| 30584 | Pancreatico duodenectomy (Whipple s procedure), with or without preservation of pylorus, including any of the following (if performed):(a) cholecystectomy;(b) pancreatico-biliary anastomosis;(c) gastro-jejunal anastomosis (Anaes.) (Assist.) | $4155.20 |
| 30589 | PANCREATICO-JEJUNOSTOMY for pancreatitis or trauma (Anaes.) (Assist.) | $2574.40 |
| 30590 | PANCREATICO-JEJUNOSTOMY following previous pancreatic surgery (Anaes.) (Assist.) | $2835.10 |
| 30593 | PANCREATECTOMY, near total or total (including duodenum), with or without splenectomy (Anaes.) (Assist.) | $3886.70 |
| 30594 | PANCREATECTOMY for pancreatitis following previously attempted drainage procedure or partial resection (Anaes.) (Assist.) | $4485.80 |
| 30596 | SPLENORRHAPHY OR PARTIAL SPLENECTOMY (Anaes.) (Assist.) | $1851.20 |
| 30599 | SPLENECTOMY, for massive spleen (weighing more than 1500 grams) or involving thoraco-abdominal incision (Anaes.) (Assist.) | $2692.70 |
| 30600 | Emergency repair of diaphragmatic laceration or hernia, following recent trauma, by any approach, including when performed in conjunction with another procedure indicated as a result of abdominal or chest trauma (Anaes.) (Assist.) | $1602.20 |
| 30601 | Diaphragmatic hernia, congenital, or delayed presentation of traumatic rupture, repair of, by thoracic or abdominal approach, on a patient 10 years of age or over, other than a service to which any of items 31569 to 31581 apply (Anaes.) (Assist.) | $1975.90 |
| 30606 | PORTAL HYPERTENSION, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (Anaes.) (Assist.) | $2288.00 |
| 30615 | Strangulated, incarcerated or obstructed hernia, repair of, without bowel resection, on a patient 10 years of age or over (Anaes.) (Assist.) | $1071.80 |
| 30621 | Repair of symptomatic umbilical, epigastric or linea alba hernia requiring mesh or other repair, by open or minimally invasive approach, in a patient 10 years of age or over, other than a service to which item 30651 or 30655 applies (Anaes.) (Assist.) | $839.50 |
| 30628 | Hydrocele, tapping of | $76.90 |
| 30629 | Orchidectomy, radical, including spermatic cord, unilateral, for tumour, inguinal approach, 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.) | $989.40 |
| 30630 | Insertion of testicular prosthesis,at least 6 months following orchidectomy (H) (Anaes.) (Assist.) | $449.70 |
| 30631 | Hydrocele, removal of, other than a service associated with a service to which item 30641, 30642 or 30644 applies (Anaes.) | $509.70 |
| 30635 | Varicocele, surgical correction of, including microsurgical techniques, other than a service associated with a service to which item 30390, 30627, 30641, 30642 or 30644 applies one procedure (Anaes.) (Assist.) | $605.10 |
| 30640 | Repair of large and irreducible scrotal hernia, if surgery exceeds 2 hours, in a patient 10 years of age or over, other than a service to which item 30615, 30621, 30648, 30651 or 30655 applies (Anaes.) (Assist.) | $1794.80 |
| 30641 | Orchidectomy, simple or subcapsular, unilateral with or without insertion of testicular prosthesis (H) (Anaes.) (Assist.) | $866.60 |
| 30642 | Orchidectomy, radical, including spermatic cord, unilateral, for tumour, inguinal approach, with insertion of testicular prosthesis, other than a service associated with a service to which item 30631, 30635, 30641, 30643, 30644 or 45051 applies (Anaes.) (Assist.) | $1006.30 |
| 30643 | Exploration of spermatic cord, inguinal approach, with or without testicular biopsy, with or without excision of spermatic cord lesion, for a patient under 10 years of age, other than a service associated with a service to which item 30629, 30630 or 30642 applies (Anaes.) (Assist.) | $1357.00 |
| 30644 | Exploration of spermatic cord, inguinal approach, with or without testicular biopsy, with or without excision of spermatic cord lesion, for a patient at least 10 years of age, other than a service associated with a service to which item 30629, 30630 or 30642 applies (Anaes.) (Assist.) | $1119.90 |
| 30648 | Femoral or inguinal hernia or infantile hydrocele, repair of, by open or minimally invasive approach, on a patient 10 years of age or over, other than a service to which item 30615 or 30651 applies (Anaes.) (Assist.) | $889.60 |
| 30651 | Ventral hernia repair involving primary fascial closure by suture, with or without onlay mesh or insertion of intraperitoneal onlay mesh repair, without closure of the defect or advancement of the rectus muscle toward the midline, by open or minimally invasive approach, in a patient 10 years of age or over, other than a service associated with a service to which item 30175, 30621, 30655 or 30657 applies (H) (Anaes.) (Assist.) | $1130.40 |
| 30652 | Recurrent groin hernia regardless of size of defect, repair of, with or without mesh, by open or minimally invasive approach, in a patient 10 years of age or over (Anaes.) (Assist.) | $1130.40 |
| 30654 | Circumcision of the penis, with topical or local analgesia, other than a service to which item 30658 applies | $91.40 |
| 30655 | Ventral hernia, repair of,with advancement of the rectus muscles to the midline using a retro-rectus, pre-peritoneal or sublay technique, by open or minimally invasive approach, in a patient 10 years of age or over, other than a service associated with a service to which item 30175, 30621 or 30651 applies (H) (Anaes.) (Assist.) | $1984.20 |
| 30657 | Unilateral abdominal wall reconstruction with component separation, including transversus abdominus release and external oblique release for abdominal wall closure by mobilising the rectus abdominis muscles to the midline, by open or minimally invasive approach (Anaes.) (Assist.) | $2825.40 |
| 30658 | Circumcision of the penis, when performed under general or regional anaesthesia and in conjunction with a service to which an item in Group T7 or Group T10 applies (Anaes.) | $274.10 |
| 30661 | Minor surgical repair following a complication from the circumcision of a penis, when performed in conjunction with a service to which an item in Group T7 or Group T10 applies, other than a service associated with a service to which item 45206 applies (H) (Anaes.) | $717.10 |
| 30662 | Complex surgical repair following a complication from the circumcision of a penis, including single stage local flap, if indicated, to repair one defect, on genitals (other than a service associated with a service to which item 37819, 37822, 45200, 45201, 45202, 45203 or 45206 applies) (H) (Anaes.) (Assist.) | $1433.90 |
| 30663 | Haemorrhage, arrest of, following circumcision requiring general anaesthesia, on a patient 10 years of age or over (Anaes.) | $291.30 |
| 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.) | $97.90 |
| 30672 | COCCYX, excision of (Anaes.) (Assist.) | $923.80 |
| 30676 | Pilonidal sinus or cyst, or sacral sinus or cyst, definitive excision of (Anaes.) | $781.40 |
| 30679 | Pilonidal sinus, injection of sclerosant fluid under anaesthesia (Anaes.) | $205.80 |
| 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.) | $2391.70 |
| 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.) | $2391.70 |
| 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.) | $2943.60 |
| 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.) | $2943.60 |
| 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.) | $1028.90 |
| 30688 | Endoscopicultrasound(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.) | $745.90 |
| 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.) | $1151.70 |
| 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.) | $745.90 |
| 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.) | $1151.70 |
| 30721 | Laparotomy or laparoscopy, or laparoscopy converted to laparotomy, with or without associated biopsies, including the division of adhesions (if performed, but only if the time taken to divide adhesions is 45 minutes or less), if no other intra-abdominal procedure is performed (Anaes.) (Assist.) | $1048.10 |
| 30722 | Laparotomy or laparoscopy, on a patient 10 years of age or over, including any of the following procedures (if performed, and including division of one or more adhesions, but only if the time taken to divide the adhesions is 45 minutes or less): (a) colostomy; (b) colotomy; (c) cholecystostomy; (d) enterostomy; (e) enterotomy; (f) gastrostomy; (g) gastrotomy; (h) caecostomy; (i) gastric fixation by cardiopexy; (j) reduction of intussusception; (k) simple repair of ruptured viscus (including perforated peptic ulcer); (l) reduction of volvulus; (m) drainage of pancreas (Anaes.) (Assist.) | $1130.40 |
| 30723 | Laparotomy, laparoscopy or extra-peritoneal approach, for drainage of an intra-abdominal, pancreatic or retroperitoneal collection or abscess (Anaes.) (Assist.) | $1130.40 |
| 30724 | Laparotomy or laparoscopy with division of adhesions, lasting more than 45 minutes but less than 2 hours, performed either:(a) as a primary procedure; or(b) when the division of adhesions is performed in conjunction with another primary procedure to provide access to a surgical field (but excluding mobilisation or normal anatomical dissection of the organ or structure for which the primary procedure is being carried out) (Anaes.) (Assist.) | $1135.80 |
| 30725 | Laparotomy or laparoscopy for intestinal obstruction or division of extensive, complex adhesions, lasting 2 hours or more, performed either:a) as a primary procedure; orb) when the division of adhesions is performed in conjunction with another procedure to provide access to a surgical field, but excluding mobilisation or normal anatomical dissection of the organ or structure for which the other procedure is being carried out (Anaes.) (Assist.) | $2012.80 |
| 30730 | Small intestine, resection of, including either of the following:(a) a small bowel diverticulum (such as Meckel s procedure) with anastomosis;(b) stricturoplasty (Anaes.) (Assist.) | $2099.00 |
| 30731 | Intraoperative enterotomy for visualisation of the small intestine by endoscopy, including endoscopic examination using a flexible endoscope, with or without biopsies (Anaes.) (Assist.) | $1574.50 |
| 30732 | Peritonectomy, lasting more than 5 hours, including hyperthermic intra-peritoneal chemotherapy (Anaes.) (Assist.) | $8620.40 |
| 30750 | Oesophagectomy with colon or jejunal interposition graft, by any approach, including:(a) any gastrointestinal anastomoses (except vascular anastomoses); and(b) anastomoses in the chest or neck (if appropriate)One surgeon (Anaes.) (Assist.) | $4472.20 |
| 30751 | Oesophagectomy with colon or jejunal interposition graft, by any approach, including:(a) any gastrointestinal anastomoses (except vascular anastomoses); and(b) anastomoses in the chest or neck (if appropriate)Conjoint surgery, principal surgeon (Anaes.) (Assist.) | $4472.20 |
| 30752 | Oesophagectomy with colon or jejunal interposition graft, by any approach, including:(a) any gastrointestinal anastomoses (except vascular anastomoses); and(b) anastomoses in the chest or neck (if appropriate)Conjoint surgery, co-surgeon (Anaes.) (Assist.) | $3354.20 |
| 30753 | Oesophagectomy, by any approach, including:(a) gastric reconstruction by abdominal mobilisation, thoracotomy or thoracoscopy; and(b) anastomosis in the neck or chest One surgeon (Anaes.) (Assist.) | $3732.00 |
| 30754 | Oesophagectomy, by any approach, including:(a) gastric reconstruction by abdominal mobilisation, thoracotomy or thoracoscopy; and(b) anastomosis in the neck or chest Conjoint surgery, principal surgeon (Anaes.) (Assist.) | $3732.00 |
| 30755 | Oesophagectomy by any approach, including:(a) gastric reconstruction by abdominal mobilisation, thoracotomy or thoracoscopy; and(b) anastomosis in the neck or chest Conjoint surgery, co-surgeon (Anaes.) (Assist.) | $2799.00 |
| 30760 | Vagotomy, with or without gastroenterostomy, pyloroplasty or other drainage procedure (Anaes.) (Assist.) | $1275.40 |
| 30762 | Gastrectomy, subtotal or total radical, for carcinoma, by open or minimally invasive approach, including all necessary anastomoses, including either or both of the following (if performed):(a) extended lymph node dissection;(b) splenectomy (Anaes.) (Assist.) | $3605.70 |
| 30763 | Gastric tumour, 2cm or greater in diameter, removal of, by local excision, by endoscopic approach, including any required anastomosis, excluding polypectomy, other than a service to which item 30518 applies (Anaes.) (Assist.) | $1464.50 |
| 30771 | Portal hypertension, porto-caval, meso-caval or selective spleno-renal shunt for (Anaes.) (Assist.) | $3658.20 |
| 30790 | Pancreatic cyst anastomosis to stomach, duodenum or small intestine, by endoscopic, open or minimally invasive approach, with or without the use of endoscopic or intraoperative ultrasound (Anaes.) (Assist.) | $1520.90 |
| 30791 | Pancreatic necrosectomy, by open, laparoscopic or endoscopic approach, excluding aftercare, subsequent procedure (Anaes.) (Assist.) | $944.80 |
| 30792 | Distal pancreatectomy with splenectomy, by open or minimally invasive approach (Anaes.) (Assist.) | $2589.90 |
| 30800 | Splenectomy, by open or minimally invasive approach, other than a service to which item 30792 applies (Anaes.) (Assist.) | $1561.80 |
| 30810 | Exploration of pancreas or duodenum for endocrine tumour, including associated imaging, either: (a) followed by local excision of tumour; or (b) when, after extensive exploration, no tumour is found (Anaes.) (Assist.) | $2487.90 |
| 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.) | $1195.30 |
| 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.) | $1563.20 |
| 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.) | $1857.30 |
| 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.) | $1096.80 |
| 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.) | $1370.90 |
| 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.) | $1645.20 |
| 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.) | $187.30 |
| 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.) | $241.60 |
| 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.) | $281.50 |
| 31220 | Tumours (other than viral verrucae (common warts) and seborrheic keratoses), lipomas, 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.) | $456.50 |
| 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.) | $420.90 |
| 31225 | Tumours (other than viral verrucae (common warts) and seborrheic keratoses), lipomas, 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.) | $815.40 |
| 31227 | Tumour, lipoma or cyst, removal of single lesion by excision and suture, where removal is from subcutaneous tissue and the specimen excised is sent for histological examination (Anaes.) | $241.70 |
| 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.) | $765.80 |
| 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.) | $786.90 |
| 31340 | Note: Multiple Operation and Multiple Anaesthetic rules apply to this item. 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.) 75% of the fee for excision of malignant tumour. | DF |
| 31345 | Lipoma, removal of, by surgical excision or liposuction, if:(a) the lesion is: (i) subcutaneous and 50 mm or more in diameter but less than 150 mm in diameter; or(ii) sub fascial; and (b) the specimen excised is sent for histological confirmation of diagnosis (Anaes.) | $436.70 |
| 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.) | $427.90 |
| 31350 | Benign tumour of soft tissue (other than tumours of skin, cartilage and bone, simple lipomas covered by item 31345 and lipomata), removal of, by surgical excision, on a patient 10 years of age or over, if the specimen excised is sent for histological confirmation of diagnosis, other than a service to which another item in this Group applies (Anaes.) (Assist.) | $921.90 |
| 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.) | $1531.90 |
| 31356 | Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), 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.) | $434.10 |
| 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.) | $215.30 |
| 31358 | Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), 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.) | $531.30 |
| 31359 | Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), 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.) | $647.50 |
| 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.) | $329.70 |
| 31361 | Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), 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.) | $366.30 |
| 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.) | $262.70 |
| 31363 | Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), 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.) | $479.30 |
| 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.) | $329.70 |
| 31365 | Malignant skin lesion (other than a malignant skin lesion covered by item 31369, 31370, 31371, 31372, 31373, 31377, 31378 or 31379), 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.) | $310.60 |
| 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.) | $187.30 |
| 31367 | Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), 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.) | $419.00 |
| 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.) | $246.10 |
| 31369 | Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), 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.) | $482.40 |
| 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.) | $281.50 |
| 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, including excision of the primary tumour bed, 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.) | $700.30 |
| 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, including excision of the primary tumour bed, 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 a service to which item 45201 applies (Anaes.) | $605.60 |
| 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, including excision of the primary tumour bed, 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.) | $699.80 |
| 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, including excision of the primary tumour bed, 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 a service to which item 45201 applies (Anaes.) | $553.10 |
| 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, including excision of the primary tumour bed, 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 a service to which item 45201 applies (Anaes.) | $595.10 |
| 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, including excision of the primary tumour bed, 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.) | $689.60 |
| 31377 | Clinically suspected melanoma, 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 a service to which item 45201 applies (Anaes.) | $201.80 |
| 31378 | Clinically suspected melanoma, 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.) | $309.20 |
| 31379 | Clinically suspected melanoma, 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 a service to which item 45201 applies (Anaes.) | $246.30 |
| 31380 | Clinically suspected melanoma, 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.) | $309.20 |
| 31381 | Clinically suspected melanoma, 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 31377, 31378, 31379 or 31380; 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 a service to which item 45201 applies (Anaes.) | $175.60 |
| 31382 | Clinically suspected melanoma, 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 31377, 31378, 31379 or 31380; 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; not in association with a service to which item 45201 applies (Anaes.) | $231.00 |
| 31383 | Clinically suspected melanoma, 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 31377, 31378, 31379 or 31380; and (b) the necessary excision diameter is more than 30 mm; and (c) the excised specimen is sent for histological examination (Anaes.) | $264.10 |
| 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.) | $564.50 |
| 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.) | $650.90 |
| 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.) | $1020.00 |
| 31409 | PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) | $3255.40 |
| 31412 | RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) | $3956.50 |
| 31423 | Lymph nodes of neck, selective dissection of one or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck, on a patient 10 years of age or over, other than a service associated with a service to which item 30256 or 30275 applies on the same side (Anaes.) (Assist.) | $825.60 |
| 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,other than a service associated with a service to which item 30256 or 30275 applies on the same side(H) (Anaes.) (Assist.) | $1875.00 |
| 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, other than a service associated with a service to which item 30256 or 30275 applies on the same side(H) (Anaes.) (Assist.) | $2580.30 |
| 31432 | Lymph nodes of neck, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections),other than a service associated with a service to which item 30256 or 30275 applies on the same side(H) (Anaes.) (Assist.) | $3120.00 |
| 31435 | Lymph nodes of neck, comprehensive dissection of all 5 lymph node levels on one side of the neck,other than a service associated with a service to which item 30256 or 30275 applies on the same side(H) (Anaes.) (Assist.) | $2023.70 |
| 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, other than a service associated with a service to which item 30256 or 30275 applies on the same side(H) (Anaes.) (Assist.) | $3305.00 |
| 31454 | Laparoscopy or laparotomy with drainage of bile, as an independent procedure (H) (Anaes.) (Assist.) | $1198.90 |
| 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.) | $495.90 |
| 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.) | $594.90 |
| 31460 | PERCUTANEOUS GASTROSTOMY TUBE, jejunal extension to, including any associated imaging services (Anaes.) (Assist.) | $775.90 |
| 31462 | OPERATIVE FEEDING JEJUNOSTOMY performed in conjunction with major upper gastro-intestinal resection (Anaes.) (Assist.) | $1109.10 |
| 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.) | $2805.30 |
| 31468 | Para-oesophageal hiatus hernia, repair of, with complete reduction of hernia, resection of sac and repair of hiatus, with or without fundoplication, other than a service associated with a service to which item 30756 or 31466 applies (Anaes.) (Assist.) | $3061.10 |
| 31472 | Cholecystoduodenostomy, cholecystoenterostomy, choledochojejunostomy or Roux-en-y loop to provide biliary drainage or bypass, other than a service associated with a service to which item 30584 applies (Anaes.) (Assist.) | $2593.80 |
| 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.) | $534.70 |
| 31503 | BREAST, BENIGN LESION more than 50mm in diameter, excision of (Anaes.) (Assist.) | $737.90 |
| 31506 | BREAST, ABNORMALITY detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of (Anaes.) (Assist.) | $802.60 |
| 31509 | BREAST, MALIGNANT TUMOUR, open surgical biopsy of, with or without frozen section histology (Anaes.) | $708.20 |
| 31512 | Breast, malignant tumour, complete local excision of, with or without frozen section histology, other than a service associated with a service to which:(a) item 45523 or 45558 applies; and(b) item 31513, 31514, 45520, 45522 or 45556 applies on the same side (if performed by the same medical practitioner)(H) (Anaes.) (Assist.) | $1340.80 |
| 31515 | BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excision of malignant tumour (Anaes.) (Assist.) | $937.70 |
| 31516 | BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology when targeted intraoperative radiation therapy(using an Intrabeam or Xoft Axxent device) is performed concurrently, if the patient satisfies the requirements mentioned in paragraphs(a) to (g) of item 15900 Applicable only once per breast per lifetime (H) (Anaes.) (Assist.) | $1736.40 |
| 31519 | Total mastectomy (unilateral) (H) (Anaes.) (Assist.) | $1508.10 |
| 31525 | Mastectomy for gynaecomastia (unilateral), with or without liposuction (suction assisted lipolysis), if:(a) breast enlargement is not due to obesity and is not proportionate to body habitus; and(b) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes;not being a service associated with a service to which item 45585 applies (H) (Anaes.) (Assist.) | $1065.20 |
| 31530 | Breast, biopsy of solid tumour or tissue of, using a vacuum-assisted breast biopsy device under imaging guidance, for histological examination, if imaging has demonstrated:(a) microcalcification of lesion; or(b) impalpable lesion less than one cm in diameter;including pre-operative localisation of lesion, if performed, other than a service associated with a service to which item 31548 applies | $1231.70 |
| 31533 | FINE NEEDLE ASPIRATION of an impalpable breast lesion detected by mammography or ultrasound, imaging guided—but not including imaging (Anaes.) | $285.10 |
| 31536 | Breast, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques, but not including imaging (Anaes.) (Anaes.) | $391.60 |
| 31548 | Breast, biopsy of solid tumour or tissue of, using mechanical biopsy device, for histological examination, other than a service associated with a service to which item 31530 applies (Anaes.) (Anaes.) | $329.90 |
| 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.) | $448.10 |
| 31554 | BREAST, microdochotomy of, for benign or malignant condition (Anaes.) (Assist.) | $898.50 |
| 31557 | BREAST CENTRAL DUCTS, excision of, for benign condition (Anaes.) (Assist.) | $713.20 |
| 31560 | ACCESSORY BREAST TISSUE, excision of (Anaes.) (Assist.) | $714.00 |
| 31563 | Inverted nipple, surgical eversion of, with or without flap repair, if the nipple cannot readily be everted manually (Anaes.) | $535.00 |
| 31566 | Accessory nipple, excision of (Anaes.) | $264.70 |
| 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.) | $1794.60 |
| 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.) | $2208.20 |
| 31575 | Sleeve gastrectomy, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.) | $1794.60 |
| 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.) | $1794.60 |
| 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.) | $2208.20 |
| 31584 | Surgical reversal of previous bariatric procedure, including revision or conversion, if:a) the previous procedure involved any of the following:(i) placement of adjustable gastric banding;(ii) gastric bypass;(iii) sleeve gastrectomy;(iv) gastroplasty (excluding gastric plication);(v) biliopancreatic diversion; and(b) any of items 31569 to 31581 applied to the previous procedureother than a service associated with a service to which item 31585 applies (Anaes.) (Assist.) | $3251.00 |
| 31585 | Removal of adjustable gastric band (Anaes.) (Assist.) | $1804.60 |
| 31587 | Adjustment of gastric band as an independent procedure including any associated consultation | $206.90 |
| 31590 | Adjustment of gastric band reservoir, repair, revision or replacement of (Anaes.) (Assist.) | $531.90 |
| **Colorectal** | | |
| 32000 | LARGE INTESTINE, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Anaes.) (Assist.) | $2142.70 |
| 32003 | LARGE INTESTINE, resection of, with anastomosis, including right hemicolectomy (Anaes.) (Assist.) | $2238.70 |
| 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, 32006 or 32030 applies (H) (Anaes.) (Assist.) | $2364.10 |
| 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, 32006 or 32030 applies (H) (Anaes.) (Assist.) | $2676.50 |
| 32006 | Left hemicolectomy, including the descending and sigmoid colon (including formation of stoma), other than a service associated with a service to which item 32024, 32025, 32026 or 32028 applies (H) (Anaes.) (Assist.) | $2364.10 |
| 32009 | TOTAL COLECTOMY AND ILEOSTOMY (Anaes.) (Assist.) | $2825.70 |
| 32012 | TOTAL COLECTOMY AND ILEORECTAL ANASTOMOSIS (Anaes.) (Assist.) | $3121.60 |
| 32015 | TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY1 surgeon (Anaes.) (Assist.) | $3975.20 |
| 32018 | TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; ABDOMINAL RESECTION (including aftercare) (Anaes.) (Assist.) | $3262.80 |
| 32021 | TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; PERINEAL RESECTION (Assist.) | $1142.50 |
| 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.) | $1200.10 |
| 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 32000, 32030, 32106 or 32232 applies (H) (Anaes.) (Assist.) | $2908.40 |
| 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 32000, 32030, 32106 or 32232 applies (H) (Anaes.) (Assist.) | $3784.30 |
| 32026 | Rectum, ultra-low restorative resection, with or without covering stoma and with or without colonic reservoir, if the anastomosis is sited in the anorectal region and is 6 cm or less from the anal verge, not being a service associated with a service to which item 32000, 32030, 32106, 32117 or 32232 applies (H) (Anaes.) (Assist.) | $4479.30 |
| 32028 | Rectum, low or ultra-low restorative resection, with per anal sutured coloanal anastomosis, with or without covering stoma and with or without colonic reservoir, not being a service associated with a service to which item 32000, 32030, 32106, 32117 or 32232 applies (H) (Anaes.) (Assist.) | $4762.60 |
| 32030 | RECTOSIGMOIDECTOMY, including formation of stoma (H) (Anaes.) (Assist.) | $2119.90 |
| 32033 | RESTORATION OF BOWEL continuity following rectosigmoidectomy or similar operation, including dismantling of the stoma (H) (Anaes.) (Assist.) | $3105.20 |
| 32036 | SACROCOCCYGEAL AND PRESACRAL TUMOUR excision of (Anaes.) (Assist.) | $3971.00 |
| 32039 | RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF1 surgeon (Anaes.) (Assist.) | $3167.40 |
| 32042 | RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION abdominal resection (Anaes.) (Assist.) | $2684.30 |
| 32045 | RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION perineal resection (Assist.) | $1029.40 |
| 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.) | $1540.70 |
| 32047 | PERINEAL PROCTECTOMY (Anaes.) (Assist.) | $1793.10 |
| 32051 | TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy1 surgeon (Anaes.) (Assist.) | $4801.80 |
| 32054 | TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomyconjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.) | $4461.10 |
| 32057 | TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoirconjoint surgery, perineal surgeon (Assist.) | $1168.20 |
| 32060 | Restorative proctectomy, involving rectal resection with formation of ileal reservoir and ileoanal anastomosis, including ileostomy mobilisation, with or without mucosectomy or temporary loop ileostomy, 1 surgeon (H) (Anaes.) (Assist.) | $4801.80 |
| 32063 | ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomyconjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.) | $4314.30 |
| 32066 | ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomyconjoint surgery, perineal surgeon (Assist.) | $1142.50 |
| 32069 | ILEOSTOMY RESERVOIR, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes.) | $3550.50 |
| 32072 | Sigmoidoscopic examination (with rigid sigmoidoscope), with or without biopsy | $102.80 |
| 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.) | $168.70 |
| 32084 | Sigmoidoscopy or 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.) | $229.40 |
| 32087 | Endoscopic examination of the colon up to the hepatic flexure by sigmoidoscopy or colonoscopy for the removal of one or more polyps, other than a service associated with a service to which any of items 32222 to 32228 applies (Anaes.) (Anaes.) | $421.80 |
| 32094 | Endoscopic dilatation of colorectal strictures including colonoscopy (Anaes.) | $1136.10 |
| 32095 | Endoscopic examination of small bowel with flexible endoscope passed by stoma, with or without biopsies (Anaes.) | $272.60 |
| 32096 | RECTAL BIOPSY, full thickness, to diagnose or exclude Hirschsprung’s Disease, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital (Anaes.) (Assist.) | $562.50 |
| 32105 | ANORECTAL CARCINOMA per anal full thickness excision of (Anaes.) (Assist.) | $1029.40 |
| 32106 | Anterolateral intraperitoneal rectal tumour, per anal excision of, using rectoscopy digital viewing system and pneumorectum, if:(a) clinically appropriate; and(b) removal requires dissection within the peritoneal cavity; excluding use of a colonoscope as the operating platform and not being a service associated with a service to which item 32024, 32025 or 32232 applies (Anaes.) (Assist.) | $2822.80 |
| 32108 | RECTAL TUMOUR, transsphincteric excision of (Kraske or similar operation) (Anaes.) (Assist.) | $2130.60 |
| 32117 | Rectal prolapse, abdominal rectopexy of, excluding ventral mesh rectopexy, not being a service associated with a service to which item 32025 or 32026 applies (H) (Anaes.) (Assist.) | $2286.80 |
| 32118 | Treatment of external rectal prolapse, or of symptomatic high grade rectal intussusception (the rectum descends to the level of or into the anal canal, confirmed by diagnostic imaging): (a) by minimally invasive surgery involving: (i) ventral dissection of the extra-peritoneal rectum;and (ii)suspension of the rectum from the sacral promontory by means of a prosthesis; and (b) including suspension of the vagina if performed, and any associated repair; other than a service associated with a service to which item 30390, 35595 or 35597 applies (H) (Anaes.) (Assist.) | $2348.10 |
| 32123 | ANAL STRICTURE, anoplasty for (Anaes.) (Assist.) | $691.20 |
| 32129 | ANAL SPHINCTER, repair (H) (Anaes.) (Assist.) | $1311.70 |
| 32131 | RECTOCELE, transanal repair of rectocele (Anaes.) (Assist.) | $1105.10 |
| 32135 | Treatment of haemorrhoids or rectal prolapse, including rubber band ligation or sclerotherapy for, not being a service to which item 32139 applies (Anaes.) | $140.10 |
| 32139 | Operative treatment of haemorrhoids involving third-degree or fourth-degree haemorrhoids, including excision of anal skin tags when performed, not being a service associated with a service to which item 32135 or 32233 applies (H) (Anaes.) (Assist.) | $756.40 |
| 32147 | Perianal thrombosis, incision of (Anaes.) | $93.30 |
| 32150 | Operation for anal fissure, including excision, injection of Botulinum toxin or sphincterotomy, excluding dilatation (Anaes.) (Assist.) | $528.70 |
| 32156 | Anal fistula, subcutaneous, excision of (Anaes.) | $276.20 |
| 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.) | $677.50 |
| 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.) | $1029.40 |
| 32165 | Operative treatment of anal fistula, repair by mucosal advancement flap, including ligation of inter-sphincteric fistula tract (LIFT) or other complex sphincter sparing surgery (Anaes.) (Assist.) | $1311.70 |
| 32166 | Anal fistula—readjustment of Seton (Anaes.) | $428.40 |
| 32171 | Anorectal examination, with or without biopsy, under general anaesthetic, with or without faecal disimpaction, other than a service associated with a service to which another item in this Group applies (H) (Anaes.) | $189.20 |
| 32174 | INTR-AANAL, perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.) | $181.80 |
| 32175 | INTRA-ANAL, PERIANAL or ISCHIO-RECTAL ABSCESS, draining of, undertaken in the operating theatre of a hospital (excluding aftercare) (Anaes.) | $346.60 |
| 32183 | INTESTINAL SLING PROCEDURE prior to radiotherapy (Anaes.) (Assist.) | $1161.00 |
| 32186 | COLONIC LAVAGE, total, intra operative (Anaes.) (Assist.) | $1161.00 |
| 32212 | ANO-RECTAL APPLICATION OF FORMALIN in the treatment of radiation proctitis, where performed in the operating theatre of a hospital, excluding aftercare (Anaes.) | $276.20 |
| 32213 | Sacral nerve lead or leads, placement of, percutaneous or open, including intraoperative test stimulation and programming, for the management of faecal incontinence (H) (Anaes.) | $1366.40 |
| 32215 | Sacral nerve electrode or electrodes, management, adjustment and electronic programming of the neurostimulator by a medical practitioner, to manage faecal incontinence, not being a service associated with a service to which item 32213, 32216, 32218 or 32237 applies. Applicable once per day for the same patient by the same practitioner | $255.00 |
| 32216 | Sacral nerve lead or leads, inserted for the management of faecal incontinence in a patient with faecal incontinence refractory to conservative non-surgical treatment, either:(a) percutaneous surgical repositioning of the lead or leads, using fluoroscopic guidance; or(b) open surgical repositioning of the lead or leads; to correct displacement or unsatisfactory positioning (including intraoperative test stimulation), not being a service associated with a service to which item 32213 applies (H) (Anaes.) | $1227.00 |
| 32218 | Sacral nerve lead or leads, removal (H) (Anaes.) | $322.10 |
| 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. (Anaes.) (Assist.) | $1910.00 |
| 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.) | $625.40 |
| 32223 | Endoscopic examination of the colon to the caecum by colonoscopy, for a patient: (a) who has had a colonoscopy that revealed: (i) 1 to 4 adenomas, each of which was less than 10 mm in diameter, had no villous features and had no high grade dysplasia; or (ii) 1 or 2 sessile serrated lesions, each of which was less than 10 mm in diameter, and without 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.) | $625.40 |
| 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 10 mm or greater in diameter; or (ii) had villous features; or (iii) had high grade dysplasia; or (b) having had a previous colonoscopy that revealed: (i) 5 to 9 adenomas, each of which was less than 10 mm in diameter, had no villous features and had no high grade dysplasia; or (ii) 1 or 2 sessile serrated lesions, each of which was 10 mm or greater in diameter or had dysplasia; or (iii) a hyperplastic polyp that was 10 mm or greater in diameter; or (iv) 3 or more sessile serrated lesions, each of which was less than 10 mm in diameter and had no dysplasia; or (v) 1 or 2 traditional serrated adenomas, of any size Applicable only once in any 3 year period (Anaes.) | $625.40 |
| 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.) | $625.40 |
| 32226 | Endoscopic examination of the colon to the caecum by colonoscopy, for a patient who has a high risk of colorectal cancer due to: (a) having either: (i) a known or suspected familial condition, such as familial adenomatous polyposis, Lynch syndrome or serrated polyposis syndrome; or (ii) a genetic mutation associated with hereditary colorectal cancer; or (b) having had a previous colonoscopy that revealed: (i) 5 or more sessile serrated lesions, each of which was less than 10 mm in diameter and had no dysplasia; or (ii) 3 or more sessile serrated lesions, 1 or more of which was 10 mm or greater in diameter or had dysplasia; or (iii) 3 or more traditional serrated adenomas, of any size Applicable only once in any 12 month period (Anaes.) | $625.40 |
| 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.) | $877.50 |
| 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.) | $625.40 |
| 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.) | $504.40 |
| 32230 | Endoscopic mucosal resection using electrocautery of a non invasive sessile or flat superficial colorectal neoplasm which is at least 25mm in diameter, if the service is: (a) provided by a specialist gastroenterologist or surgical endoscopist; and (b) supported by photographic evidence to confirm the size of the polyp in situ, and (c) performed within 6 months after a service to which item 32222, 32223, 32224, 32225, 32226 or 32228 applies has been performed Applicable only once per polyp (H) (Anaes.) | $1279.80 |
| 32231 | Rectal tumour, per anal excision of (H) (Anaes.) (Assist.) | $622.90 |
| 32232 | Rectal tumour, per anal excision of, using a rectoscopy digital viewing system and pneumorectum if clinically appropriate and excluding use of a colonoscope as the operating platform, not being a service associated with a service to which item 32024, 32025 or 32106 applies (H) (Anaes.) (Assist.) | $1688.80 |
| 32233 | Perineal repair of rectal prolapse, not being a service associated with a service to which item 32139 applies (H) (Anaes.) (Assist.) | $1199.50 |
| 32234 | Rectal stricture, treatment of (H) (Anaes.) | $237.10 |
| 32235 | Anal skin tags or anal polyps, excision of one or more of (Anaes.) | $229.00 |
| 32236 | Anal warts, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block), not being a service associated with a service to which item 35507 or 35508 applies (H) (Anaes.) | $325.70 |
| 32237 | Neurostimulator or receiver, subcutaneous placement of, replacement of, or removal of, including programming and placement and connection of an extension wire or wires to sacral nerve electrode(s), for the management of faecal incontinence (H) (Anaes.) (Assist.) | $528.20 |
| **Vascular** | | |
| 32500 | Varicose veins, multiple injections of sclerosant using continuous compression techniques, including associated consultation, one or both legs, if: (a) proximal reflux of 0.5 seconds or longer has been demonstrated; and (b) the service is not for cosmetic purposes; and (c) the service is not associated with: (i) any other varicose vein operation on the same leg (excluding aftercare); or (ii) a service on the same leg (excluding aftercare) to which any of the following items apply: (A) 35200; (B) 59970 to 60078; (C) 60500 to 60509; (D) 61109 Applicable to a maximum of 6 treatments in a 12 month period (Anaes.) | $250.00 |
| 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.) | $625.00 |
| 32507 | Varicose veins, sub fascial ligation of one or more incompetent perforating veins in one leg of a patient, if the service: (a) is performed by open surgical technique (not including endoscopic ligation) and the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; and (b) is not associated with: (i) any other varicose vein operation on the same leg; or (ii) a service (on the same leg) to which item 35200, 60072, 60075 or 60078 applies (H) (Anaes.) (Assist.) | $1096.70 |
| 32508 | Varicose veins, complete dissection at the sapheno femoral or sapheno popliteal junction, with or without either ligation or stripping, or both, of the great or small saphenous veins in one leg of a patient, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both, if the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (a) ache; (b) pain; (c) tightness; (d) skin irritation; (e) heaviness; (f) muscle cramps; (g) limb swelling; (h) discolouration; (i) discomfort; (j) any other signs or symptoms attributable to venous dysfunction (H) (Anaes.) (Assist.) | $1135.70 |
| 32511 | Varicose veins, complete dissection at the sapheno femoral and sapheno popliteal junction, with or without either ligation or stripping, or both, of the great or small saphenous veins in one leg of a patient, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both, if the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (a) ache; (b) pain; (c) tightness; (d) skin irritation; (e) heaviness; (f) muscle cramps; (g) limb swelling; (h) discolouration; (i) discomfort; (j) any other signs or symptoms attributable to venous dysfunction (H) (Anaes.) (Assist.) | $1624.10 |
| 32514 | Varicose veins, ligation of the great or small saphenous vein in the same leg of a patient, with or without stripping, by re operation for recurrent veins in the same territory one leg including excision or injection of either tributaries or incompetent perforating veins, or both, if the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (a) ache; (b) pain; (c) tightness; (d) skin irritation; (e) heaviness; (f) muscle cramps; (g) limb swelling; (h) discolouration; (i) discomfort; (j) any other signs or symptoms attributable to venous dysfunction (H) (Anaes.) (Assist.) | $1917.70 |
| 32517 | Varicose veins, ligation of the great and small saphenous vein in the same leg of a patient, with or without stripping, by re operation for recurrent veins in either territory one leg including excision or injection of either tributaries or incompetent perforating veins, or both, if the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (a) ache; (b) pain; (c) tightness; (d) skin irritation; (e) heaviness; (f) muscle cramps; (g) limb swelling; (h) discolouration; (i) discomfort; (j) any other signs or symptoms attributable to venous dysfunction (H) (Anaes.) (Assist.) | $2610.50 |
| 32520 | Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great or small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using a laser probe introduced by an endovenous catheter, if all of the following apply: (a) it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) of the patient demonstrates reflux of 0.5 seconds or longer; (b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include radiofrequency diathermy, radiofrequency ablation or cyanoacrylate adhesive; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.) | $1086.10 |
| 32522 | Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great and small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using a laser probe introduced by an endovenous catheter, if all of the following apply: (a) it is documented by duplex ultrasound that the great and small saphenous veins of the patient demonstrate reflux of 0.5 seconds or longer; (b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include radiofrequency diathermy, radiofrequency ablation or cyanoacrylate adhesive; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.) | $1614.50 |
| 32523 | Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great or small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using a radiofrequency catheter introduced by an endovenous catheter, if all of the following apply: (a) 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; (b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include endovenous laser therapy or cyanoacrylate adhesive; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.) | $1153.00 |
| 32526 | Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great and small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using a radiofrequency catheter introduced by an endovenous catheter, if all of the following apply: (a) it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer; (b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include endovenous laser therapy or cyanoacrylate adhesive; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.) | $1714.40 |
| 32528 | Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great or small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using cyanoacrylate adhesive, if all of the following apply: (a) 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; (b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service include all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.) | $1030.20 |
| 32529 | Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great and small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using cyanoacrylate adhesive, if all of the following apply: (a) it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer; (b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.) | $1531.60 |
| 32700 | ARTERY OF NECK, bypass using vein or synthetic material (Anaes.) (Assist.) | $2982.10 |
| 32703 | INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of small length and reanastomosis of—with or without endarterectomy (Anaes.) (Assist.) | $2450.60 |
| 32708 | AORTIC BYPASS for occlusive disease using a straight non-bifurcated graft (Anaes.) (Assist.) | $2921.20 |
| 32710 | AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac arteries (Anaes.) (Assist.) | $3482.20 |
| 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.) | $3698.60 |
| 32712 | ILIO-FEMORAL BYPASS GRAFTING (Anaes.) (Assist.) | $2671.70 |
| 32715 | AXILLARY or SUBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL ARTERIES (Anaes.) (Assist.) | $2548.10 |
| 32718 | FEMORO-FEMORAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.) | $2528.40 |
| 32721 | RENAL ARTERY, bypass grafting to (Anaes.) (Assist.) | $3916.90 |
| 32724 | RENAL ARTERIES (both), bypass grafting to (Anaes.) (Assist.) | $4557.90 |
| 32730 | MESENTERIC VESSEL (single), bypass grafting to (Anaes.) (Assist.) | $3459.10 |
| 32733 | MESENTERIC VESSELS (multiple), bypass grafting to (Anaes.) (Assist.) | $3916.90 |
| 32736 | INFERIOR MESENTERIC ARTERY, operation on, when performed in conjunction with another intra-abdominal vascular operation (Anaes.) (Assist.) | $850.80 |
| 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.) | $2752.40 |
| 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.) | $3154.00 |
| 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.) | $3601.60 |
| 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.) | $3804.00 |
| 32751 | FEMORAL ARTERY BYPASS GRAFTING using synthetic graft, with lower anastomosis above or below the knee (Anaes.) (Assist.) | $2528.40 |
| 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.) | $3154.00 |
| 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.) | $838.80 |
| 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.) | $835.30 |
| 32763 | ARTERIAL BYPASS GRAFTING, using vein or synthetic material, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) | $2528.40 |
| 32766 | ARTERIAL OR VENOUS ANASTOMOSIS, not being a service to which another item in this Sub-group applies, as an independent procedure (Anaes.) (Assist.) | $2383.00 |
| 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.) | $562.30 |
| 33050 | BYPASS GRAFTING to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (Anaes.) (Assist.) | $3098.20 |
| 33055 | BYPASS GRAFTING to replace a popliteal aneurysm using a synthetic graft (Anaes.) (Assist.) | $2486.70 |
| 33070 | ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) | $1791.30 |
| 33075 | ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) | $2280.90 |
| 33080 | INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) | $2781.90 |
| 33100 | ANEURYSM OF COMMON OR INTERNAL CAROTID ARTERY, OR BOTH, replacement by graft of vein or synthetic material (Anaes.) (Assist.) | $2982.10 |
| 33103 | THORACIC ANEURYSM, replacement by graft (Anaes.) (Assist.) | $4185.20 |
| 33109 | THORACO-ABDOMINAL ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.) | $5189.50 |
| 33112 | SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.) | $4380.70 |
| 33115 | INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft, not being a service associated with a service to which item 33116 applies (Anaes.) (Assist.) | $2928.30 |
| 33116 | INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.) | $3032.60 |
| 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.) | $3262.20 |
| 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.) | $3201.50 |
| 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.) | $3520.90 |
| 33124 | ANEURYSM OF ILIAC ARTERY (common, external or internal), replacement by graft—unilateral (Anaes.) (Assist.) | $2511.70 |
| 33127 | ANEURYSMS OF ILIAC ARTERIES (common, external or internal), replacement by graft—bilateral (Anaes.) (Assist.) | $3219.60 |
| 33130 | ANEURYSM OF VISCERAL ARTERY, excision and repair by direct anastomosis or replacement by graft (Anaes.) (Assist.) | $2867.40 |
| 33133 | ANEURYSM OF VISCERAL ARTERY, dissection and ligation of arteries without restoration of continuity (Anaes.) (Assist.) | $2153.60 |
| 33136 | FALSE ANEURYSM, repair of, at aortic anastomosis following previous aortic surgery (Anaes.) (Assist.) | $5437.30 |
| 33139 | FALSE ANEURYSM, repair of, in iliac artery and restoration of arterial continuity (Anaes.) (Assist.) | $3377.30 |
| 33142 | FALSE ANEURYSM, repair of, in femoral artery and restoration of arterial continuity (Anaes.) (Assist.) | $3154.00 |
| 33145 | RUPTURED THORACIC AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) | $5274.80 |
| 33148 | RUPTURED THORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) | $6423.60 |
| 33151 | RUPTURED SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) | $6250.00 |
| 33154 | RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft (Anaes.) (Assist.) | $4740.20 |
| 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.) | $5288.90 |
| 33160 | RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (Anaes.) (Assist.) | $6165.00 |
| 33163 | RUPTURED ILIAC ARTERY ANEURYSM, replacement by graft (Anaes.) (Assist.) | $4330.30 |
| 33166 | RUPTURED ANEURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (Anaes.) (Assist.) | $4272.80 |
| 33169 | RUPTURED ANEURYSM OF VISCERAL ARTERY, simple ligation of (Anaes.) (Assist.) | $3326.50 |
| 33172 | ANEURYSM OF MAJOR ARTERY, replacement by graft, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) | $2649.10 |
| 33175 | RUPTURED ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) | $2505.90 |
| 33178 | RUPTURED ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) | $3190.70 |
| 33181 | RUPTURED INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) | $3900.90 |
| 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.) | $2333.70 |
| 33506 | INNOMINATE OR SUBCLAVIAN ARTERY, endarterectomy of, including closure by suture (Anaes.) (Assist.) | $2578.60 |
| 33509 | AORTIC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the aorta (Anaes.) (Assist.) | $2925.20 |
| 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.) | $3397.30 |
| 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.) | $3590.90 |
| 33518 | ILIAC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the iliac artery (Anaes.) (Assist.) | $2625.60 |
| 33521 | ILIO-FEMORAL ENDARTERECTOMY (1 side), including closure by suture (Anaes.) (Assist.) | $2844.50 |
| 33524 | RENAL ARTERY, endarterectomy of (Anaes.) (Assist.) | $3459.10 |
| 33527 | RENAL ARTERIES (both), endarterectomy of (Anaes.) (Assist.) | $3916.90 |
| 33530 | COELIAC OR SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) | $3459.10 |
| 33533 | COELIAC AND SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) | $3829.70 |
| 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.) | $2731.20 |
| 33539 | ARTERY OF EXTREMITIES, endarterectomy of, including closure by suture (Anaes.) (Assist.) | $1997.40 |
| 33542 | EXTENDED DEEP FEMORAL ENDARTERECTOMY where the endarterectomy is at least 7cms long (Anaes.) (Assist.) | $2869.50 |
| 33545 | ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is less than 3cm long (Anaes.) (Assist.) | $563.80 |
| 33548 | ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is 3cm long or greater (Anaes.) (Assist.) | $1183.80 |
| 33551 | VEIN, harvesting of from leg or arm for patch when not performed through same incision as operation (Anaes.) (Assist.) | $563.80 |
| 33554 | ENDARTERECTOMY, in conjunction with an arterial bypass operation to prepare the site for anastomosis—each site (Anaes.) (Assist.) | $559.80 |
| 33800 | EMBOLUS, removal of, from artery of neck (Anaes.) (Assist.) | $2445.80 |
| 33803 | EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an artery or bypass graft of trunk (Anaes.) (Assist.) | $2322.50 |
| 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.) | $1730.40 |
| 33810 | INFERIOR VENA CAVA OR ILIAC VEIN, closed thrombectomy by catheter via the femoral vein (Anaes.) (Assist.) | $1279.90 |
| 33811 | INFERIOR VENA CAVA OR ILIAC VEIN, open removal of thrombus or tumour (Anaes.) (Assist.) | $3636.80 |
| 33812 | THROMBUS, removal of, from femoral or other similar large vein (Anaes.) (Assist.) | $1934.70 |
| 33815 | MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) | $1764.60 |
| 33818 | MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.) | $2057.50 |
| 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.) | $2454.30 |
| 33824 | MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) | $2246.50 |
| 33827 | MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.) | $2623.30 |
| 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.) | $3079.30 |
| 33833 | MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by lateral suture (Anaes.) (Assist.) | $2763.10 |
| 33836 | MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by direct anastomosis (Anaes.) (Assist.) | $3377.30 |
| 33839 | MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by means of interposition graft (Anaes.) (Assist.) | $3844.80 |
| 33842 | ARTERY OF NECK, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (Anaes.) (Assist.) | $1884.70 |
| 33845 | LAPAROTOMY for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (Anaes.) (Assist.) | $1361.30 |
| 33848 | EXTREMITY, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no other procedure is performed (Anaes.) (Assist.) | $1361.30 |
| 34100 | MAJOR ARTERY OF NECK, elective ligation or exploration of, not being a service associated with any other vascular procedure (Anaes.) (Assist.) | $1505.00 |
| 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.) | $850.90 |
| 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.) | $685.00 |
| 34109 | TEMPORAL ARTERY, biopsy of (Anaes.) (Assist.) | $696.20 |
| 34112 | ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and ligation (Anaes.) (Assist.) | $1780.10 |
| 34115 | ARTERIO-VENOUS FISTULA OF THE NECK, dissection and ligation (Anaes.) (Assist.) | $1997.40 |
| 34118 | ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and ligation (Anaes.) (Assist.) | $2807.40 |
| 34121 | ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) | $2354.10 |
| 34124 | ARTERIO-VENOUS FISTULA OF THE NECK, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) | $2456.80 |
| 34127 | ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) | $3219.60 |
| 34130 | SURGICALLY CREATED ARTERIO-VENOUS FISTULA OF AN EXTREMITY, closure of (Anaes.) (Assist.) | $1022.50 |
| 34133 | SCALENOTOMY (Anaes.) (Assist.) | $1185.60 |
| 34136 | FIRST RIB, resection of portion of (Anaes.) (Assist.) | $1922.00 |
| 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.) | $1853.70 |
| 34142 | COELIAC ARTERY, decompression of, for coeliac artery compression syndrome, as an independent procedure (Anaes.) (Assist.) | $2331.00 |
| 34145 | POPLITEAL ARTERY, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (Anaes.) (Assist.) | $1737.00 |
| 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.) | $3380.00 |
| 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.) | $4063.50 |
| 34154 | RECURRENT CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Anaes.) (Assist.) | $4980.00 |
| 34157 | NECK, excision of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.) | $2411.10 |
| 34160 | AORTO-DUODENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes.) (Assist.) | $4516.60 |
| 34163 | AORTO-DUODENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum (Anaes.) (Assist.) | $5798.30 |
| 34166 | AORTO-DUODENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo-bifemoral grafting (Anaes.) (Assist.) | $6136.00 |
| 34169 | INFECTED BYPASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.) (Assist.) | $3377.30 |
| 34172 | INFECTED AXILLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of arteries (Anaes.) (Assist.) | $2752.40 |
| 34175 | INFECTED BYPASS GRAFT FROM EXTREMITIES, excision of including closure of arteries (Anaes.) (Assist.) | $2528.40 |
| 34500 | ARTERIOVENOUS SHUNT, EXTERNAL, insertion of (Anaes.) (Assist.) | $625.60 |
| 34503 | ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, in conjunction with another venous or arterial operation (Anaes.) (Assist.) | $852.80 |
| 34506 | ARTERIOVENOUS SHUNT, EXTERNAL, removal of (Anaes.) (Assist.) | $433.30 |
| 34509 | ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, not in conjunctionwith another venous or arterial operation (Anaes.) (Assist.) | $2024.00 |
| 34512 | ARTERIOVENOUS ACCESS DEVICE, insertion of (Anaes.) (Assist.) | $2286.80 |
| 34515 | ARTERIOVENOUS ACCESS DEVICE, thrombectomy of (Anaes.) (Assist.) | $1592.60 |
| 34518 | STENOSIS OF ARTERIOVENOUS FISTULA OR PROSTHETIC ARTERIOVENOUS ACCESS DEVICE, correction of (Anaes.) (Assist.) | $2736.30 |
| 34521 | INTRA-ABDOMINAL ARTERY OR VEIN, cannulation of, for infusion chemotherapy, by open operation (excluding aftercare) (Anaes.) (Assist.) | $1395.80 |
| 34524 | ARTERIAL CANNULATION for infusion chemotherapy by open operation, not being a service to which item 34521 applies (excluding after-care) (Anaes.) (Assist.) | $879.50 |
| 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 catheterisation, on a patient 10 years of age or over (Anaes.) | $1216.90 |
| 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 patient 10 years of age or over (Anaes.) | $580.30 |
| 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 catheterisation, on a patient under 10 years of age (Anaes.) | $1436.20 |
| 34530 | CENTRAL VENOUS LINE, OR OTHER CHEMOTHERAPY DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital on a patient 10 years of age or over (Anaes.) | $424.10 |
| 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.) | $2565.10 |
| 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 patient under 10 years of age (Anaes.) | $709.30 |
| 34538 | CENTRAL VEIN CATHERTERISATION by percutaneous technique, using subcutaneous tunnelled cuffed catheter or similar device, for the administration of haemodialysis or parenteral nutrition (Anaes.) | $590.80 |
| 34539 | Tunnelled cuffed catheter, or similar device, removal of, by open surgical procedure (Anaes.) | $443.10 |
| 34540 | CENTRAL VENOUS LINE, OR OTHER CHEMOTHERAPY DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital, on a patient under 10 years of age (Anaes.) | $531.90 |
| 34800 | INFERIOR VENA CAVA, plication, ligation, or application of caval clip (Anaes.) (Assist.) | $1827.60 |
| 34803 | INFERIOR VENA CAVA, reconstruction of or bypass by vein or synthetic material (Anaes.) (Assist.) | $3913.70 |
| 34806 | CROSS LEG BYPASS GRAFTING, saphenous to iliac or femoral vein (Anaes.) (Assist.) | $1968.40 |
| 34809 | SAPHENOUS VEIN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (Anaes.) (Assist.) | $1968.40 |
| 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.) | $2520.30 |
| 34815 | VEIN STENOSIS, patch angioplasty for, (excluding vein graft stenosis)-using vein or synthetic material (Anaes.) (Assist.) | $1997.40 |
| 34818 | VENOUS VALVE, plication or repair to restore valve competency (Anaes.) (Assist.) | $2271.00 |
| 34821 | VEIN TRANSPLANT to restore valvular function (Anaes.) (Assist.) | $2945.00 |
| 34824 | EXTERNAL STENT, application of, to restore venous valve competency to superficial vein—1 stent (Anaes.) (Assist.) | $1175.00 |
| 34827 | EXTERNAL STENTS, application of, to restore venous valve competency to superficial vein or veins—more than 1 stent (Anaes.) (Assist.) | $1288.40 |
| 34830 | EXTERNAL STENT, application of, to restore venous valve competency to deep vein (1 stent) (Anaes.) (Assist.) | $1434.50 |
| 34833 | EXTERNAL STENTS, application of, to restore venous valve competency to deep vein or veins (more than 1 stent) (Anaes.) (Assist.) | $1861.40 |
| 35000 | LUMBAR SYMPATHECTOMY (Anaes.) (Assist.) | $1505.00 |
| 35003 | CERVICAL OR UPPER THORACIC SYMPATHECTOMY by any surgical approach (Anaes.) (Assist.) | $1943.90 |
| 35006 | CERVICAL OR UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (Anaes.) (Assist.) | $2367.20 |
| 35009 | LUMBAR SYMPATHECTOMY, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (Anaes.) (Assist.) | $1839.90 |
| 35012 | SACRAL or PRE-SACRAL SYMPATHECTOMY (Anaes.) (Assist.) | $1459.20 |
| 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.) | $760.30 |
| 35103 | Ischaemic limb, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (Anaes.) | $481.80 |
| 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.) | $353.40 |
| 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.) | $1738.80 |
| 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.) | $1061.10 |
| 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.) | $1362.40 |
| 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.) | $1266.10 |
| 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.) | $2317.70 |
| 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.) | $1567.90 |
| 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.) | $1779.30 |
| 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.) | $1868.90 |
| 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.) | $732.20 |
| 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.) | $1320.70 |
| 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.) | $1848.60 |
| 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.) | $1673.20 |
| 35324 | ANGIOSCOPY not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) | $627.90 |
| 35327 | ANGIOSCOPY combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) | $829.20 |
| 35330 | INSERTION of INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) | $1067.90 |
| 35331 | RETRIEVAL OF INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (Anaes.) | $1260.30 |
| 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.) | $1680.50 |
| 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.) | $1511.10 |
| 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.) | $1260.30 |
| 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.) | $985.80 |
| 35401 | Vertebroplasty, for one or more fractures in one or more vertebrae, performed by an interventional radiologist, for the treatment of a painful osteoporotic thoracolumbar vertebral compression fracture of the thoracolumbar spinal segment (T11, T12, L1 or L2), if: (a) pain is severe (numeric rated pain score greater than or equal to 7 out of 10); and (b) symptoms are poorly controlled by opiate therapy; and (c) severe pain duration is 3 weeks or less; and (d) there is MRI (or SPECT CT if MRI unavailable) evidence of acute vertebral fracture Applicable only once for the same fracture, but is applicable for a new fracture of the same vertebra or vertebrae (H) (Anaes.) | $1307.80 |
| 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. | $699.80 |
| 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.) | $1642.00 |
| 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.) | $1231.60 |
| 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.) | $1642.00 |
| 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 intra operative imaging, but in association with pre operative diagnostic imaging under item 60009 and one of items 60072, 60075 and 60078, including aftercare (Anaes.) (Assist.) | $5768.90 |
| 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.) | $6757.20 |
| **Gynaecological** | | |
| 35500 | GYNAECOLOGICAL EXAMINATION UNDER ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) | $167.30 |
| 35503 | Introduction of an intra-uterine device for abnormal uterine bleeding or contraception or for endometrial protection during oestrogen replacement therapy, if the service is not associated with a service to which another item in this Group applies (other than a service described in item 30062, 35506 or 35620) (Anaes.) | $122.30 |
| 35506 | Intra-uterine device, removal of under general anaesthesia, for a retained or embedded device, not being a service associated with a service to which another item in this Group applies (other than a service described in item 35503) (Anaes.) | $114.80 |
| 35507 | Vulval or vaginal warts, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block), if the time taken is less than or equal to 45 minutes other than a service associated with a service to which item 32236 applies (H) (Anaes.) | $361.10 |
| 35508 | Vulval or vaginal warts, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block), if the time taken is greater than 45 minutes other than a service associated with a service to which item 32236 applies (H) (Anaes.) (Assist.) | $528.10 |
| 35509 | Hymenectomy (Anaes.) | $183.50 |
| 35513 | Bartholin’s abscess, cyst or gland, excision of (Anaes.) | $471.70 |
| 35517 | Bartholin’s abscess, cyst or gland, marsupialisation of (Anaes.) | $316.20 |
| 35518 | Ovarian cyst aspiration, for cysts of at least 4 cm in diameter in a premenopausal patient and at least 2 cm in diameter in a postmenopausal patient, by abdominal or vaginal route, using interventional imaging techniques and not associated with services provided for assisted reproductive techniques, and not in cases of suspected or possible malignancy (Anaes.) | $442.20 |
| 35527 | Urethral caruncle, symptomatic excision of, if:(a) conservative management has failed; or(b) there is a suspicion of malignancy (Anaes.) | $308.20 |
| 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.) | $760.00 |
| 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.) | $716.90 |
| 35536 | Vulva, wide local excision or hemivulvectomy, one or both procedures, for suspected malignancy or vulval lesions with a high risk of malignancy (Anaes.) (Assist.) | $717.00 |
| 35539 | Colposcopically directed laser therapy for histologically-confirmed high grade intraepithelial neoplastic changes of the vagina, vulva, urethra or anal canal, including any associated biopsies one anatomical site (Anaes.) | $561.90 |
| 35545 | Colposcopically directed laser therapy for condylomata, unsuccessfully treated by other methods (Anaes.) | $370.80 |
| 35548 | VULVECTOMY, radical, for malignancy (H) (Anaes.) (Assist.) | $1899.90 |
| 35551 | Pelvic lymph nodes, radical excision of, unilateral, or sentinel node dissection (including any pre-operative injection) (Anaes.) (Assist.) | $1751.10 |
| 35552 | Pelvic lymph nodes, radical excision of, unilateral or sentinel node dissection, following similar previous dissection, radiation or chemotherapy (H) (Anaes.) (Assist.) | $2640.60 |
| 35554 | VAGINA, DILATATION OF, as an independent procedure including any associated consultation (Anaes.) | $87.70 |
| 35557 | Vagina, complete excision of benign tumour (including Gartner duct cyst), with histological documentation (Anaes.) | $441.80 |
| 35560 | Partial or complete vaginectomy, for either or both of the following: (a) deeply infiltrating vaginal endometriosis, if accompanied by histological confirmation from excised tissue; (b) pre-invasive or invasive lesions Not being a service associated with hysterectomy for non invasive indications (H) (Anaes.) (Assist.) | $1410.30 |
| 35561 | VAGINECTOMY, radical, for proven invasive malignancy—1 surgeon (H) (Anaes.) (Assist.) | $3119.50 |
| 35562 | VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery—abdominal surgeon (including aftercare) (H) (Anaes.) (Assist.) | $2511.30 |
| 35564 | VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery—perineal surgeon (H) (Assist.) | $1314.80 |
| 35565 | VAGINAL RECONSTRUCTION for congenital absence, gynatresia or urogenital sinus (Anaes.) (Assist.) | $1531.00 |
| 35566 | VAGINAL SEPTUM, excision of, for correction of double vagina (Anaes.) (Assist.) | $845.00 |
| 35568 | Procedures for the management of symptomatic upper vaginal (vault or cervical) prolapse by sacrospinous or ilococcygeus fixation (H) (Anaes.) (Assist.) | $1288.20 |
| 35569 | Plastic repair to enlarge vaginal orifice (Anaes.) | $342.10 |
| 35570 | Anterior vaginal compartment repair by vaginal approach for pelvic organ prolapse: (a) involving repair of urethrocele and cystocele; and (b) using native tissue without graft; other than a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.) | $1141.80 |
| 35571 | Posterior vaginal compartment repair by vaginal approach for pelvic organ prolapse: (a) involving repair of one or more of the following: (i) perineum; (ii) rectocoele; (iii) enterocoele; and (b) using native tissue without graft; other than a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.) | $1138.30 |
| 35573 | Anterior and posterior vaginal compartment repair by vaginal approach for pelvic organ prolapse: (a) involving anterior and posterior compartment defects; and (b) using native tissue without graft; other than a service associated with a service to which item 35577 or 35578 applies (Anaes.) (Assist.) | $1723.70 |
| 35577 | Manchester (Donald Fothergill) operation for pelvic organ prolapse, involving either or both of the following: (a) cervical amputation; (b) anterior and posterior native tissue vaginal wall repairs without graft (Anaes.) (Assist.) | $1395.90 |
| 35578 | Colpocleisis for pelvic organ prolapse, not being a service associated with a service to which another item (other than item 35599) in this Subgroup applies (H) (Anaes.) (Assist.) | $1437.50 |
| 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 2cm2 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.) | $1069.30 |
| 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),2cm2 or more 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.) | $1604.20 |
| 35585 | Abdominal procedure, by open, laparoscopic or robot assisted approach, if the service: (a) is for the removal of graft material: (i) in symptomatic patients with graft related complications (including graft related pain or discharge and bleeding related to graft exposure); or (ii) where the graft has penetrated adjacent organs such as the bladder (including urethra) or bowel; and (b) if required includes retroperitoneal dissection, and mobilisation, of either or both of the bladder and bowel; other than a service associated with a service to which item 35581 or 35582 applies (Anaes.) (Assist.) | $2844.20 |
| 35591 | Rectovaginal fistula repair of, by vaginal route approach, not being a service associated with a service to which item 35592, 35596, 37029, 37333 or 37336 applies (H) (Anaes.) (Assist.) | $1701.30 |
| 35592 | Vesicovaginal fistula closure of, by vaginal approach, not being a service associated with a service to which item 35591, 35596, 37029, 37333 or 37336 applies (H) (Anaes.) (Assist.) | $1701.30 |
| 35595 | Procedure for the management of symptomatic vaginal vault or cervical prolapse, by uterosacral ligament suspension, by any approach, without graft, if the uterosacral ligaments are separately identified, transfixed and then incorporated into rectovaginal and pubocervical fascia of the vaginal vault, including cystoscopy to check ureteric integrity (H) (Anaes.) (Assist.) | $1925.00 |
| 35596 | Fistula between genital and urinary or alimentary tracts, repair of, other than a service to which item 35591, 35592, 37029, 37333 or 37336 applies (H) (Anaes.) (Assist.) | $1549.80 |
| 35597 | Sacral colpopexy, by any approach where graft or mesh is secured to vault, anterior and posterior compartments and to sacrum for correction of symptomatic upper vaginal vault prolapse (H) (Anaes.) (Assist.) | $3227.40 |
| 35599 | Stress incontinence, procedure using a female synthetic mid-urethral sling, with diagnostic cystoscopy to assess the integrity of the lower urinary tract, other than a service associated with a service to which item 36812 applies (H) (Anaes.) (Assist.) | $1593.80 |
| 35608 | Cervix, one or more biopsies, cauterisation (other than by chemical means), ionisation, diathermy or endocervical curettage of, with or without dilatation of cervix (Anaes.) | $132.40 |
| 35609 | Cervix, cone biopsy or amputation (Anaes.) | $401.00 |
| 35610 | Cervix, cone biopsy for histologically proven malignancy (Anaes.) | $701.80 |
| 35611 | Removal of cervical or vaginal polyp or polypi, with or without dilatation of cervix, not being a service associated with a service to which item 35608 applies (Anaes.) | $131.40 |
| 35612 | Cervix, residual stump, removal of, by abdominal approach for non-malignant lesions (Anaes.) (Assist.) | $1077.00 |
| 35614 | Examination of the lower genital tract using a colposcope in a patient who:(a) has a human papilloma virus related gynaecology indication; or(b) has symptoms or signs suspicious of lower genital tract malignancy; or(c) is undergoing follow-up treatment of lower genital tract malignancy; or(d) is undergoing assessment or surveillance of a vulvovaginal pre-malignant or malignant disease; or(e) is undergoing assessment or surveillance as part of an identified at risk population | $131.60 |
| 35615 | Vulva or vagina, biopsy of, when performed in conjunction with a service to which item 35614 applies | $121.70 |
| 35616 | Endometrial ablation by thermal balloon or radiofrequency electrosurgery, for abnormal uterine bleeding, with or without endometrial sampling, including any hysteroscopy performed on the same day (H) (Anaes.) | $956.60 |
| 35620 | Endometrial biopsy for pathological assessment in women with abnormal uterine bleeding or post-menopausal bleeding (Anaes.) | $113.70 |
| 35622 | Endometrial ablation, using hysteroscopically guided electrosurgery or laser energy for abnormal uterine bleeding, with or without endometrial sampling, not being a service associated with a service to which item 30390 applies (H) (Anaes.) | $1238.20 |
| 35623 | Endometrial ablation and resection of myoma or uterine septum (or both), using hysteroscopic guided electrosurgery or laser energy, for abnormal uterine bleeding, with or without endometrial sampling (H) (Anaes.) | $1692.10 |
| 35626 | Hysteroscopy for investigation of suspected intrauterine pathology, with or without local anaesthesia, including any associated endometrial biopsy, not being a service associated with a service to which item 35630 applies | $189.20 |
| 35630 | Hysteroscopy for investigation of suspected intrauterine pathology if performed under general anaesthesia, including any associated endometrial biopsy, not being a service associated with a service to which item 35626 applies (H) (Anaes.) | $397.70 |
| 35631 | Operative laparoscopy, including any of the following:(a) unilateral or bilateral ovarian cystectomy;(b) salpingo-oophorectomy;(c) salpingectomy for tubal pathology (including ectopic pregnancy by tubal removal or salpingostomy, but excluding sterilisation);(d) excision of mild endometriosis;not being a service associated with a service to which any other intraperitoneal or retroperitoneal procedure item (other than item 30724 or 30725) applies (H) (Anaes.) (Assist.) | $1309.00 |
| 35632 | Complicated operative laparoscopy, including either or both of the following:(a) excision of moderate endometriosis;(b) laparoscopic myomectomy for a myoma of at least 4cm, including incision and repair of the uterus; not being a service associated with a service to which any other intraperitoneal or retroperitoneal procedure item (other than item 30724 or 30725 or 35658) applies (H) (Anaes.) (Assist.) | $1636.20 |
| 35633 | Hysteroscopy, under visual guidance, including any of the following:(a) removal of an intra-uterine device;(b) removal of polyps by any method;(c) division of minor intrauterine adhesions (Anaes.) | $451.10 |
| 35635 | Hysteroscopy involving division of:(a) a uterine septum; or(b) moderate to severe intrauterine adhesions (H) (Anaes.) | $754.60 |
| 35636 | Hysteroscopy, resection of myoma or myoma and uterine septum (if both are performed) (H) (Anaes.) | $913.20 |
| 35637 | Operative laparoscopy, including any of the following: (a) excision or ablation of minimal endometriosis; (b) division of pathological adhesions; (c) sterilisation by application of clips, division, destruction or removal of tubes; not being a service associated with another laparoscopic procedure (H) 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.) | $866.20 |
| 35640 | Uterus, curettage of, with or without dilation (including curettage for incomplete miscarriage), if performed under:(a) general anaesthesia; or(b) epidural or spinal (intrathecal) nerve block; or(c) sedation; including procedures (if performed) to which item 35626 or 35630 applies (Anaes.) | $377.10 |
| 35641 | Severe endometriosis, laparoscopic resection of, involving 2 of the following procedures:(a) resection of the pelvic side wall including dissection of endometriosis or scar tissue from the ureter;(b) resection of the Pouch of Douglas; (c) resection of an ovarian endometrioma greater than 2 cm in diameter;(d) dissection of bowel from uterus from the level of the endocervical junction or above (H) (Anaes.) (Assist.) | $2687.90 |
| 35643 | Evacuation of the contents of the gravid uterus by curettage or suction curettage, if performed under:(a) local anaesthesia; or(b) general anaesthesia; or(c) epidural or spinal (intrathecal) nerve block; or(d) sedation; including procedures (if performed) to which item 35626 or 35630 applies (Anaes.) | $439.90 |
| 35644 | Cervix, ablation by electrocoagulation diathermy, laser or cryotherapy, with colposcopy, including any local anaesthesia and biopsies, for previously biopsy confirmed HSIL (CIN 2/3) in a patient with a Type 1 or 2 (completely visible) transformation zone, if there is:(a) no evidence of invasive or glandular disease; and(b) no discordance between cytology and previous histology; not being a service associated with a service to which item 35647 or 35648 applies (Anaes.) | $411.20 |
| 35645 | Cervix, ablation by electrocoagulation diathermy, laser or cryotherapy, with colposcopy, including any local anaesthesia or biopsies, in conjunction with ablative therapy of additional areas of biopsy proven high grade intraepithelial lesions of one or more sites of the vagina, vulva, urethra or anus, for previously biopsy confirmed HSIL (CIN2/3) in a patient with a Type 1 of 2 (completely visible) transformation zone, if there is:(a) no evidence of invasive or glandular disease; and(b) no discordance between cytology and previous histology; not being a service associated with a service to which item 35647 or 35648 applies (Anaes.) | $654.90 |
| 35647 | Cervix, complete excision of the endocervical transformation zone, using large loop or laser therapy, including any local anaesthesia and biopsies (Anaes.) | $449.00 |
| 35648 | Cervix, complete excision of the endocervical transformation zone, using large loop or laser therapy, including any local anaesthesia and biopsies, in conjunction with ablative treatment of additional areas of biopsy-proven high grade intraepithelial lesions of one or more sites of the vagina, vulva, urethra or anus (Anaes.) | $679.50 |
| 35649 | Myomectomy, one or more myomas, when undertaken by an open abdominal approach (H) (Anaes.) (Assist.) | $1158.70 |
| 35653 | Hysterectomy, abdominal, with or without removal of fallopian tubes and ovaries (H) (Anaes.) (Assist.) | $1386.20 |
| 35657 | Hysterectomy, vaginal, with or without uterine curettage, inclusive of posterior culdoplasty, not being a service associated with a service to which item 35673 applies (H) (Anaes.) (Assist.) | $1435.70 |
| 35658 | Uterus (at least equivalent in size to a 10 week gravid uterus), debulking of, prior to vaginal or laparoscopic removal at hysterectomy or myoma of at least 4 cm removed by laparoscopy when retrieved from the abdomen (H) (Anaes.) (Assist.) | $896.80 |
| 35661 | Hysterectomy, abdominal, that concurrently requires extensive retroperitoneal dissection with exposure of one or both ureters and complex side wall dissection, including when performed with one or more of the following procedures:(a) salpingectomy;(b) oophorectomy;(c) excision of ovarian cyst(H) (Anaes.) (Assist.) | $2018.50 |
| 35667 | Radical hysterectomy or radical trachelectomy (with or without excision of uterine adnexae) for proven malignancy, including excision of any one or more of the following:(a) parametrium;(b) paracolpos;(c) upper vagina;(d) contiguous pelvic peritoneum;utilising nerve sparing techniques and involving ureterolysis, if performed (H) (Anaes.) (Assist.) | $2798.50 |
| 35668 | Hysterectomy, radical (with or without excision of uterine adnexae) including excision of any one or more of the following:(a) parametrium;(b) paracolpos;(c) upper vagina;(d) contiguous pelvic peritoneum;utilising nerve sparing techniques and involving ureterolysis, if performed in a patient with malignancy and previous pelvic radiation or chemotherapy treatment (H) (Anaes.) (Assist.) | $3406.00 |
| 35669 | Hysterectomy, peripartum, performed for histologically proven placenta increta or percreta, or placenta accreta, if the patient has been referred to another practitioner for the management of severe intractable peripartum haemorrhage (H) (Anaes.) (Assist.) | $3406.00 |
| 35671 | Hysterectomy, peripartum, for ongoing intractable haemorrhage where other haemorrhage control techniques have failed, for the purpose of providing lifesaving emergency treatment, not being a service associated with a service to which item 35667, 35668 or 35669 applies (H) (Anaes.) (Assist.) | $2671.90 |
| 35673 | Hysterectomy, vaginal, with or without uterine curettage, with salpingectomy, oophorectomy or excision of ovarian cyst, one or more, one or both sides, inclusive of a posterior culdoplasty, not being a service associated with a service to which item 35657 applies (H) (Anaes.) (Assist.) | $1561.50 |
| 35674 | Ultrasound guided needling and injection of ectopic pregnancy | $419.90 |
| 35680 | BICORNUATE UTERUS, plastic reconstruction for (Anaes.) (Assist.) | $1219.10 |
| 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 explanatory note before submitting a claim. (Anaes.) (Assist.) | $329.00 |
| 35694 | Tuboplasty (salpingostomy or salpingolysis), unilateral or bilateral, one or more procedures (H) (Anaes.) (Assist.) | $1313.70 |
| 35697 | Microsurgical or laparoscopic tuboplasty (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.) | $1961.20 |
| 35700 | FALLOPIAN TUBES, unilateral microsurgical or laparoscopic anastomosis of (H) (Anaes.) (Assist.) | $1575.00 |
| 35703 | HYDROTUBATION OF FALLOPIAN TUBES as a nonrepetitive procedure (Anaes.) | $148.00 |
| 35717 | Laparotomy, involving oophorectomy, salpingectomy, salpingo-oophorectomy, removal of ovarian, parovarian, fimbrial or broad ligament cyst one or more such procedures, unilateral or bilateral, including adhesiolysis, for benign disease (including ectopic pregnancy by tubal removal or salpingostomy), not being a service associated with hysterectomy (H) (Anaes.) (Assist.) | $1231.30 |
| 35720 | Radical debulking, involving the radical excision of a macroscopically disseminated gynaecological malignancy from the pelvic cavity, including resection of peritoneum from the following:(a) the pelvic side wall;(b) the pouch of Douglas;(c) the bladder; for macroscopic disease confined to the pelvis, not being a service associated with a service to which item 35721 applies (H) (Anaes.) (Assist.) | $1550.10 |
| 35721 | Radical debulking, involving the radical excision of a macroscopically disseminated gynaecological malignancy from the abdominal and pelvic cavity, where cancer has extended beyond the pelvis, including any of the following:(a) resection of peritoneum over any of the following: (i) the diaphragm; (ii) the paracolic gutters; (iii) the greater or lesser omentum; (iv) the porta hepatis;(b) cytoreduction of recurrent gynaecological malignancy from the abdominal cavity following previous abdominal surgery, radiation or chemotherapy;(c) cytoreduction of recurrent gynaecological malignancy from the pelvic cavity following previous pelvic surgery, radiation or chemotherapy; not being a service to which a service associated with a service to which item 35720 or 35726 applies (H) (Anaes.) (Assist.) | $5868.70 |
| 35723 | Para-aortic lymph node dissection from above the level of the aortic bifurcation (unilateral), for staging or restaging of gynaecological malignancy (H) (Anaes.) (Assist.) | $1112.20 |
| 35724 | Para-aortic lymph node dissection (pelvic or above the aortic bifurcation) after prior similar dissection, radiotherapy or chemotherapy for malignancy (H) (Anaes.) (Assist.) | $3839.20 |
| 35726 | Infra-colic omentectomy, with or without multiple peritoneal biopsies, for staging or restaging of gynaecological malignancy, not being a service associated with a service to which item 35721 applies (H) (Anaes.) (Assist.) | $1052.50 |
| 35729 | OVARIAN TRANSPOSITION out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy (Anaes.) | $478.40 |
| 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.) | $420.60 |
| 35750 | Hysterectomy, laparoscopic assisted vaginal, by any approach, including any endometrial sampling, with or without removal of the tubes or ovarian cystectomy or removal of the ovaries and tubes due to other pathology, not being a service associated with a service to which item 35595 or 35673 applies. (H) (Anaes.) (Assist.) | $1706.00 |
| 35751 | Hysterectomy, laparoscopic, by any approach, including any endometrial sampling, with or without removal of the tubes, not being a service associated with a service to which item 35595 applies (H) (Anaes.) (Assist.) | $1443.60 |
| 35753 | Hysterectomy, complex laparoscopic, by any approach, including endometrial sampling, with either or both of the following procedures:(a) unilateral or bilateral salpingo-oophorectomy (excluding salpingectomy);(b) excision of moderate endometriosis or ovarian cyst; including any associated laparoscopy, not being a service associated with a service to which item 35595 applies (H) (Anaes.) (Assist.) | $1819.90 |
| 35754 | Hysterectomy, complex laparoscopic, by any approach, that concurrently requires either extensive retroperitoneal dissection or complex side wall dissection, or both, with any of the following procedures (if performed):(a) endometrial sampling; (b) unilateral or bilateral salpingectomy, oophorectomy or salpingo-oophorectomy;(c) excision of ovarian cyst; (d) any other associated laparoscopy; not being a service associated with a service to which item 35595 or 35641 applies (H) (Anaes.) (Assist.) | $2848.50 |
| 35756 | Hysterectomy, laparoscopic, by any approach, if the procedure is completed by open hysterectomy for control of bleeding or extensive pathology, including any associated laparoscopy, not being a service associated with a service to which item 35595 or 35641 applies (H) (Anaes.) (Assist.) | $1775.60 |
| 35759 | Procedure for the control of post operative haemorrhage following gynaecological surgery, under general anaesthesia, utilising a vaginal, abdominal or laparoscopic approach if no other procedure is performed (H) (Anaes.) (Assist.) | $1166.10 |
| **Urological** | | |
| 36502 | PELVIC LYMPHADENECTOMY, open or laparoscopic, or both, unilateral or bilateral (Anaes.) (Assist.) | $1475.00 |
| 36503 | RENAL TRANSPLANT (not being a service to which item 36506 or 36509 applies) (Anaes.) (Assist.) | $2974.90 |
| 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 or 37215 applies (Anaes.) | $556.70 |
| 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.) | $437.50 |
| 36506 | RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together vascular anastomosis including aftercare (Anaes.) (Assist.) | $1980.50 |
| 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.) | $733.00 |
| 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.) | $1428.20 |
| 36509 | RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together ureterovesical anastomosis including aftercare (Assist.) | $1609.60 |
| 36516 | Nephrectomy, complete, by open, laparoscopic or robot-assisted approach, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) | $1903.70 |
| 36519 | Nephrectomy, complete, by open, laparoscopic or robot-assisted approach, complicated by previous surgery on the same kidney, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) | $2659.30 |
| 36522 | Nephrectomy, partial, by open, laparoscopic or robot-assisted approach, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) | $2285.00 |
| 36525 | Nephrectomy, partial, by open, laparoscopic or robot assisted approach: (a) if complicated by previous surgery or ablative procedure on the same kidney; or (b) for a patient with a solitary functioning kidney; or (c) for a patient with an estimated glomerular filtration rate (eGFR) of less than 60ml/min/1.73m2; other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) | $3235.00 |
| 36528 | Nephrectomy, radical, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10 cm in diameter, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) | $2665.00 |
| 36529 | Nephrectomy, radical, by open, laparoscopic or robot assisted approach, with or without en bloc dissection of lymph nodes, with or without adrenalectomy: (a) for a tumour 10 cm or more in diameter; or (b) if complicated by previous open or laparoscopic surgery on the same kidney; other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) | $3224.10 |
| 36530 | Renal cell carcinoma, not more than 4 cm in diameter, destruction of, by percutaneous, laparoscopic or open cryoablation (including any associated imaging services), if: (a) malignancy has previously been confirmed by histopathological examination; and (b) a multi disciplinary team has reviewed treatment options for the patient and assessed that partial nephrectomy is not suitable; and (c) the service is not a service associated with a service to which item 36522 or 36525 applies (H) (Anaes.) | $1513.70 |
| 36531 | Nephroureterectomy, complete, by open, laparoscopic or robot-assisted approach, including associated bladder repair and any associated endoscopic procedure, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) | $2370.60 |
| 36532 | Nephroureterectomy, for tumour, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures, other than a service to which item 36533 applies or a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) | $3348.30 |
| 36533 | Nephroureterectomy, for tumour, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures, if complicated by previous open or laparoscopic surgery on the same kidney or ureter, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) | $4054.10 |
| 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.) | $1429.70 |
| 36543 | Nephrolithotomy or pyelolithotomy, or both, extended, for one or more renal stones, including one or more of nephrostomy, pyelostomy, pedicle control with or without freezing, calyorrhaphy or pyeloplasty (Anaes.) (Assist.) | $2752.90 |
| 36546 | EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY (ESWL) to urinary tract and posttreatment care for 3 days, including pretreatment consultation, unilateral (Anaes.) | $1421.90 |
| 36549 | Ureterolithotomy, by open, laparoscopic or robot-assisted approach (Anaes.) (Assist.) | $1727.30 |
| 36552 | NEPHROSTOMY or pyelostomy, open, as an independent procedure (Anaes.) (Assist.) | $1586.40 |
| 36558 | RENAL CYST OR CYSTS, excision or unroofing of (Anaes.) (Assist.) | $1335.00 |
| 36561 | Renal biopsy, performed under image guidance (closed) (Anaes.) | $352.60 |
| 36564 | Pyeloplasty, (plastic reconstruction of the pelvi-ureteric junction) by open, laparoscopic or robot-assisted approach, with or without the use of a retroperitoneal approach (Anaes.) (Assist.) | $1905.00 |
| 36567 | Pyeloplasty in a kidney that is congenitally abnormal (in addition to the presence of pelvi-ureteric junction obstruction), or in a solitary kidney, by open, laparoscopic or robot-assisted approach, with or without the use of a retroperitoneal approach (Anaes.) (Assist.) | $2177.10 |
| 36570 | Pyeloplasty, complicated by previous surgery on the same kidney, by open, laparoscopic or robot-assisted approach, with or without the use of a retroperitoneal approach (Anaes.) (Assist.) | $2665.00 |
| 36573 | DIVIDED URETER, repair of (Anaes.) (Assist.) | $1913.90 |
| 36576 | Kidney, exposure and exploration of, including repair or nephrectomy, for trauma, by open, laparoscopic or robot assisted approach, other than a service associated with: (a) any other procedure performed on the kidney, renal pelvis or renal pedicle; or (b) a service to which item 30390 or 30627 applies (Anaes.) (Assist.) | $2380.00 |
| 36579 | Ureterectomy, complete or partial: (a) for a tumour within the ureter, proven by histopathology at the time of surgery; or (b) for congenital anomaly; with or without associated bladder repair (Anaes.) (Assist.) | $1525.00 |
| 36585 | URETER, transplantation of, into skin (Anaes.) (Assist.) | $1504.80 |
| 36588 | URETER, reimplantation into bladder (Anaes.) (Assist.) | $1980.50 |
| 36591 | URETER, reimplantation into bladder with psoas hitch or Boari flap or both (Anaes.) (Assist.) | $2380.50 |
| 36594 | URETER, transplantation of, into intestine (Anaes.) (Assist.) | $1972.90 |
| 36597 | URETER, transplantation of, into another ureter (Anaes.) (Assist.) | $1914.00 |
| 36600 | URETER, transplantation of, into isolated intestinal segment, unilateral (Anaes.) (Assist.) | $2360.40 |
| 36603 | URETERS, transplantation of, into isolated intestinal segment, bilateral (Anaes.) (Assist.) | $2654.80 |
| 36604 | Ureteric stent, passage of through percutaneous nephrostomy tube, using interventional radiology techniques, but not including imaging (Anaes.) | $553.80 |
| 36606 | INTESTINAL URINARY RESERVOIR, continent, formation of, including formation of nonreturn valves and implantation of ureters (1 or both) into reservoir (Anaes.) (Assist.) | $4938.00 |
| 36607 | Ureteric stent insertion of, with balloon dilatation of: (a) the pelvicalyceal system; or (b) ureter; or (c) the pelvicalyceal system and ureter; through a nephrostomy tube using interventional radiology techniques, but not including imaging (Anaes.) | $1484.00 |
| 36608 | Ureteric stent, exchange of, percutaneously through either the ileal conduit or bladder, using interventional radiology techniques, but not including imaging, not being a service associated with a service to which items 36811 to 36854 apply (Anaes.) | $553.90 |
| 36609 | Intestinal urinary conduit, reservoir or ureterostomy, revision of (Anaes.) (Assist.) | $1539.40 |
| 36610 | Intestinal urinary conduit, incontinent, formation of (including associated small bowel resection and anastomosis), including implantation of one or both ureters into reservoir (Anaes.) (Assist.) | $3369.40 |
| 36611 | Intestinal urinary reservoir, continent, formation of (including associated small bowel resection and anastomosis), including formation of non-return valves and implantation of one or both ureters into reservoir, performed by open, laparoscopic or robot-assisted approach (Anaes.) (Assist.) | $5314.40 |
| 36612 | URETER, exploration of, with or without drainage of, as an independent procedure (Anaes.) (Assist.) | $1383.30 |
| 36615 | Ureterolysis, unilateral, with or without repositioning of the ureter, for obstruction of the ureter, if: (a) the obstruction: (i) is evident either radiologically or by proximal ureteric dilatation at operation; and (ii) is secondary to retroperitoneal fibrosis; and (b) there is biopsy proven fibrosis, endometriosis or cancer at the site of the obstruction at time of surgery (Anaes.) (Assist.) | $1581.40 |
| 36618 | REDUCTION URETEROPLASTY (Anaes.) (Assist.) | $1318.70 |
| 36621 | CLOSURE OF CUTANEOUS URETEROSTOMY (Anaes.) (Assist.) | $961.20 |
| 36624 | Nephrostomy, percutaneous, using interventional radiology techniques, but not including imaging (Anaes.) (Assist.) | $1191.40 |
| 36627 | Nephroscopy, percutaneous, with or without any one or more of; stone extraction, biopsy or diathermy, not being a service to which item 36639 or 36645 applies (Anaes.) | $1427.50 |
| 36633 | Nephroscopy, percutaneous, with incision of any one 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 or 36645 applies (Anaes.) (Assist.) | $1586.40 |
| 36636 | Nephroscopy, percutaneous, with incision of any one 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 or 36645 applies (Anaes.) (Assist.) | $820.00 |
| 36639 | Nephroscopy, percutaneous, with destruction and extraction of one or two stones using ultrasound or electrohydraulic shock waves orlasers, other than a service to which item 36645 applies (Anaes.) | $1772.20 |
| 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.) | $2204.20 |
| 36649 | Nephrostomy drainage tube, exchange of, using interventional radiology techniques, but not including imaging (Anaes.) (Assist.) | $553.80 |
| 36650 | Nephrostomy tube, removal of, using interventional radiology techniques, but not including imaging, if the ureter has been stented with a double J ureteric stent and that stent is left in place (Anaes.) | $318.50 |
| 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.) | $1341.00 |
| 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.) | $1788.30 |
| 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.) | $2196.10 |
| 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.) | $1357.50 |
| 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.) | $1204.10 |
| 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 | $254.40 |
| 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.) | $759.00 |
| 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.) | $317.30 |
| 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.) | $317.30 |
| 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 | $377.60 |
| 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 | $377.60 |
| 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 | $377.60 |
| 36800 | Bladder, catheterisation of, where no other procedure is performed (Anaes.) | $56.80 |
| 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 or 36848 applies (Anaes.) (Assist.) | $959.30 |
| 36806 | Ureteroscopy, of one ureter: (a) with or without one or more of the following: (i) cystoscopy; (ii) endoscopic incision of pelviureteric junction or ureteric stricture; (iii) ureteric meatotomy; (iv) ureteric dilatation; and (b) with either or both of the following: (i) extraction of stone from the ureter; (ii) biopsy or diathermy of the ureter; other than: (c) a service associated with a service to which item 36803 or 36812 applies; or (d) a service associated with a service, performed on the same ureter, to which item 36809, 36824 or 36848 applies (Anaes.) (Assist.) | $1337.50 |
| 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 or 36848 applies to a procedure performed on the same ureter (Anaes.) (Assist.) | $1712.60 |
| 36811 | Cystoscopy, with insertion of one or more urethral or prostatic prostheses, other than a service associated with a service to which item 37203, 37207 or 37230 applies (Anaes.) | $666.50 |
| 36812 | Either or both of cystoscopy and urethroscopy, with or without urethral dilatation, other than a service associated with any other urological endoscopic procedure on the lower urinary tract (Anaes.) | $342.90 |
| 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.) | $490.30 |
| 36818 | Cystoscopy, with ureteric catheterisation, unilateral or bilateral, guided by fluoroscopic imaging of the upper urinary tract, other than a service associated with a service to which item 36824 or 36830 applies (Anaes.) | $568.50 |
| 36821 | Cystoscopy with one or more of; ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or renal pelvis, unilateral (Anaes.) (Assist.) | $666.70 |
| 36822 | Cystoscopy, with ureteric catheterisation, unilateral: (a) guided by fluoroscopic imaging of the upper urinary tract; and (b) including one or more of ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or of renal pelvis; other than a service associated with a service to which item 36818, 36821 or 36830 applies (Anaes.) (Assist.) | $876.10 |
| 36823 | Cystoscopy, with removal of ureteric stent and ureteric catheterisation, unilateral: (a) guided by fluoroscopic imaging of the upper urinary tract; and (b) including either or both of the following: (i) ureteric dilatation; or (ii) insertion of ureteric stent of ureter or of renal pelvis; other than a service associated with a service to which item 36818, 36821, 36830 or 36833 applies (Anaes.) (Assist.) | $1007.30 |
| 36824 | Cystoscopy, with ureteric catheterisation, unilateral or bilateral, other than a service associated with a service to which item 36818 applies (Anaes.) | $440.00 |
| 36827 | Cystoscopy, with controlled hydrodilatation of the bladder, other than a service associated with a service to which item 37011 or 37245 applies (Anaes.) | $477.50 |
| 36830 | Cystoscopy, with ureteric meatotomy (Anaes.) | $418.50 |
| 36833 | Cystoscopy, with removal of ureteric stent or other foreign body in the lower urinary tract, unilateral (Anaes.) | $588.70 |
| 36836 | Cystoscopy, with biopsy of bladder, not being a service associated with a service to which item 36812, 36830, 36840, 36845, 36848, 36854, 37203 or 37215 applies (Anaes.) | $472.30 |
| 36840 | Cystoscopy, with diathermy, resection or visual laser destruction of bladder tumour or other lesion of the bladder, for: (a) a tumour or lesion in only one quadrant of the bladder; or (b) a solitary tumour of not more than 2 cm in diameter; other than a service associated with a service to which item 36845 applies (Anaes.) | $666.20 |
| 36842 | Cystoscopy, with lavage of blood clots from bladder, including any associated cautery of prostate or bladder, other than a service associated with a service to which any of items 36812, 36827 to 36863 and 37203 apply (H) (Anaes.) | $674.00 |
| 36845 | Cystoscopy, with diathermy, resection or visual laser destruction of: (a) multiple tumours in 2 or more quadrants of the bladder; or (b) a solitary bladder tumour of more than 2 cm in diameter (Anaes.) | $1472.30 |
| 36848 | CYSTOSCOPY, with resection of ureterocele (Anaes.) | $473.00 |
| 36851 | Cystoscopy, with injection into bladder wall, other than a service associated with a service to which item 18375 or 18379 applies (H) (Anaes.) | $477.50 |
| 36854 | CYSTOSCOPY, with endoscopic incision or resection of external sphincter, bladder neck or both (Anaes.) | $959.50 |
| 36860 | Endoscopic examination of intestinal conduit or reservoir (Anaes.) | $355.60 |
| 36863 | Litholapaxy, with or without cystoscopy (Anaes.) | $991.70 |
| 37000 | BLADDER, partial excision of (Anaes.) (Assist.) | $1509.80 |
| 37004 | BLADDER, repair of rupture (Anaes.) (Assist.) | $1390.30 |
| 37008 | Open cystostomy or cystotomy, suprapubic, other than: (a) a service to which item 37011 applies; or (b) a service associated with a service to which item 37245 applies; or (c) another open bladder procedure (Anaes.) (Assist.) | $857.60 |
| 37011 | Suprapubic stab cystotomy, other than a service associated with a service to which item 36827 applies (Anaes.) | $190.00 |
| 37014 | BLADDER, total excision of (Anaes.) (Assist.) | $2156.10 |
| 37015 | Bladder, total excision of, following previous open, laparoscopic or robot-assisted surgery, or radiation therapy or chemotherapy to the pelvis (Anaes.) (Assist.) | $2428.80 |
| 37016 | Cystectomy, including prostatectomy and pelvic lymph node dissection, other than a service associated with a service to which items 37000, 37014, 37015, 37209, 35551 or 36502 applies (Anaes.) (Assist.) | $3787.10 |
| 37018 | Cystectomy, including prostatectomy and pelvic lymph node dissection, following previous open, laparoscopic or robot-assisted surgery, or radiation therapy or chemotherapy to the pelvis, other than a service associated with a service to which items 37000, 37014, 37015, 37016, 37209, 35551 or 36502 applies (Anaes.) (Assist.) | $5680.90 |
| 37019 | Cystectomy, including anterior exenteration and pelvic lymph node dissection, other than a service associated with a service to which any of items 37000, 37014, 37015, 35551, 36502, and 35653 to 35756 apply (Anaes.) (Assist.) | $3782.90 |
| 37020 | BLADDER DIVERTICULUM, excision or obliteration of (Anaes.) (Assist.) | $1526.30 |
| 37021 | Cystectomy, including anterior exenteration and pelvic lymph node dissection, following previous open, laparoscopic or robot-assisted surgery, radiation therapy or chemotherapy to the pelvis, other than a service associated with a service to which any of items 37000, 37014, 37015, 35551, 36502 and 35653 to 35756 apply (Anaes.) (Assist.) | $5674.40 |
| 37023 | Vesical fistula, cutaneous, operation for (Anaes.) | $855.00 |
| 37026 | CUTANEOUS VESICOSTOMY, establishment of (Anaes.) (Assist.) | $844.90 |
| 37029 | VESICOVAGINAL FISTULA, closure of, by abdominal approach (Anaes.) (Assist.) | $1967.50 |
| 37038 | VESICOINTESTINAL FISTULA, closure of, excluding bowel resection (Anaes.) (Assist.) | $1424.90 |
| 37039 | Bladder stress incontinence, sling procedure for, using a non-autologous biological sling (Anaes.) (Assist.) | $1280.40 |
| 37040 | Bladder stress incontinence, sling procedure for, using a non-adjustable synthetic male sling system, other than a service associated with a service to which item 37042 applies (H) (Anaes.) (Assist.) | $1787.60 |
| 37041 | BLADDER ASPIRATION by needle | $96.20 |
| 37042 | Bladder stress incontinence sling procedure for, using autologous fascial sling, including harvesting of sling, other than a service associated with a service to which item 35599 applies (H) (Anaes.) (Assist.) | $1880.60 |
| 37044 | Bladder stress incontinence, suprapubic operation for (such as Burch colposuspension), open or laparoscopic route, using native tissue without graft, with diagnostic cystoscopy to assess the integrity of the lower urinary tract, not being a service associated with a service to which item 35599 or 36812 applies (H) (Anaes.) (Assist.) | $1587.20 |
| 37045 | Continent catheterisation bladder stomas (eg. mitrofanoff), formation of (Anaes.) (Assist.) | $2958.10 |
| 37046 | Suprapubic or perineal procedure for excision of graft material, either singly or in multiple pieces, for a symptomatic patient with graft related complications (including graft related pain or discharge and bleeding related to graft exposure), if not more than one service to which this item applies has been provided to the patient by the same practitioner in the preceding 12 months (Anaes.) (Assist.) | $1314.30 |
| 37047 | BLADDER ENLARGEMENT using intestine (Anaes.) (Assist.) | $3567.10 |
| 37048 | Bladder neck closure for the management of urinary incontinence (Anaes.) (Assist.) | $1755.10 |
| 37050 | BLADDER EXSTROPHY CLOSURE, not involving sphincter reconstruction (Anaes.) (Assist.) | $1586.40 |
| 37053 | BLADDER TRANSECTION AND RE-ANASTOMOSIS TO TRIGONE (Anaes.) (Assist.) | $1738.30 |
| 37200 | Prostatectomy, by open, laparoscopic or robot-assisted approach (Anaes.) (Assist.) | $2095.00 |
| 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, 37207, 37208, 37245, 37303, 37321 or 37324 applies (H) (Anaes.) | $1765.20 |
| 37203 | Prostatectomy, transurethral resection using cautery, with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37201, 37207, 37208, 37245, 37303, 37321 or 37324 applies (H) (Anaes.) | $2227.60 |
| 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, 37203, 37245, 37303, 37321 or 37324 applies (H) (Anaes.) | $2178.10 |
| 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.) | $992.30 |
| 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.) | $2665.00 |
| 37210 | Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated) with or without bladder neck reconstruction, other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.) | $3275.00 |
| 37211 | Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated): (a) with or without bladder neck reconstruction; and (b) with pelvic lymphadenectomy; other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.) | $3980.00 |
| 37213 | Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated): (a) complicated by: (i) previous radiation therapy (including brachytherapy) on the prostate; or (ii) previous ablative procedures on the prostate; and (b) with bladder neck reconstruction; other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.) | $4536.60 |
| 37214 | Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated): (a) complicated by: (i) previous radiation therapy (including brachytherapy) on the prostate; or (ii) previous ablative procedures on the prostate; and (b) with bladder neck reconstruction and pelvic lymphadenectomy; other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.) | $5510.40 |
| 37215 | Prostate, biopsy of, endoscopic, with or without cystoscopy (Anaes.) | $858.70 |
| 37216 | Prostate or prostatic bed, needle biopsy of, by the transrectal route, using prostatic ultrasound guidance and obtaining one or more prostatic specimens, being a service associated with a service to which item 55603 applies (Anaes.) | $266.70 |
| 37217 | Prostate, implantation of radio-opaque fiducial markers into the prostate gland or prostate surgical bed, under ultrasound guidance, being an item associated with a service to which item 55603 applies (Anaes.) | $303.00 |
| 37218 | Prostate, injection into, one or more, excluding insertion of fiduciary markers (Anaes.) | $284.40 |
| 37219 | Prostate or prostatic bed, needle biopsy of, by the transperineal route, using prostatic ultrasound guidance and obtaining one or more prostatic specimens, being a service associated with a service to which item 55600 or 55603 applies (Anaes.) | $659.80 |
| 37220 | Prostate, radioactive seed implantation of, urological component, using transrectal ultrasound guidance: (a) for a patient with: (i) localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate); and (ii) a Gleason score of less than or equal to 7 (Grade Group 1 to Grade Group 3); and (iii) a prostate specific antigen (PSA) of not more than 10ng/ml at the time of diagnosis; and (b) performed by a urologist at an approved site in association with a radiation oncologist; and (c) being a service associated with: (i) services to which items 15338 and 55603 apply; and (ii) a service to which item 60506 or 60509 applies (Anaes.) | $2185.00 |
| 37221 | Prostatic abscess, endoscopic drainage of (Anaes.) | $950.00 |
| 37223 | Prostatic coil, insertion of, under ultrasound control (Anaes.) | $442.70 |
| 37224 | Prostate, diathermy or cauterisation, other than a service associated with a service to which item 37201, 37203, 37207, 37208 or 37215 applies (Anaes.) | $688.60 |
| 37226 | Prostate or prostatic bed, needle biopsy of, using prostatic magnetic resonance imaging techniques and obtaining 1 or more prostatic specimens. (Anaes.) (Anaes.) | $525.20 |
| 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.) | $2185.00 |
| 37245 | Prostate, endoscopic enucleation of, for the treatment of benign prostatic hyperplasia: (a) with morcellation, including mechanical morcellation or by an endoscopic technique; and (b) with or without cystoscopy; and (c) with or without urethroscopy; and other than a service associated with a service to which item 36827, 36854, 37008, 37201, 37203, 37207, 37208, 37303, 37321 or 37324 applies (H) (Anaes.) | $2727.20 |
| 37300 | Urethral sounds, passage of, as an independent procedure (Anaes.) | $96.30 |
| 37303 | Urethral stricture, dilatation of (Anaes.) | $152.30 |
| 37306 | URETHRA, repair of rupture of distal section (Anaes.) (Assist.) | $1342.70 |
| 37309 | URETHRA, repair of rupture of prostatic or membranous segment (Anaes.) (Assist.) | $1914.30 |
| 37318 | Urethroscopy, with or without cystoscopy, with one or more of biopsy, diathermy, visual laser destruction of urethral calculi or removal of foreign body or calculi (Anaes.) | $569.20 |
| 37321 | Urethral meatotomy, external (Anaes.) | $193.30 |
| 37324 | Urethrotomy or urethrostomy, internal or external (Anaes.) (Assist.) | $472.30 |
| 37327 | URETHROTOMY, optical, for urethral stricture (Anaes.) (Assist.) | $664.70 |
| 37330 | URETHRECTOMY, partial or complete, for removal of tumour (Anaes.) (Assist.) | $1334.90 |
| 37333 | URETHROVAGINAL FISTULA, closure of (Anaes.) (Assist.) | $1132.40 |
| 37336 | URETHRORECTAL FISTULA, closure of (Anaes.) (Assist.) | $1586.40 |
| 37338 | Urethral synthetic male sling system, division or removal of, for urethral obstruction, sling erosion, pain or infection, following previous surgery for urinary incontinence, other than a service associated with a service to which item 37340 or 37341 applies (Anaes.) (Assist.) | $1787.60 |
| 37339 | Periurethral or transurethral injection of urethral bulking agents 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.) | $495.10 |
| 37340 | Urethral synthetic sling, division or removal of, for urethral obstruction, sling erosion, pain or infection following previous surgery for urinary incontinence, vaginal approach, other than a service associated with a service to which item 37341 or 37344 applies (Anaes.) (Assist.) | $1006.30 |
| 37341 | Urethral sling, division or removal of, for urethral obstruction, sling erosion, pain or infection following previous surgery for urinary incontinence, suprapubic, combined suprapubic and vaginal or combined suprapubic and perineal approach, other than a service associated with a service to which item 37340 or 37344 applies (Anaes.) (Assist.) | $1872.90 |
| 37342 | URETHROPLASTYsingle stage operation (Anaes.) (Assist.) | $1715.00 |
| 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.) | $2861.40 |
| 37344 | Urethral autologous fascial sling (or other biological sling), division or removal of, for urethral obstruction, sling erosion, pain or infection following previous surgery for urinary incontinence, vaginal approach, other than a service to which 37340 or 37341 applies (Anaes.) (Assist.) | $1729.90 |
| 37345 | URETHROPLASTY2 stage operationfirst stage (Anaes.) (Assist.) | $1430.00 |
| 37348 | URETHROPLASTY2 stage operationsecond stage (Anaes.) (Assist.) | $1430.00 |
| 37351 | URETHROPLASTY, not being a service to which another item in this Group applies (Anaes.) (Assist.) | $589.70 |
| 37354 | HYPOSPADIAS, meatotomy and hemicircumcision (Anaes.) (Assist.) | $670.00 |
| 37369 | Urethra, excision of prolapse of (Anaes.) | $398.00 |
| 37372 | URETHRAL DIVERTICULUM, excision of (Anaes.) (Assist.) | $1110.20 |
| 37375 | URETHRAL SPHINCTER, reconstruction by bladder tubularisation technique or similar procedure (Anaes.) (Assist.) | $2380.00 |
| 37381 | ARTIFICIAL URINARY SPHINCTER, insertion of cuff, perineal approach (Anaes.) (Assist.) | $1525.00 |
| 37384 | ARTIFICIAL URINARY SPHINCTER, insertion of cuff, abdominal approach (Anaes.) (Assist.) | $2380.00 |
| 37387 | ARTIFICIAL URINARY SPHINCTER, insertion of pressure regulating balloon and pump (Anaes.) (Assist.) | $665.00 |
| 37388 | Artificial urinary sphincter, sterile, percutaneous adjustment of filling volume | $185.90 |
| 37390 | ARTIFICIAL URINARY SPHINCTER, revision or removal of, with or without replacement (Anaes.) (Assist.) | $1901.20 |
| 37393 | PRIAPISM, decompression by glanular stab cavernosospongiosum shunt or penile aspiration with or without lavage (Anaes.) | $474.80 |
| 37396 | PRIAPISM, shunt operation for, not being a service to which item 37393 applies (Anaes.) (Assist.) | $1504.80 |
| 37402 | PENIS, partial amputation of (Anaes.) (Assist.) | $950.00 |
| 37405 | PENIS, complete or radical amputation of (Anaes.) (Assist.) | $1905.00 |
| 37408 | PENIS, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.) | $950.00 |
| 37411 | PENIS, repair of avulsion (Anaes.) (Assist.) | $1876.10 |
| 37415 | Penis, injection of, for the investigation and treatment of erectile dysfunction. Applicable not more than twice in a 36 month period | $99.20 |
| 37417 | Penis, correction of chordee by plication techniques including Nesbit s corporoplasty (Anaes.) (Assist.) | $1140.00 |
| 37418 | Penis, correction of chordee with incision or excision of fibrous plaque or plaques, with or without mobilisation of one or both of the neuro-vascular bundle and urethra (Anaes.) (Assist.) | $1525.00 |
| 37423 | Penis, lengthening by translocation of corpora, in conjunction with partial penectomy or penile epispadias secondary repair, either as primary or secondary procedures (Anaes.) (Assist.) | $1905.00 |
| 37426 | PENIS, artificial erection device, insertion of, into 1 or both corpora (Anaes.) (Assist.) | $2000.00 |
| 37429 | PENIS, artificial erection device, insertion of pump and pressure regulating reservoir (Anaes.) (Assist.) | $665.00 |
| 37432 | PENIS, artificial erection device, complete or partial revision or removal of components, with or without replacement (Anaes.) (Assist.) | $1899.50 |
| 37435 | Penis, frenuloplasty as an independent procedure (Anaes.) | $190.00 |
| 37438 | Scrotum, partial excision of, for histologically proven malignancy or infection (Anaes.) (Assist.) | $572.50 |
| 37601 | Spermatocele or epididymal cyst, excision of, 1 or more of, on 1 side (Anaes.) | $588.60 |
| 37604 | Exploration of scrotal contents, with or without fixation and with or without biopsy, unilateral or bilateral, other than a service associated with sperm harvesting for IVF (Anaes.) | $565.00 |
| 37605 | Transcutaneous sperm retrieval, unilateral, from either the testis or the epididymis, for the purposes ofintracytoplasmic sperm injection, for male factor infertility, excluding a service to which item 13218 applies. (Anaes.) | $767.90 |
| 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.) | $1140.60 |
| 37607 | Bilateral retroperitoneal lymph node dissection, for testicular tumour, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) | $2182.70 |
| 37610 | Bilateral retroperitoneal lymph node dissection, for testicular tumour, following previous similar retroperitoneal dissection, retroperitoneal radiation therapy or chemotherapy, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) | $3313.40 |
| 37613 | Epididymectomy (Anaes.) | $570.00 |
| 37616 | VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, using operating microscope, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.) | $2050.50 |
| 37619 | VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.) | $1176.10 |
| 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.) | $477.30 |
| 37800 | PATENT URACHUS, excision of, on a patient 10 years of age or over. (Anaes.) (Assist.) | $1110.50 |
| 37803 | UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37806 applies, on a patient 10 years of age or over. (Anaes.) (Assist.) | $1076.10 |
| 37804 | UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37807 applies, on a patient under 10 years of age (Anaes.) (Assist.) | $1357.00 |
| 37806 | UNDESCENDED TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for, on a patient 10 years of age or over (Anaes.) (Assist.) | $1293.50 |
| 37807 | UNDESCENDED TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for, on a patient under 10 years of age (Anaes.) (Assist.) | $1568.00 |
| 37809 | UNDESCENDED TESTIS, revision orchidopexy for, on a patient 10 years of age or over. (Anaes.) (Assist.) | $1232.80 |
| 37810 | UNDESCENDED TESTIS, revision orchidopexy for, on a patient under 10 years of age (Anaes.) (Assist.) | $1568.00 |
| 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 patient 10 years of age or over. (Anaes.) (Assist.) | $1144.40 |
| 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 patient under 10 years of age (Anaes.) (Assist.) | $1447.60 |
| 37815 | HYPOSPADIAS, examination under anaesthesia with erection test on a patient 10 years of age or over. (Anaes.) | $192.40 |
| 37816 | HYPOSPADIAS, examination under anaesthesia with erection test, on a patient under 10 years of age (Anaes.) | $241.60 |
| 37818 | HYPOSPADIAS, glanuloplasty incorporating meatal advancement, on a patient 10 years of age or over (Anaes.) (Assist.) | $1012.80 |
| 37819 | HYPOSPADIAS, glanuloplasty incorporating meatal advancement, on a patient under 10 years of age (Anaes.) (Assist.) | $1279.70 |
| 37821 | HYPOSPADIAS, distal, 1 stage repair, on a patient 10 years of age or over. (Anaes.) (Assist.) | $1717.40 |
| 37822 | HYPOSPADIAS, distal, 1 stage repair, on a patient under 10 years of age (Anaes.) (Assist.) | $2169.10 |
| 37824 | HYPOSPADIAS, proximal, 1 stage repair, on a patient 10 years of age or over (Anaes.) (Assist.) | $2380.00 |
| 37825 | HYPOSPADIAS, proximal, 1 stage repair, on a patient under 10 years of age (Anaes.) (Assist.) | $3015.60 |
| 37827 | HYPOSPADIAS, staged repair, first stage, on a patient 10 years of age or over (Anaes.) (Assist.) | $1077.10 |
| 37828 | HYPOSPADIAS, staged repair, first stage, on a patient under 10 years of age (Anaes.) (Assist.) | $1389.40 |
| 37830 | HYPOSPADIAS, staged repair, second stage, on a patient 10 years of age or over (Anaes.) (Assist.) | $1395.70 |
| 37831 | HYPOSPADIAS, staged repair, second stage, on a patient under 10 years of age (Anaes.) (Assist.) | $1800.40 |
| 37833 | Hypospadias, repair of urethral fistula, on a patient 10 years of age or over (Anaes.) (Assist.) | $668.60 |
| 37834 | Hypospadias, repair of urethral fistula, on a patient under 10 years of age (Anaes.) (Assist.) | $859.00 |
| 37836 | EPISPADIAS, staged repair, first stage (Anaes.) (Assist.) | $1403.20 |
| 37839 | EPISPADIAS, staged repair, second stage (Anaes.) (Assist.) | $1590.00 |
| 37842 | Exstrophy of bladder or epispadias, primary or secondary repair with or without bladder neck tightening, with or without ureteric reimplantation (Anaes.) (Assist.) | $3156.50 |
| 37845 | Congenital disorder of sexual differentiation with urogenital sinus, external genitoplasty, with or without endoscopy (Anaes.) (Assist.) | $1403.20 |
| 37848 | Congenital disorder of sexual differentiation with urogenital sinus, external genitoplasty with endoscopy and vaginoplasty (Anaes.) (Assist.) | $2525.40 |
| 37851 | Congenital disorder of sexual differentiation, vaginoplasty for, with or without endoscopy (Anaes.) (Assist.) | $1870.90 |
| 37854 | Urethral valve, destruction of, including cystoscopy and urethroscopy (Anaes.) | $758.70 |
| **Cardio-thoracic** | | |
| 38200 | Right heart catheterisation with any one or more of the following: (a) fluoroscopy; (b) oximetry; (c) dye dilution curves; (d) cardiac output measurement by any method; (e) shunt detection; (f) exercise stress test; other than a service associated with a service to which item 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38254 or 38368 applies (Anaes.) | $954.80 |
| 38203 | Left heart catheterisation by percutaneous arterial puncture, arteriotomy or percutaneous left ventricular puncture, with any one or more of the following: (a) fluoroscopy; (b) oximetry; (c) dye dilution curves; (d) cardiac output measurements by any method; (e) shunt detection; (f) exercise stress test; other than a service associated with a service to which item 38200, 38206, 38244, 38247, 38248, 38249, 38251, 38252 or 38254 applies (Anaes.) | $1141.50 |
| 38206 | Right heart catheterisation with left heart catheterisation via the right heart or by another procedure, with any one or more of the following: (a) fluoroscopy; (b) oximetry; (c) dye dilution curves; (d) cardiac output measurements by any method; (e) shunt detection; (f) exercise stress test; other than a service associated with a service to which item 38200, 38203, 38244, 38247, 38248, 38249, 38251, 38252 or 38254 applies (Anaes.) | $1380.60 |
| 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.) | $1664.10 |
| 38212 | Cardiac electrophysiological study for: (a) the investigation of supraventricular tachycardia involving 4 or more catheters; or (b) complex tachycardia inductions; or (c) multiple catheter mapping; or (d) acute intravenous anti arrhythmic drug testing with pre and post drug inductions; or (e) catheter ablation to intentionally induce complete atrioventricular block; or (f) intraoperative mapping; other than a service associated with a service to which item 38209 or 38213 applies (Anaes.) | $2847.40 |
| 38213 | Cardiac electrophysiological study, performed either: (a) during insertion of implantable defibrillator; or (b) for defibrillation threshold testing at a different time to implantation; other than a service associated with a service to which item 38209 or 38212 applies (Anaes.) | $869.30 |
| 38241 | Use of a coronary pressure wire, if the service is: (a) performed during selective coronary angiography, percutaneous angioplasty or transluminal insertion of one or more stents; and (b) to measure fractional flow reserve, non-hyperaemic pressure ratios or coronary flow reserve in intermediate coronary artery or graft lesions (stenosis of 50 to 70%); and (c) to determine whether revascularisation is appropriate, if previous functional imaging: (i) has not been performed; or (ii) has been performed but the results are inconclusive or do not apply to the vessel being interrogated; and (d) performed on one or more coronary vascular territories (Anaes.) | $968.70 |
| 38244 | Note: (acute coronary syndrome)the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Selective coronary angiography: (a) for a patient who is eligible for the service under clause 5.10.17A; and (b) with placement of one or more catheters and injection of opaque material into native coronary arteries; and (c) with or without left heart catheterisation, left ventriculography or aortography; and (d) including all associated imaging; other than a service associated with a service to which 38200, 38203, 38206, 38247, 38248, 38249, 38251 or 38252 applies (Anaes.) | $1917.50 |
| 38247 | Note: (acute coronary syndrome—graft) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Selective coronary and graft angiography: (a) for a patient who is eligible for the service under clause 5.10.17A; and (b) with placement of one or more catheters and injection of opaque material into the native coronary arteries; and (c) if free coronary grafts attached to the aorta or direct internal mammary artery grafts are present with placement of one or more catheters and injection of opaque material into those grafts (irrespective of the number of grafts); and (d) with or without left heart catheterisation, left ventriculography or aortography; and (e) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38248, 38249, 38251 or 38252 applies (Anaes.) | $3072.00 |
| 38248 | Note: (stable coronary syndrome) the service only applies if the patient meets the requirements of the descriptor and the of Note: TR.8.3 and TR.8.5 Selective coronary angiography: (a) for a patient who is eligible for the service under clause 5.10.17B; and (b) as part of the management of the patient; and (c) with placement of catheters and injection of opaque material into native coronary arteries; and (d) with or without left heart catheterisation, left ventriculography or aortography; and (e) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38249, 38251 or 38252 applies applicable each 3 months (Anaes.) | $1917.50 |
| 38249 | Note: (stable coronary syndrome—graft) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.3 and TR.8.5 Selective coronary and graft angiography: (a) for a patient who is eligible for the service under clause 5.10.17B; and (b) as part of the management of the patient; and (c) with placement of one or more catheters and injection of opaque material into native coronary arteries; and (d) if free coronary grafts attached to the aorta or direct internal mammary artery grafts are present with placement of one or more catheters and injection of opaque material into those grafts (irrespective of the number of grafts);and (e) with or without left heart catheterisation, left ventriculography or aortography; and (f) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38251 or 38252 applies applicable once each 3 months (Anaes.) | $3072.00 |
| 38251 | Note: (pre-operative assessment) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.5 Selective coronary angiography: (a) for a symptomatic patient with valvular or other non-coronary structural heart disease; and (b) as part of the management of the patient for: (i) pre-operative assessment for planning non-coronary cardiac surgery, including by transcatheter approaches; or (ii) evaluation of valvular heart disease or other non-coronary structural heart disease where clinical impression is discordant with non-invasive assessment; and (c) with placement of catheters and injection of opaque material into native coronary arteries; and (d) with or without left heart catheterisation, left ventriculography or aortography; and (e) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249 or 38252 applies applicable once each 12 months (Anaes.) | $1917.50 |
| 38252 | Note: (pre-operative assessment—graft) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.5 Selective coronary and graft angiography: (a) for a symptomatic patient with valvular or other non-coronary structural heart disease; and (b) as part of the management of the patient for: (i) pre-operative assessment for planning non-coronary cardiac surgery, including by transcatheter approaches; or (ii) evaluation of valvular heart disease or other non-coronary structural heart disease where clinical impression is discordant with non-invasive assessment; and (c) with placement of one or more catheters and injection of opaque material into the native coronary arteries; and (d) if free coronary grafts attached to the aorta or direct internal mammary artery grafts are present with placement of one or more catheters and injection of opaque material into those grafts (irrespective of the number of grafts); and (e) with or without left heart catheterisation, left ventriculography or aortography; and (f) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249 or 38251 applies applicable once each 12 months (Anaes.) | $3072.00 |
| 38254 | Right heart catheterisation: (a) performed at the same time as a service to which item 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313 or 38314 applies; and (b) including any of the following (if performed): (i) fluoroscopy; (ii) oximetry; (iii) dye dilution curves; (iv) cardiac output measurement; (v) shunt detection; (vi) exercise stress test (Anaes.) | $966.00 |
| 38256 | Temporary transvenous pacemaking electrode, insertion of (Anaes.) | $581.40 |
| 38270 | BALLOON VALVULOPLASTY OR ISOLATED ATRIAL SEPTOSTOMY, including cardiac catheterisations before and after balloon dilatation (Anaes.) (Assist.) | $1962.20 |
| 38272 | Atrial septal defect or patent foramen closure: (a) for congenital heart disease in a patient with documented evidence of right heart overload or paradoxical embolism; and (b) using a septal occluder or similar device, by transcatheter approach; and (c) including right or left heart catheterisation (or both); other than a service associated with a service to which item 38200, 38203, 38206 or 38254 applies (Anaes.) (Assist.) | $1940.40 |
| 38273 | Patent ductus arteriosus, transcatheter closure of, including cardiac catheterisation and any imaging associated with the service (Anaes.) (Assist.) | $1869.20 |
| 38274 | Ventricular septal defect, transcatheter closure of, with cardiac catheterisation, excluding imaging (H) (Anaes.) (Assist.) | $1130.00 |
| 38275 | Myocardial biopsy, by cardiac catheterisation (Anaes.) | $617.40 |
| 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, if: (a) the patient is at increased risk of thromboembolism demonstrated by: (i) a prior stroke (whether of an ischaemic or unknown type), transient ischaemic attack or non central nervous system systemic embolism; or (ii) at least 2 of the following risk factors: (A) an age of 65 years or more; (B) hypertension; (C) diabetes mellitus; (D) heart failure or left ventricular ejection fraction of 35% or less (or both); (E) vascular disease (prior myocardial infarction, peripheral artery disease or aortic plaque); and (b) the patient has an absolute and permanent contraindication to oral anticoagulation (confirmed by written documentation that is provided by a medical practitioner, independent of the practitioner rendering the service); and (c) the service is not associated with a service to which item 38200, 38203, 38206 or 38254 applies (H) (Anaes.) (Assist.) | $1761.40 |
| 38285 | Insertion of implantable ECG loop recorder, by a specialist or consultant physician, for the diagnosis of a primary disorder, including initial programming and testing, if: (a) the patient has recurrent unexplained syncope and does not have a structural heart defect associated with a high risk of sudden cardiac death; and (b) a diagnosis has not been achieved through all other available cardiac investigations; and (c) a neurogenic cause is not suspected (Anaes.) | $315.00 |
| 38286 | Removal of implantable ECG loop recorder (Anaes.) | $285.00 |
| 38287 | ABLATION OF ARRHYTHMIA CIRCUIT OR FOCUS or isolation procedure involving 1 atrial chamber (Anaes.) (Assist.) | $4353.60 |
| 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.) | $372.40 |
| 38290 | ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Anaes.) (Assist.) | $5540.90 |
| 38293 | VENTRICULAR ARRHYTHMIA with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes.) (Assist.) | $5950.20 |
| 38307 | Note: (acute coronary syndrome -1 coronary territory with selective coronary angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17A; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; (ii) transluminal insertion of one or more stents; and (d) performed on one coronary vascular territory; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.) | $3844.50 |
| 38308 | Note:(acute coronary syndrome -2 coronary territories with selective coronary angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17A; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 2 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.) | $4423.10 |
| 38309 | Percutaneous transluminal rotational atherectomy of one or more coronary arteries, including all associated imaging, if: (a) the target stenosis within at least one coronary artery is heavily calcified and balloon angioplasty with or without stenting is not feasible without rotational artherectomy; and (b) the service is performed in conjunction with a service to which item 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies Applicable only once on each occasion the service is performed (Anaes.) (Assist.) | $2059.00 |
| 38310 | Note: (acute coronary syndrome -3 coronary territories with selective coronary angiography)the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17A; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 3 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.) | $5001.80 |
| 38311 | Note: (stablemulti-vessel disease-1 coronary territory with selective angiography)the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible under clause 5.10.17C for the service and a service to which item 38314 applies; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on one coronary vascular territory; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.) | $3844.50 |
| 38313 | Note: (stablemulti-vessel disease-2 coronary territories with selective angiography)the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible under clause 5.10.17C for the service and a service to which item 38314 applies; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 2 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.) | $4423.10 |
| 38314 | Note: (stable multi-vessel disease—3 coronary territory with selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17C; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 3 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.) | $5001.80 |
| 38316 | Note: (acute coronary syndrome -1 coronary territory without selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17A; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on one coronary vascular territory; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.) | $3436.70 |
| 38317 | Note: (acute coronary syndrome -2 coronary territories without selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17A; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 2 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 3808, 38310, 38311, 38313, 38314, 38316, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.) | $4353.40 |
| 38319 | Note: (acute coronary syndrome -3 coronary territories without selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.2 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17A; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 3 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38320, 38322 or 38323 applies (Anaes.) (Assist.) | $4932.10 |
| 38320 | Note: (stablemulti-vessel disease-1 coronary territory without selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible under clause 5.10.17C for the service and a service to which item 38323 applies; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on one coronary vascular territory; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38322 or 38323 applies (Anaes.) (Assist.) | $3436.70 |
| 38322 | Note: (stablemulti-vessel disease-2 coronary territories with selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible under clause 5.10.17C for the service and a service to which item 38323 applies; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 2 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320 or 38323 applies (Anaes.) (Assist.) | $4353.40 |
| 38323 | Note: (stablemulti-vessel disease-3 coronary territories with selective angiography) the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.4 and TR.8.5 Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17C; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 3 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320 or 38322 applies (Anaes.) (Assist.) | $4932.10 |
| 38325 | Use of intravascular ultrasound (IVUS) during transluminal insertion of stents, to optimise procedural strategy, appropriate stent size and assessment of stent apposition, for a patient documented with: (a) one or more left main coronary artery lesions; or (b) one or more lesions at least 28mm in length in other locations; if performed in association with a service to which item 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies Applicable once per episode of care (for one or more lesions) (H) (Anaes.) | $763.10 |
| 38350 | Single chamber permanent transvenous electrode, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) | $1411.30 |
| 38353 | Permanent cardiac pacemaker, insertion, removal or replacement of, not for cardiac resynchronisation therapy, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) | $550.30 |
| 38356 | Dual chamber permanent transvenous electrodes, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) | $1843.70 |
| 38358 | Extraction of one or more chronically implanted transvenous pacing or defibrillator leads, by percutaneous method, with locking stylets and snares, with extraction sheaths (if any), if: (a) the leads have been in place for more than 6 months and require removal; and (b) the service is performed: (i) in association with a service to which item 61109 or 60509 applies; and (ii) by a specialist or consultant physician who has undertaken the training to perform the service; and (iii) in a facility where cardiothoracic surgery is available and a thoracotomy can be performed immediately and without transfer; and (c) if the service is performed by an interventional cardiologist a cardiothoracic surgeon is in attendance during the service (H) (Anaes.) (Assist.) | $6053.00 |
| 38359 | Pericardium, paracentesis of (excluding aftercare) (Anaes.) | $276.80 |
| 38362 | Intra-aortic balloon pump, percutaneous insertion of (Anaes.) | $796.60 |
| 38365 | Insertion, removal or replacement of permanent cardiac synchronisation device, if the patient: (a) has all of the following: (i) chronic heart failure, classified as New York Heart Association class III or IV (despite optimised medical therapy); (ii) left ventricular ejection fraction of less than 35%; (iii) QRS duration of greater than or equal to 130 ms; or (b) has all of the following: (i) chronic heart failure, classified as New York Heart Association class II (despite optimised medical therapy); (ii) left ventricular ejection fraction of less than 35%; (iii) QRS duration of greater than or equal to 150 ms; other than a service associated with a service to which item 38212 applies(H) (Anaes.) (Assist.) | $584.90 |
| 38368 | Insertion, removal or replacement of permanent transvenous left ventricular electrode, through the coronary sinus, for the purpose of cardiac resynchronisation therapy, including right heart catheterisation and any associated venograms, if the patient: (a) has all of the following: (i) chronic heart failure, classified as New York Heart Association class III or IV (despite optimised medical therapy); (ii) left ventricular ejection fraction of less than 35%; (iii) QRS duration of greater than or equal to 130 ms; or (b) has all of the following: (i) chronic heart failure, classified as New York Heart Association class II (despite optimised medical therapy); (ii) left ventricular ejection fraction of less than 35%; (iii) QRS duration of greater than or equal to 150 ms; other than a service associated with a service to which item 35200, 38200 or 38212 applies (H) (Anaes.) (Assist.) | $2522.60 |
| 38372 | Leadless permanent cardiac pacemaker, single-chamber ventricular, percutaneous insertion of, for the treatment of bradycardia, including cardiac electrophysiological services (other than a service associated with a service to which item 38350 applies) (H) (Anaes.) | $1245.50 |
| 38373 | Leadless permanent cardiac pacemaker, single chamber ventricular, percutaneous retrieval and replacement of, including cardiac electrophysiological services, during the same percutaneous procedure, if: (a) the service is performed by a specialist or consultant physician who has undertaken training to perform the service; and (b) if the service is performed at least 4 weeks after the pacemaker was inserted the service is performed in a facility where cardiothoracic surgery is available and a thoracotomy can be performed immediately and without transfer; and (c) if the service is performed by an interventional cardiologist at least 4 weeks after the pacemaker was inserted a cardiothoracic surgeon is in attendance during the service; other than a service associated with a service to which item 38350 applies (H) (Anaes.) | $1245.50 |
| 38374 | Leadless permanent cardiac pacemaker, single chamber ventricular, percutaneous retrieval of, if: (a) the service is performed by a specialist or consultant physician who has undertaken training to perform the service; and (b) if the service is performed at least 4 weeks after the pacemaker was inserted the service is performed in a facility where cardiothoracic surgery is available and a thoracotomy can be performed immediately and without transfer; and (c) if the service is performed by an interventional cardiologist at least 4 weeks after the pacemaker was inserted a cardiothoracic surgeon is in attendance during the service (H) (Anaes.) | $1245.50 |
| 38375 | Leadless permanent cardiac pacemaker, single-chamber ventricular, explantation of, by open surgical approach (H) (Anaes.) (Assist.) | $4660.70 |
| 38416 | Endoscopic ultrasound guided fine needle aspiration biopsy or biopsies (endoscopy with ultrasound imaging) to obtain one or more specimens from either or both of the following: (a) mediastinal masses; (b) locoregional nodes to stage non-small cell lung carcinoma; other than a service associated with a service to which an item in Subgroup 1 of this Group, or item 38417 or 55054, applies (Anaes.) | $1226.70 |
| 38417 | Endobronchial ultrasound guided biopsy or biopsies (bronchoscopy with ultrasound imaging, with or without associated fluoroscopic imaging) to obtain one or more specimens by: (a) transbronchial biopsy or biopsies of peripheral lung lesions; or (b) fine needle aspirations of one or more mediastinal masses; or (c) fine needle aspirations of locoregional nodes to stage non-small cell lung carcinoma; other than a service associated with a service to which an item in Subgroup 1 of this Group, item 38416, 38420 or 38423, or an item in Subgroup I5 of Group I3, applies (Anaes.) | $1226.70 |
| 38419 | Bronchoscopy, as an independent procedure (Anaes.) | $366.70 |
| 38420 | Bronchoscopy with one or more endobronchial biopsies or other diagnostic or therapeutic procedures (Anaes.) | $483.30 |
| 38422 | Bronchus, removal of foreign body in (Anaes.) (Assist.) | $790.50 |
| 38423 | Fibreoptic bronchoscopy with one or more transbronchial lung biopsies, with or without bronchial or broncho-alveolar lavage, with or without the use of interventional imaging (Anaes.) (Assist.) | $527.80 |
| 38425 | Endoscopic resection of endobronchial tumours for relief of obstruction including any associated endoscopic procedures, other than a service associated with a service to which another item in Group T8 applies (H) (Anaes.) (Assist.) | $1249.40 |
| 38426 | Trachea or bronchus, dilatation of stricture and endoscopic insertion of stent (Anaes.) (Assist.) | $937.20 |
| 38428 | Bronchoscopy with treatment of tracheal stricture (Anaes.) | $472.30 |
| 38429 | Tracheal excision and repair of, without cardiopulmonary bypass (H) (Anaes.) (Assist.) | $2997.20 |
| 38431 | Tracheal excision and repair of, with cardiopulmonary bypass (H) (Anaes.) (Assist.) | $4053.80 |
| 38461 | TMVr, by transvenous or transeptal techniques, for permanent coaptation of mitral valve leaflets using one or more Mitraclips , including intra operative diagnostic imaging, if: (a) the patient has each of the following risk factors: (i) moderate to severe, or severe, symptomatic degenerative (primary) mitral valve regurgitation (grade 3+ or 4+); (ii) left ventricular ejection fraction of 20% or more; (iii) symptoms of mild, moderate or severe chronic heart failure (New York Heart Association class II, III or IV); and (b) as a result of a TMVr suitability case conference, the patient has been: (i) assessed as having an unacceptably high risk for surgical mitral valve replacement; and (ii) recommended as being suitable for the service; and (c) the service is performed: (i) by a cardiothoracic surgeon, or an interventional cardiologist, accredited by the TMVr accreditation committee to perform the service; and (ii) via transfemoral venous delivery, unless transfemoral venous delivery is contraindicated or not feasible; and (iii) in a hospital that is accredited by the TMVr accreditation committee as a suitable hospital for the service; and (d) a service to which this item, or item 38463, applies has not been provided to the patient in the previous 5 years (H) (Anaes.) (Assist.) | $3106.00 |
| 38463 | TMVr, by transvenous or transeptal techniques, for permanent coaptation of mitral valve leaflets using one or more Mitraclips , including intra operative diagnostic imaging, if: (a) the patient has each of the following risk factors: (i) moderate to severe, or severe, symptomatic functional (secondary) mitral valve regurgitation (grade 3+ or 4+); (ii) left ventricular ejection fraction of 20% to 50%; (iii) left ventricular end systolic diameter of not more than 70mm; (iv) symptoms of mild, moderate or severe chronic heart failure (New York Heart Association class II, III or IV) that persist despite maximally tolerated guideline directed medical therapy; and (b) as a result of a TMVr suitability case conference, the patient has been: (i) assessed as having an unacceptably high risk for surgical mitral valve replacement; and (ii) recommended as being suitable for the service; and (c) the service is performed: (i) by a cardiothoracic surgeon, or an interventional cardiologist, accredited by the TMVr accreditation committee to perform the service; and (ii) via transfemoral venous delivery, unless transfemoral venous delivery is contraindicated or not feasible; and (iii) in a hospital that is accredited by the TMVr accreditation committee as a suitable hospital for the service; and (d) a service to which this item, or item 38461, applies has not been provided to the patient in the previous 5 years (H) (Anaes.) (Assist.) | $3106.00 |
| 38467 | Insertion, removal or replacement of permanent myocardial electrode, by open surgical approach, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $2078.50 |
| 38471 | Insertion of implantable defibrillator, including insertion of patches for the insertion of one or more transvenous endocardial leads, if the patient has one of the following: (a) a history of haemodynamically significant ventricular arrhythmias in the presence of structural heart disease; (b) documented high-risk genetic cardiac disease; (c) ischaemic heart disease, with a left ventricular ejection fraction of less than 30% at least one month after experiencing a myocardial infarction and while on optimised medical therapy; (d) chronic heart failure, classified as New York Heart Association class II or III, with a left ventricular ejection fraction of less than 35% (despite optimised medical therapy); other than a service to which item 38212 applies (H) (Anaes.) (Assist.) | $2282.90 |
| 38472 | Insertion, replacement or removal of implantable defibrillator generator, if the patient has one of the following: (a) a history of haemodynamically significant ventricular arrhythmias in the presence of structural heart disease; (b) documented high-risk genetic cardiac disease; (c) ischaemic heart disease, with a left ventricular ejection fraction of less than 30% at least one month after experiencing a myocardial infarction and while on optimised medical therapy; (d) chronic heart failure, classified as New York Heart Association class II or III, with a left ventricular ejection fraction of less than 35% (despite optimised medical therapy); other than a service to which item 38212 applies (H) (Anaes.) (Assist.) | $624.30 |
| 38474 | Repair, augmentation or replacement of branch pulmonary arteries left or right (or both), with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4704.20 |
| 38477 | Valve annuloplasty with insertion of ring, other than: (a) a service to which item 38516 or 38517 applies; or (b) a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4134.40 |
| 38484 | Aortic or pulmonary valve replacement with bioprosthesis or mechanical prosthesis, including retrograde cardioplegia (if performed), other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4402.20 |
| 38485 | MITRAL ANNULUS, reconstruction of, after decalcification, when performed in association with valve surgery (Anaes.) (Assist.) | $1683.40 |
| 38487 | MITRAL VALVE, open valvotomy of (Anaes.) (Assist.) | $3491.80 |
| 38490 | Reconstruction and re-implantation of sub-valvular structures, if performed in conjunction with a service to which item 38499 applies (H) (Anaes.) (Assist.) | $1141.70 |
| 38493 | OPERATIVE MANAGEMENT of acute infective endocarditis, in association with heart valve surgery (Anaes.) (Assist.) | $4036.90 |
| 38495 | TAVI, for the treatment of symptomatic severe aortic stenosis, performed via transfemoral delivery, unless transfemoral delivery is contraindicated or not feasible, if: (a) the TAVI Patient is at high risk for surgery; and (b) the service: (i) is performed by a TAVI Practitioner in a TAVI Hospital; and (ii) includes all intraoperative diagnostic imaging that the TAVI Practitioner performs upon the TAVI Patient; and (iii) includes valvuloplasty, if required; not being a service which has been rendered within 5 years of a service to which this item or item 38514 or 38522 applies (H) (Anaes.) (Assist.) | $2765.00 |
| 38499 | Mitral or tricuspid valve replacement with bioprothesis or mechanical prosthesis, including retrograde cardioplegia (if performed), other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4402.20 |
| 38502 | Coronary artery bypass, including cardiopulmonary bypass, with or without retrograde cardioplegia, with or without vein grafts, and including at least one of the following: (a) harvesting of left internal mammary artery and vein graft material; (b) harvesting of left internal mammary artery; (c) harvesting of vein graft material; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies(H) (Anaes.) (Assist.) | $5109.50 |
| 38508 | Repair or reconstruction of left ventricular aneurysm, including plication, resection and primary and patch repairs, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4621.60 |
| 38509 | Repair of ischaemic ventricular septal rupture,, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $5133.90 |
| 38510 | Artery harvesting (other than of the left internal mammary), for coronary artery bypass, if: (a) more than one arterial graft is required; and (b) the service is performed in conjunction with coronary artery bypass surgery performed by any medical practitioner (H) (Anaes.) (Assist.) | $1353.20 |
| 38511 | Coronary artery bypass, with the aid of tissue stabilisers, if the service is performed: (a) without cardiopulmonary bypass; and (b) in conjunction with a service to which item 38502 applies (H) (Anaes.) (Assist.) | $1301.10 |
| 38512 | Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving one atrial chamber only, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4322.20 |
| 38513 | Creation of Y graft, T graft and graft to graft extensions, with micro arterial or micro venous anastomosis using microsurgical techniques, if: (a) the service is for one or more anastomoses; and (b) the service is performed in conjunction with a service to which item 38502 applies (H) (Anaes.) (Assist.) | $2168.70 |
| 38514 | TAVI, for the treatment of symptomatic severe aortic stenosis, performed via transfemoral delivery, unless transfemoral delivery is contraindicated or not feasible, if: (a) the TAVI Patient is at intermediate risk for surgery; and (b) the service: (i) is performed by a TAVI Practitioner in a TAVI Hospital; and (ii) includes all intraoperative diagnostic imaging that the TAVI Practitioner performs upon the TAVI Patient; and (iii) includes valvuloplasty, if required; not being a service which has been rendered within 5 years of a service to which this item or item 38495 or 38522 applies (H) (Anaes.) (Assist.) | $2635.10 |
| 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, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $5529.20 |
| 38516 | Simple valve repair: (a) with or without annuloplasty; and (b) including quadrangular resection, cleft closure or alfieri; and (c) including retrograde cardioplegia (if performed); other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $5229.70 |
| 38517 | Complex valve repair: (a) with or without annuloplasty; and (b) including retrograde cardioplegia (if performed); and (c) including one of the following: (i) neochords; (ii) chordal transfer; (iii) patch augmentation; (iv) multiple leaflets; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies(H) (Anaes.) (Assist.) | $6368.90 |
| 38518 | Ventricular arrhythmia with mapping and muscle ablation, with or without aneurysmeotomy, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $6166.20 |
| 38519 | Valve explant of a previous prosthesis, if performed during open cardiac surgery, not being a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $2292.60 |
| 38522 | TAVI, for the treatment of symptomatic severe native calcific aortic stenosis, performed via transfemoral delivery, unless transfemoral delivery is contraindicated or not feasible, if: (a) the TAVI Patient is at low risk for surgery; and (b) the service: (i) is performed by a TAVI Practitioner in a TAVI Hospital; and (ii) includes all intraoperative diagnostic imaging that the TAVI Practitioner performs upon the TAVI Patient; and (iii) includes valvuloplasty, if required; not being a service which has been rendered within 5 years of a service to which this item or item 38495 or 38514 applies (H) (Anaes.) (Assist.) | $2677.20 |
| 38523 | Percutaneous transcatheter delivery of dual-filter cerebral embolic protection system during a TAVI procedure, for the reduction of postoperative embolic ischaemic strokes, if: the service is performed upon a TAVI Patient in a TAVI Hospital; and where the service is performed by the practitioner performing the TAVI procedure, the service includes all intraoperative diagnostic imaging that the TAVI Practitioner performs upon the TAVI Patient (H) (Anaes.) (Assist.) | $486.60 |
| 38550 | Repair or replacement of ascending thoracic aorta: (a) including: (i) cardiopulmonary bypass; and (ii) retrograde cardioplegia (if performed); and (b) not including valve replacement or repair or implantation of coronary arteries; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4901.60 |
| 38553 | Repair or replacement of ascending thoracic aorta: (a) including: (i) aortic valve replacement or repair; and (i) cardiopulmonary bypass; and (ii) retrograde cardioplegia (if performed); and (b) not including implantation of coronary arteries; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $5865.00 |
| 38554 | Valve sparing aortic root surgery, with reimplantation of aortic valve and coronary arteries and replacement of the ascending aorta, including cardiopulmonary bypass, and including retrograde cardioplegia (if performed), other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $8829.60 |
| 38555 | Simple replacement or repair of aortic arch, performed in conjunction with a service to which item 38550, 38553, 38554, 38556, 38568 or 38571 applies, including: (a) deep hypothermic circulatory arrest; and (b) peripheral cannulation for cardiopulmonary bypass; and (c) antegrade or retrograde cerebral perfusion (if performed); other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38603, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $6402.90 |
| 38556 | Repair or replacement of ascending thoracic aorta, including: (a) aortic valve replacement or repair; and (b) implantation of coronary arteries; and (c) cardiopulmonary bypass; and (d) retrograde cardioplegia (if performed); other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38603, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $6647.10 |
| 38557 | Complex replacement or repair of aortic arch, performed in conjunction with a service, performed by any medical practitioner, to which item 38550, 38553, 38554, 38556, 38568 or 38571 applies, including: (a) debranching and reimplantation of head and neck vessels; and (b) deep hypothermic circulatory arrest; and (c) peripheral cannulation for cardiopulmonary bypass; and (d) antegrade or retrograde cerebral perfusion (if performed); other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $8116.50 |
| 38558 | Aortic repair involving augmentation of hypoplastic or interrupted aortic arch, if: (a) the patient is a neonate; and (b) the service includes: (i) the use of antegrade cerebral perfusion or deep hypothermic circulatory arrest and associated myocardial preservation; and (ii) retrograde cardioplegia; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $10595.40 |
| 38568 | Repair or replacement of descending thoracic aorta, without shunt or cardiopulmonary bypass, by open exposure, percutaneous or endovascular means, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828or 45503 applies (H) (Anaes.) (Assist.) | $3963.70 |
| 38571 | Repair or replacement of descending thoracic aorta, with shunt or cardiopulmonary bypass, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4652.90 |
| 38572 | Operative management of acute rupture or dissection, if the service: (a) is performed in conjunction with a service to which item 38550, 38553, 38554, 38555, 38556, 38557, 38558, 38568, 38571, 38706 or 38709 applies; and (b) is not associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38603, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4231.60 |
| 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.) | $3294.10 |
| 38603 | Peripheral cannulation for cardiopulmonary bypass, excluding post-operative management, other than a service: (a) in which peripheral cannulation is used in preference to central cannulation for valve or coronary bypass procedures; or (b) associated with a service to which item 38555 or 38572 applies (H) (Anaes.) (Assist.) | $2037.90 |
| 38609 | Insertion of intra-aortic balloon pump, by arteriotomy, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies(H) (Anaes.) (Assist.) | $989.20 |
| 38612 | Removal of intra-aortic balloon pump, with closure of artery by direct suture, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 338816, 38828 or 45503 applies(H) (Anaes.) (Assist.) | $1089.60 |
| 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 ventricularassist 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 6weeks; other than a service associated with a service to which: (d) item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies; or (e) another item in this Schedule applies if the service described in the item is for the use of a ventricular assist device as destination therapy in the management of a patient with heart failure who is not expected to be a suitable candidate for cardiac transplantation (H) (Anaes.) (Assist.) | $3294.10 |
| 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; other than a service associated with a service to which: (d) item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies; or (e) another item in this Schedule applies if the service described in the item is for the use of a ventricular assist device as destination therapy in the management of a patient with heart failure who is not expected to be a suitable candidate for cardiac transplantation (H) (Anaes.) (Assist.) | $4101.60 |
| 38621 | Left or right ventricular assist device, removal of, as an independent procedure, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38627,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $1628.80 |
| 38624 | Left and right ventricular assist device, removal of, as an independent procedure, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38627, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $1839.30 |
| 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, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38627, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $1353.60 |
| 38637 | Patent diseased coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $1193.60 |
| 38653 | Open heart surgery, other than a service: (a) to which another item in this Group applies; or (b) associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828or 45503 applies (H) (Anaes.) (Assist.) | $4114.20 |
| 38670 | Cardiac tumour, excision of, involving the wall of the atrium or inter-atrial septum, without patch or conduit reconstruction, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $3960.40 |
| 38673 | Cardiac tumour, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4463.00 |
| 38677 | Cardiac tumour arising from ventricular myocardium, partial thickness excision of, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4317.50 |
| 38680 | Cardiac tumour arising from ventricular myocardium, full thickness excision of including repair or reconstruction, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $5121.40 |
| 38700 | Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $2190.90 |
| 38703 | Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4139.10 |
| 38706 | Aorta, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $3913.40 |
| 38709 | Anastomosis or repair of aorta, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4590.40 |
| 38715 | Main Pulmonary Artery, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $3462.00 |
| 38718 | Banding, debanding or repair of main pulmonary artery, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies(H) (Anaes.) (Assist.) | $4413.50 |
| 38721 | Vena Cava, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $3212.10 |
| 38724 | Vena cava, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4486.10 |
| 38727 | Anastomosis or repair of intrathoracic vessels, without cardiopulmonary bypass, performed as a primary procedure, other than a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38700, 38703, 38706, 38709, 38715, 38718, 38721, 38724, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $3220.10 |
| 38730 | Anastomosis or repair of intrathoracic vessels, with cardiopulmonary bypass, performed as a primary procedure, other than a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38700, 38703, 38706, 38709, 38715, 38718, 38721, 38724, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4590.40 |
| 38733 | Systemic pulmonary or Cavo-pulmonary shunt, creation of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $3035.00 |
| 38736 | Systemic pulmonary or Cavo-pulmonary shunt, creation of, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4331.20 |
| 38739 | Atrial septectomy, with or without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4288.00 |
| 38742 | Atrial septal defect, closure by open exposure and direct suture or patch, for congenital heart disease in a patient with documented evidence of right heart overload or paradoxical embolism, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $3966.70 |
| 38745 | Intra-atrial baffle, insertion of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4391.40 |
| 38748 | Ventricular septectomy, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4405.00 |
| 38751 | Ventricular septal defect, closure by direct suture or patch, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828or 45503 applies (H) (Anaes.) (Assist.) | $4418.00 |
| 38754 | Intraventricular baffle or conduit, insertion of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $5422.10 |
| 38757 | Extracardiac conduit, insertion of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4405.00 |
| 38760 | Extracardiac conduit, replacement of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4331.20 |
| 38764 | Ventricular myectomy, for relief of right or left ventricular obstruction, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824,38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4629.00 |
| 38766 | Ventricular augmentation, right or left, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $4398.80 |
| 38800 | THORACIC CAVITY, aspiration of, for diagnostic purposes, not being a service associated with a service to which item 38803 applies | $79.60 |
| 38803 | Thoracic cavity, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample | $165.30 |
| 38812 | Percutaneous needle biopsy of lung (Anaes.) | $444.90 |
| 38815 | Thoracoscopy, with or without division of pleural adhesions, with or without biopsy, including insertion of intercostal catheter where necessary, other than a service associated with: (a) a service to which item 18258, 18260 or 38828 applies; or (b) a service to which item 38816 applies that is performed on the same lung (H) (Anaes.) (Assist.) | $434.90 |
| 38816 | Thoracotomy, exploratory, with or without biopsy, including insertion of an intercostal catheter where necessary, other than a service associated with: (a) a service to which item 18258, 18260 or 38828 applies; or (b) a service to which item 38815 applies that is performed on the same lung (H) (Anaes.) (Assist.) | $1669.10 |
| 38817 | Thoracotomy, thoracoscopy or sternotomy, by any procedure: (a) including any division of adhesions if the time taken to divide the adhesions exceeds 30 minutes; and (b) other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18258, 18260, 33824, 38815, 38816, 38818, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $2623.90 |
| 38818 | Thoracotomy, thoracoscopy or median sternotomy for post operative bleeding, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18258, 18260, 33824, 38815, 38816, 38817, 38828 or 45503 applies (H) (Anaes.) (Assist.) | $1669.10 |
| 38820 | Lung, wedge resection of, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38820, 38821 or 38828 applies (H) (Anaes.) (Assist.) | $1998.00 |
| 38821 | Lung, wedge resection of, 2 or more wedges, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38820 or 38828 applies (H) (Anaes.) (Assist.) | $2996.90 |
| 38822 | Pneumonectomy, lobectomy, bilobectomy or segmentectomy, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38823, 38824 or 38828 applies (H) (Anaes.) (Assist.) | $2668.00 |
| 38823 | Radical lobectomy, pneumonectomy, bilobectomy, segmentectomy or formal mediastinal node dissection (greater than 4 nodes), other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38822, 38824 or 38828 applies (H) (Anaes.) (Assist.) | $3296.70 |
| 38824 | Segmentectomy, lobectomy, bilobectomy or pneumonectomy, including resection of chest wall, diaphragm, pericardium, and formal mediastinal node dissection (greater than 4 nodes), other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38822, 38823 or 38828 applies (H) (Anaes.) (Assist.) | $4120.70 |
| 38828 | Intercostal drain, insertion of: (a) not involving resection of rib; and (b) excluding aftercare; and (c) other than a service associated with a service to which item 38815, 38816, 38829, 38830, 38831, 38832, 38833 or 38834 applies (Anaes.) | $232.60 |
| 38829 | Intercostal drain, insertion of, with pleurodesis: (a) not involving resection of rib; and (b) excluding aftercare; and (c) other than a service associated with a service to which item 38815, 38816, 38828, 38830, 38831, 38832, 38833 or 38834 applies (Anaes.) | $286.60 |
| 38830 | Empyema, radical operation for, involving resection of rib, other than a service associated with a service to which item 38828, 38829, 38831, 38832, 38833 or 38834 applies (H) (Anaes.) (Assist.) | $695.50 |
| 38831 | Thoracoscopy or thoracotomy and drainage of paraneumonic effusion and empyema, exploratory, with or without biopsy, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38829, 38830, 38832, 38833 or 38834 applies (H) (Anaes.) (Assist.) | $2503.70 |
| 38832 | Thoracotomy or thoracoscopy, with pulmonary decortication, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38829, 38830, 38831, 38833 or 38834 applies (H) (Anaes.) (Assist.) | $2668.00 |
| 38833 | Thoracotomy or thoracoscopy, with pleurectomy or pleurodesis, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38829, 38830, 38831, 38832 or 38834 applies (H) (Anaes.) (Assist.) | $1669.10 |
| 38834 | Thoracotomy and radical extra pleural pneumonectomy or radical lung preserving decortication and pleurectomy for malignancy, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38829, 38830, 38831, 38832 or 38833 applies (H) (Anaes.) (Assist.) | $6181.20 |
| 38837 | Mediastinum, cervical exploration of, with or without biopsy, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) (Assist.) | $632.30 |
| 38838 | Thoracotomy or thoracoscopy or sternotomy, for removal of thymus or mediastinal tumour, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) (Assist.) | $2061.10 |
| 38839 | Pericardium, subxiphoid open surgical drainage of, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38840 applies (H) (Anaes.) (Assist.) | $999.20 |
| 38840 | Pericardium, transthoracic (thoracotomy or thoracoscopy) open surgical drainage of, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38839 applies (H) (Anaes.) (Assist.) | $1491.90 |
| 38841 | Pericardiectomy via sternotomy or thoracoscopy or anterolateral thoracotomy without cardiopulmonary bypass, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) (Assist.) | $2668.00 |
| 38842 | Pericardiectomy via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) (Assist.) | $3732.60 |
| 38845 | Sternal wire or wires, removal of, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) | $479.60 |
| 38846 | Pectus excavatum or pectus carinatum, repair or radical correction of, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38847, 38848 or 38849 applies (H) (Anaes.) (Assist.) | $2490.90 |
| 38847 | Pectus excavatum, repair of, with implantation of subcutaneous prosthesis, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38846, 38848 or 38849 applies (H) (Anaes.) (Assist.) | $1327.70 |
| 38848 | Pectus excavatum, repair of, with insertion of a concave bar, by any method, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38846 or 38847 applies (H) (Anaes.) (Assist.) | $1992.70 |
| 38849 | Pectus excavatum, removal of a concave bar, by any method, not being a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38846 or 38847 applies (H) (Anaes.) (Assist.) | $996.20 |
| 38850 | Sternotomy wound, debridement of, not involving reopening of the mediastinum, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38851 applies (H) (Anaes.) | $568.60 |
| 38851 | Sternotomy wound, debridement of, involving curettage of infected bone, with or without removal of wires, but not involving reopening of the mediastinum, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38850 applies (H) (Anaes.) | $618.00 |
| 38852 | Sternum, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38853 applies (H) (Anaes.) (Assist.) | $1668.50 |
| 38853 | Sternum and mediastinum, reoperation for infection of, involving muscle advancement flaps and/or greater omentum, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38852 applies (H) (Anaes.) (Assist.) | $2615.70 |
| 38857 | Chest wall resection, sternum and/or ribs without reconstruction, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38824, 38828 or 38858 applies (H) (Anaes.) (Assist.) | $3161.20 |
| 38858 | Chest wall resection, sternum and / or ribs with reconstruction, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38824, 38828 or 38857 applies (H) (Anaes.) (Assist.) | $4120.70 |
| 38859 | Plating of multiple ribs for flail segment, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) (Assist.) | $1669.10 |
| 38864 | Intrathoracic operations on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than one of those organs, not being a service to which another item in this Group applies, other than a service associated with a service to which item 18258, 18260 or 38828 applies (H) (Anaes.) (Assist.) | $2668.00 |
| **Neurosurgical** | | |
| 39000 | Lumbar puncture (Anaes.) | $172.80 |
| 39007 | Procedure to obtain access to intracranial space (including subdural space, ventricle or basal cistern), percutaneously or by burr-hole (Anaes.) | $302.60 |
| 39013 | Injection of one or more zygo-apophyseal or costo-transverse joints with one or more of contrast media, local anaesthetic or corticosteroid under image guidance (Anaes.) | $232.40 |
| 39014 | Medial branch block of one or more primary posterior rami, injection of an anaesthetic agent under image guidance (Anaes.) | $229.80 |
| 39015 | Intracranial parenchymal pressure monitoring device, insertion of including burr hole (excluding after care) (Anaes.) | $773.80 |
| 39018 | Cerebrospinal reservoir, ventricular reservoir or external ventricular drain, insertion of, with or without stereotaxy (Anaes.) (Assist.) | $887.10 |
| 39100 | Injection of primary branch of trigeminal nerve (ophthalmic, maxillary or mandibular branches) with alcohol, cortisone, phenol, or similar neurolytic substance, under image guidance (Anaes.) | $482.20 |
| 39109 | Trigeminal gangliotomy by radiofrequency, balloon or glycerol, including stereotaxy (Anaes.) (Assist.) | $1254.20 |
| 39110 | Left lumbar percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.) | $493.20 |
| 39111 | Right lumbar percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.) | $493.20 |
| 39113 | Cranial nerve, neurectomy or intracranial decompression of, using microsurgical techniques, including stereotaxy and cranioplasty (Anaes.) (Assist.) | $4514.00 |
| 39116 | Left thoracic percutaneous zygapophyseal joint denervation by radio-frequency probe or cryoprobe using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.) | $548.00 |
| 39117 | Right thoracic percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.) | $548.00 |
| 39118 | Left cervical percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.) | $672.20 |
| 39119 | Right cervical percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.) | $602.80 |
| 39121 | PERCUTANEOUS CORDOTOMY (Anaes.) (Assist.) | $1281.70 |
| 39124 | CORDOTOMY OR MYELOTOMY, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes.) (Assist.) | $3775.00 |
| 39125 | Spinal catheter, insertion or replacement of, and connection to a subcutaneous implanted infusion pump, for the management of chronic pain, including cancer pain (H) (Anaes.) (Assist.) | $659.40 |
| 39126 | All of the following:(a) infusion pump, subcutaneous implantation or replacement of;(b) connection of the pump to a spinal catheter;(c) filling of reservoir with a therapeutic agent or agents; with or without programming the pump, for the management of chronic pain, including cancer pain (H) (Anaes.) (Assist.) | $770.80 |
| 39127 | Subcutaneous reservoir and spinal catheter, insertion of, for the management of chronic pain, including cancer pain (H) (Anaes.) | $1084.00 |
| 39128 | All of the following:(a) infusion pump, subcutaneous implantation of;(b) spinal catheter, insertion of;(c) connection of pump to catheter;(d) filling of reservoir with a therapeutic agent or agents; with or without programming the pump, for the management of chronic pain, including cancer pain (H) (Anaes.) (Assist.) | $1358.30 |
| 39129 | Peripheral lead or leads, percutaneous placement of, including intraoperative test stimulation, for the management of chronic neuropathic pain (H) (Anaes.) (Assist.) | $1116.30 |
| 39130 | Epidural lead or leads, percutaneous placement of, including intraoperative test stimulation, for the management of chronic neuropathic pain or pain from refractory angina pectoris (H) (Anaes.) (Assist.) | $1385.60 |
| 39131 | Epidural or peripheral nerve electrodes (management, adjustment, or reprogramming of neurostimulator), with a medical practitioner attending, for the management of chronic neuropathic pain or pain from refractory angina pectoris each day | $274.00 |
| 39133 | Either:(a) subcutaneously implanted infusion pump, removal of; or(b) spinal catheter, removal or repositioning of;for the management of chronic pain, including cancer pain (H) (Anaes.) | $340.00 |
| 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 neuropathic pain or pain from refractory angina pectoris (H) (Anaes.) (Assist.) | $707.50 |
| 39135 | Neurostimulator or receiver that was inserted for the management of chronic neuropathic pain or pain from refractory angina pectoris, open surgical removal of, performed in the operating theatre of a hospital (H) (Anaes.) (Assist.) | $329.60 |
| 39136 | Epidural or peripheral nerve lead that was implanted for the management of chronic neuropathic pain or pain from refractory angina pectoris, open surgical removal of, performed in the operating theatre of a hospital (H) (Anaes.) (Assist.) | $340.00 |
| 39137 | Epidural or peripheral nerve lead that was implanted for the management of chronic neuropathic pain or pain from refractory angina pectoris, open surgical repositioning of, to correct displacement or unsatisfactory positioning, including intraoperative test stimulation, other than a service to which item 39130, 39138 or 39139 applies (H) (Anaes.) (Assist.) | $1287.90 |
| 39138 | Peripheral nerve lead or leads, surgical placement of, including intraoperative test stimulation, for the management of chronic neuropathic pain where the leads are intended to remain in situ long term (H) (Anaes.) (Assist.) | $1390.80 |
| 39139 | Epidural lead, surgical placement of one or more of by partial or total laminectomy, including intraoperative test stimulation, for the management of chronic neuropathic pain or pain from refractory angina pectoris (H) (Anaes.) (Assist.) | $1961.90 |
| 39140 | EPIDURAL CATHETER, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (Anaes.) | $624.30 |
| 39141 | Epidural or peripheral nerve electrodes (management, adjustment, or reprogramming of neurostimulator), with a medical practitioner attending remotely by video conference, for the management of chronic neuropathic pain or pain from refractory angina pectoris each day | $239.00 |
| 39300 | Nerve, digital or cutaneous, primary repair of, using microsurgical techniques, other than a service associated with a service to which item 39330 applies applicable once per nerve (H) (Anaes.) (Assist.) | $726.10 |
| 39303 | Nerve, digital or cutaneous, delayed repair of, using microsurgical techniques, including either or both of the following (if performed): (a) neurolysis; (b) transposition of nerve to facilitate repair; other than a service associated with a service to which item 30023 applies that is performed at the same site applicable once per nerve (H) (Anaes.) (Assist.) | $1021.30 |
| 39306 | Nerve trunk, primary repair of, using microsurgical techniques, other than a service associated with a service to which item 39330 applies (H) (Anaes.) (Assist.) | $1454.00 |
| 39307 | Reconstruction of nerve trunk using biological or synthetic nerve conduit, using microsurgical techniques, other than a service associated with a service to which item 39330 applies (Anaes.) (Assist.) | $1787.30 |
| 39309 | Nerve trunk, delayed repair of, using microsurgical techniques, including either or both of the following (if performed): (a) neurolysis; (b) transposition of nerve or nerve transfer to facilitate repair; other than a service associated with: (c) a service to which item 39321 applies; or (d) a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.) | $1568.70 |
| 39312 | Nerve trunk, internal (interfascicular), neurolysis of, using microsurgical techniques, other than a service associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.) | $815.30 |
| 39315 | Nerve trunk, nerve graft to, by cable graft, using microsurgical techniques, including any of the following (if performed): (a) harvesting of nerve graft; (b) proximal and distal anastomosis of nerve graft; (c) transposition of nerve to facilitate grafting; (d) neurolysis; other than a service associated with: (e) a service to which item 39330 applies; or (f) a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.) | $2122.80 |
| 39318 | Nerve, digital or cutaneous, nerve graft to, using microsurgical techniques, including either or both of the following (if performed): (a) harvesting of nerve graft from separate donor site; (b) proximal and distal anastomosis of nerve graft; other than a service associated with a service to which item 39330 applies (H) (Anaes.) (Assist.) | $1308.70 |
| 39319 | Reconstruction of digital or cutaneous nerve using biological or synthetic nerve conduit, using microsurgical techniques, other than a service associated with a service to which item 39330 applies (Anaes.) (Assist.) | $1010.80 |
| 39321 | Transposition of nerve, excluding the ulnar nerve at the elbow, other than a service associated with a service to which item 39330 applies (H) (Anaes.) (Assist.) | $1043.50 |
| 39323 | Percutaneous denervation (excluding medial branch nerve) by cryotherapy or radiofrequency probe, other than a service to which another item applies, applicable not more than 6 times for a given nerve in a 12 month period (Anaes.) | $569.60 |
| 39324 | Neurectomy or removal of tumour or neuroma from superficial peripheral nerve (Anaes.) (Assist.) | $570.60 |
| 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.) | $1039.10 |
| 39328 | Neurectomy, neurotomy or removal of tumour from deep peripheral nerve, by open operation, for upper limb surgery (H) (Anaes.) (Assist.) | $1027.40 |
| 39329 | Extensive neurolysis of radial, median or ulnar nerve trunk nerve in the forearm or arm, other than a service associated with: (a) a service to which item 39303, 39309, 39312, 39315, 39318, 39324 or 39327 applies; or (b) a service to which item 30023 applies that is performed at the same site (Anaes.) (Assist.) | $766.40 |
| 39330 | Neurolysis by open operation without transposition, other than a service associated with: (a) a service to which item 39321, 39328, 39329, 39332, 39336, 39339, 39342, 39345, 49774 or 49775 applies; or (b) a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.) | $583.00 |
| 39331 | Carpal tunnel release, including division of transverse carpal ligament or release of median nerve, by any method, including either or both of the following (if performed): (a) synovectomy; (b) neurolysis; other than a service associated with: (c) a service to which item 46339 applies; or (d) a service to which item 30023 applies that is performed at the same site (Anaes.) (Assist.) | $602.60 |
| 39332 | Revision of carpal tunnel release, including division of transverse carpal ligament or release of median nerve, by any method, including either or both of the following (if performed): (a) synovectomy; (b) neurolysis; other than a service associated with: (c) a service to which item 46339 applies; or (d) a service to which item 30023 applies that is performed at the same site (Anaes.) (Assist.) | $900.50 |
| 39336 | Ulnar nerve decompression at elbow or wrist (cubital tunnel or Guyon s canal) without transposition, by any method, including neurolysis (if performed), other than a service associated with a service to which item 30023 applies that is performed at the same site (Anaes.) (Assist.) | $600.20 |
| 39339 | Revision of ulnar nerve decompression at elbow (cubital tunnel) without transposition, by any method, including neurolysis (if performed), other than a service associated with a service to which item 30023 applies that is performed at the same site (Anaes.) (Assist.) | $900.50 |
| 39342 | Ulnar nerve decompression at elbow (cubital tunnel), including any of the following (if performed): (a) associated transposition; (b) subcutaneous or submuscular transposition of the nerve; (c) medial epicondylectomy; (d) ostetomy and reconstruction of the flexor origin; (e) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site (Anaes.) (Assist.) | $1181.20 |
| 39345 | Localised decompression of radial, median or ulnar nerve, or branches of, in the forearm for compressive neuropathy, including neurolysis (if performed), other than a service associated with a service to which item 30023 applies that is performed at the same site (Anaes.) (Assist.) | $600.20 |
| 39503 | FACIO-HYPOGLOSSAL nerve or FACIO-ACCESSORY nerve, anastomosis of (Anaes.) (Assist.) | $2036.00 |
| 39604 | Any of the following procedures for intracranial haemorrhage or swelling:(a) craniotomy, craniectomy or burr-holes for removal of intracranial haemorrhage, including stereotaxy;(b) craniotomy or craniectomy for brain swelling, stroke, or raised intracranial pressure, including for subtemporal decompression, including stereotaxy; or(c) post-operative re-opening, including for swelling or post-operative cerebrospinal fluid leak. (Anaes.) (Assist.) | $3404.50 |
| 39610 | Fractured skull, without brain laceration or dural penetration, repair of (Anaes.) (Assist.) | $1812.80 |
| 39612 | Fractured skull, with brain laceration or dural penetration but without cerebrospinal fluid, rhinorrhoea or otorrhoea, repair of (Anaes.) (Assist.) | $2270.10 |
| 39615 | Fractured skull, after trauma, with cerebrospinal fluid rhinorrhoea or otorrhoea, repair of, including stereotaxy and dermofat graft (Anaes.) (Assist.) | $2843.50 |
| 39638 | Anterior or middle cranial fossa or cavernous sinus, tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty conjoint surgery, principal surgeon (Anaes.) (Assist.) | $8080.70 |
| 39639 | Anterior or middle cranial fossa or cavernous sinus, tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty conjoint surgery, co surgeon (Assist.) | $6457.40 |
| 39641 | Anterior or middle cranial fossa or cavernous sinus, tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty—one surgeon (Anaes.) (Assist.) | $8523.20 |
| 39651 | Petro-clival, clival or foramen magnum tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty—one surgeon (Anaes.) (Assist.) | $10515.30 |
| 39654 | Petro-clival, clival or foramen magnum tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty conjoint surgery, principal surgeon (Anaes.) (Assist.) | $8135.80 |
| 39656 | Petro clival, clival or foramen magnum tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty conjoint surgery, co surgeon (Assist.) | $7248.50 |
| 39700 | Skull tumour, benign or malignant, excision of, including stereotaxy and cranioplasty (Anaes.) (Assist.) | $1511.80 |
| 39703 | Intracranial tumour, cyst or other brain tissue, either or both of: (a) burr hole and biopsy of; (b) drainage of; including stereotaxy (Anaes.) (Assist.) | $1350.90 |
| 39710 | Intracranial tumour, one or more, biopsy, drainage, decompression or removal of, through a single craniotomy, including stereotaxy and cranioplasty (Anaes.) (Assist.) | $4600.00 |
| 39712 | Transcranial tumour removal or biopsy of one or more of any of the following: (a) meningioma; (b) pinealoma; (c) cranio pharyngioma; (d) pituitary tumour; (e) intraventricular lesion; (f) brain stem lesion; (g) any other intracranial tumour; by any means (with or without endoscopy), through a single craniotomy, including stereotaxy and cranioplasty (Anaes.) (Assist.) | $6739.30 |
| 39715 | Pituitary tumour, removal of, by transphenoidal approach, including stereotaxy and dermis, dermofat or fascia grafting, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) | $4857.70 |
| 39718 | Arachnoidal cyst, craniotomy for, including stereotaxy and neuroendoscopy (Anaes.) (Assist.) | $2354.30 |
| 39720 | Awake craniotomy for functional neurosurgery (Anaes.) (Assist.) | $6573.00 |
| 39801 | Aneurysm, clipping, proximal ligation, or reinforcement of sac, including stereotaxy and cranioplasty (Anaes.) (Assist.) | $10515.30 |
| 39803 | Intracranial arteriovenous malformation or fistula, treatment through a craniotomy, including stereotaxy, cranioplasty and all angiography (Anaes.) (Assist.) | $6723.00 |
| 39815 | CAROTID-CAVERNOUS FISTULA, obliteration of—combined cervical and intracranial procedure (Anaes.) (Assist.) | $3707.70 |
| 39818 | Intracranial vascular bypass using indirect techniques, including stereotaxy (Anaes.) (Assist.) | $4842.70 |
| 39821 | Intracranial vascular bypass using direct anastomosis techniques, including stereotaxy (Anaes.) (Assist.) | $5110.80 |
| 39900 | Intracranial infection, treated by burr hole, including stereotaxy, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) | $1222.50 |
| 39903 | Intracranial infection, treated by craniotomy, including stereotaxy, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) | $3730.10 |
| 39906 | Osteomyelitis of skull or removal of infected bone flap, craniectomy for, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) | $1696.00 |
| 40004 | Ventricular, lumbar or cisternal shunt diversion, insertion or revision of, including stereotaxy (Anaes.) (Assist.) | $3140.40 |
| 40012 | Endoscopic ventriculostomy for treatment of cerebrospinal fluid circulation disorders, including stereotaxy (Anaes.) (Assist.) | $2426.20 |
| 40018 | Lumbar cerebrospinal fluid drain, insertion of, other than a service associated with a service to which item 22053 applies (Anaes.) | $340.00 |
| 40104 | Spinal myelomeningocele or spinal meningocele, excision and closure of, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) | $1927.00 |
| 40106 | Chiari malformation, decompression or reconstruction of, including laminectomy, dermofat graft and stereotaxy, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) | $3258.00 |
| 40109 | Encephalocoele or cranial meningocele, excision and closure of, including stereotaxy and dermofat graft (Anaes.) (Assist.) | $3503.50 |
| 40112 | Tethered cord, release of, including lipomeningocele or diastematomyelia, multiple levels, including laminectomy and rhizolysis, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) | $3428.80 |
| 40119 | Craniostenosis, operation for, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) | $1812.80 |
| 40600 | Cranioplasty, reconstructive, other than a service associated with a service to which item 39113, 39638, 39639, 39641, 39651, 39654, 39656, 39700, 39710, 39712, 39715, 39801, 39803, 40703 or 41887 applies(H) (Anaes.) (Assist.) | $2063.70 |
| 40700 | Corpus callosotomy, for epilepsy, including stereotaxy (Anaes.) (Assist.) | $4786.00 |
| 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.) | $657.60 |
| 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.) | $307.70 |
| 40703 | Corticectomy, topectomy or partial lobectomy, for epilepsy, including stereotaxy and cranioplasty (Anaes.) (Assist.) | $3570.50 |
| 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.) | $1301.60 |
| 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.) | $1168.70 |
| 40706 | Hemispherectomy or functional hemispherectomy, for intractable epilepsy, including stereotaxy (Anaes.) (Assist.) | $4776.00 |
| 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 | $366.30 |
| 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.) | $657.60 |
| 40709 | Intracranial electrode placement by burr hole, including stereotaxy (Anaes.) (Assist.) | $1619.70 |
| 40712 | Intracranial electrode placement by craniotomy, single or multiple, including stereotactic EEG, including stereotaxy (Anaes.) (Assist.) | $3288.60 |
| 40801 | Functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation, and lesion production, by any method, in the basal ganglia, brain stem or deep white matter tracts, other than a service associated with deep brain stimulation for Parkinson s disease, essential tremor or dystonia (Anaes.) (Assist.) | $4480.00 |
| 40803 | Intracranial stereotactic procedure by any method, other than: (a) a service to which item 40801 applies; or (b) a service associated with a service to which item 39018, 39109, 39113, 39604, 39615, 39638, 39639, 39641, 39651, 39654, 39656, 39700, 39703, 39710, 39712, 39715, 39718, 39720, 39801, 39803, 39818, 39821, 39900, 39903, 40004, 40012, 40106, 40109, 40700, 40703, 40706, 40709 or 40712 applies (Anaes.) (Assist.) | $2563.80 |
| 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.) | $4649.20 |
| 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.) | $10125.00 |
| 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.) | $870.00 |
| 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.) | $1062.70 |
| 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.) | $655.00 |
| 40858 | DEEP BRAIN STIMULATION (unilateral) placement, removal or replacement of extension leadfor 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.) | $1328.80 |
| 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.) | $4174.10 |
| 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.) | $383.10 |
| 40863 | Deep brain stimulation (unilateral), remote electronic analysis and programming of neurostimulator pulse generator for the treatment of: (a) Parkinson s disease, if the patient s response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or (b) essential tremor or dystonia, if the patient s symptoms cause severe disability Applicable not more than 8 times in any 12 month period | $354.50 |
| 40905 | Craniotomy, performed by a neurosurgeon in conjunction with the correction of craniofacial abnormalities (Anaes.) (Assist.) | $1220.90 |
| **Ear, nose and throat** | | |
| 41500 | EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.) | $167.20 |
| 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 or malignant 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 | $347.10 |
| 41503 | Ear, foreign body in (other than ventilating tube), removal of, involving incision of external auditory canal, other than a service associated with a service to which another item in this Subgroup applies (Anaes.) | $491.50 |
| 41506 | Aural polyp, removal of (Anaes.) | $297.20 |
| 41509 | External auditory meatus, surgical removal of keratosis obturans from, performed under general anaesthesia, other than: (a) a service to which another item in this Subgroup applies; or (b) a service associated with a service to which item 41647 applies (H) (Anaes.) | $330.40 |
| 41512 | MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (Anaes.) (Assist.) | $1213.90 |
| 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.) | $779.60 |
| 41518 | EXTERNAL AUDITORY MEATUS, removal of EXOSTOSES IN (Anaes.) (Assist.) | $1920.00 |
| 41521 | Correction of auditory canal stenosis, including meatoplasty, with or without grafting, other than a service associated with a service to which an item in Subgroup 18 applies(H) (Anaes.) (Assist.) | $2020.00 |
| 41524 | Reconstruction of external auditory canal(H) (Anaes.) (Assist.) | $585.00 |
| 41539 | Ossicular chain reconstruction, other than a service associated with a service to which item 41611 applies(H) (Anaes.) (Assist.) | $2340.40 |
| 41542 | Ossicular chain reconstruction and myringoplasty, other than a service associated with a service to which item 41611 applies(H) (Anaes.) (Assist.) | $2470.30 |
| 41548 | OBLITERATION OF THE MASTOID CAVITY (Anaes.) (Assist.) | $1422.10 |
| 41569 | Decompression of facial nervein its mastoid portion,other than a service associated with a service to which item 41617 applies(H) (Anaes.) (Assist.) | $2453.70 |
| 41572 | LABYRINTHOTOMY OR DESTRUCTION OF LABYRINTH (Anaes.) (Assist.) | $2129.10 |
| 41575 | CEREBELLOPONTINE ANGLE TUMOUR, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approachtransmastoid, translabyrinthine or retromastoid procedure (including aftercare) (Anaes.) (Assist.) | $5051.70 |
| 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.) | $7776.60 |
| 41578 | CEREBELLOPONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure)—conjoint surgery, principal surgeon (Anaes.) (Assist.) | $5321.10 |
| 41579 | CEREBELLO-PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure)—conjoint surgery, co-surgeon (Assist.) | $3992.20 |
| 41581 | TUMOUR INVOLVING INFRA-TEMPORAL FOSSA, removal of, involving craniotomy and radical excision of (Anaes.) (Assist.) | $5778.10 |
| 41584 | PARTIAL TEMPORAL BONE RESECTION for removal of tumour involving mastoidectomy with or without decompression of facial nerve (Anaes.) (Assist.) | $4192.40 |
| 41587 | TOTAL TEMPORAL BONE RESECTION for removal of tumour (Anaes.) (Assist.) | $5397.90 |
| 41590 | ENDOLYMPHATIC SAC, TRANSMASTOID DECOMPRESSION with or without drainage of (Anaes.) (Assist.) | $2575.40 |
| 41593 | TRANSLABYRINTHINE VESTIBULAR NERVE SECTION (Anaes.) (Assist.) | $3158.40 |
| 41596 | RETROLABYRINTHINE VESTIBULAR NERVE SECTION or COCHLEAR NERVE SECTION, or BOTH (Anaes.) (Assist.) | $3805.50 |
| 41599 | INTERNAL AUDITORY MEATUS, exploration by middle cranial fossa approach with cranial nerve decompression (Anaes.) (Assist.) | $3805.50 |
| 41603 | Osseo-integration procedure-implantation of bone conduction hearing system device, in a patient: (a) With a permanent or long-term hearing loss; and (b) Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and (c) With bone conduction thresholds that accord with recognised criteria for the implantable bone conduction hearing device being inserted. other than a service associated with a service to which item 41554, 45794 or 45797 applies (Anaes.) | $1260.00 |
| 41608 | STAPEDECTOMY (Anaes.) (Assist.) | $2350.30 |
| 41611 | Stapes mobilisation, other than a service associated with a service to which item 41539, 41542, or an item in Subgroup 18, applies(H) (Anaes.) (Assist.) | $1452.40 |
| 41614 | Round window surgery including repair of cochleotomy, other than a service associated with a service to which item 41617 applies (Anaes.) (Assist.) | $2246.50 |
| 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.) | $2248.90 |
| 41617 | Cochlear implant, insertion of, including mastoidectomy, cochleotomy and exposure of facial nerve where required, other than a service associated with a service to which item 41569 or 41614 applies(H) (Anaes.) (Assist.) | $3932.50 |
| 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.) | $3623.60 |
| 41620 | GLOMUS TUMOUR, transtympanic removal of (Anaes.) (Assist.) | $1700.30 |
| 41623 | GLOMUS TUMOUR, transmastoid removal of, including mastoidectomy (Anaes.) (Assist.) | $2540.50 |
| 41626 | Incision of tympanic membrane, or installation of therapeutic agent, to the middle ear through an intact drum: (a) not including local anaesthetic; and (b) excluding aftercare; and (c) other than a service associated with a service to which item 41632 applies (Anaes.) | $296.00 |
| 41632 | Middle ear, insertion of tube fordrainage of (including myringotomy), other than a service associated with a service to which item 41626 applies (Anaes.) | $508.30 |
| 41641 | Perforation of tympanum, cauterisation or diathermy of (Anaes.) | $104.00 |
| 41644 | EXCISION OF RIM OF EARDRUM PERFORATION, not being a service associated with myringoplasty (Anaes.) | $293.50 |
| 41647 | Micro inspection of tympanic membrane and auditory canal, requiring use of operating microscope or endoscope, including any removal of wax, with or without general anaesthesia, other than a service associated with a service to which item 41509 applies. Not applicable for the removal of uncomplicated wax in the absence of other disorders of the ear (Anaes.) | $223.10 |
| 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.) | $241.60 |
| 41656 | NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) | $252.40 |
| 41659 | Nose, removal of foreign body in, other than by simple probing (Anaes.) | $165.30 |
| 41662 | Nasal polyp or polypi (simple), removal of, other than a service associated with a service to which item 41702, 41703 or 41705 applies on the same side | $179.50 |
| 41668 | Nasal polyp or polypi,removal of (Anaes.) | $478.20 |
| 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.) | $207.30 |
| 41677 | NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) | $186.50 |
| 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.) | $250.70 |
| 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.) | $164.00 |
| 41698 | Maxillary antrum, proof puncture and lavage of, other than a service associated with a service to which item 41702, 41703, 41705, 41710, 41734 or 41737 applies on the same side (Anaes.) | $67.40 |
| 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.) | $189.70 |
| 41704 | MAXILLARY ANTRUM, LAVAGE OF each attendance at which the procedure is performed, including any associated consultation (Anaes.) | $74.90 |
| 41707 | Maxillaryor sphenopalatine artery, ligation of (H) (Anaes.) (Assist.) | $922.60 |
| 41713 | Vidian neurectomy or exposure of vidian canal (H) (Anaes.) (Assist.) | $1248.40 |
| 41719 | Antrum, drainage of, through tooth socket, other than a service associated with a service to which item 41722 applies (Anaes.) | $240.00 |
| 41722 | Oroantral fistula, plastic closure of, other than a service associated with a service to which item 41719 or 45009 applies (Anaes.) (Assist.) | $1258.10 |
| 41725 | Ligation of ethmoidal artery or arteries, anterior, posterior or both, by any approach (unilateral) (H) (Anaes.) (Assist.) | $924.00 |
| 41728 | Removal of sinonasal or nasopharyngeal tumour, excluding inflammatory nasal polyps, by any approach (H) (Anaes.) (Assist.) | $1857.50 |
| 41740 | Frontal sinus, catheterisation of, other than a service associated with a service to which item 41749 applies on the same side (H) (Anaes.) | $122.00 |
| 41743 | Frontal sinus, trephine of, other than a service associated with a service to which item 41749 applieson the same side (H) (Anaes.) (Assist.) | $696.70 |
| 41746 | Paranasal sinus, radical obliteration of, including any graft harvest (Anaes.) (Assist.) | $1665.30 |
| 41749 | Paranasal sinus, external operation on, unilateral, other than a service associated with a service to which item 41740 or 41743 applies on the same side (H) (Anaes.) (Assist.) | $1247.40 |
| 41755 | Eustachian tube, catheterisation of (Anaes.) | $95.60 |
| 41764 | Nasendoscopy or sinoscopy or fibreoptic examination of nasopharynx and larynx, one or more of these procedures, unilateral or bilateral examination, other than a service associated with a service to which item 41693, 41702, 41703, 41705, 41734 or 41737 applies (Anaes.) | $267.10 |
| 41770 | PHARYNGEAL POUCH, removal of, with or without cricopharyngeal myotomy (Anaes.) (Assist.) | $1430.00 |
| 41776 | Cricopharyngeal myotomyby any approach, including open inversion of pharyngeal pouch or endoscopic repair of pharyngeal pouch(H) (Anaes.) (Assist.) | $1184.80 |
| 41779 | PHARYNGOTOMY (lateral), with or without total excision of tongue (Anaes.) (Assist.) | $1422.90 |
| 41785 | Partial pharyngectomy, by any approach, with or without partial glossectomy (H) (Anaes.) (Assist.) | $2410.00 |
| 41786 | UVULOPALATOPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.) (Assist.) | $1488.30 |
| 41789 | Tonsils or tonsils and adenoids, removal of, in a patient 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.) | $596.80 |
| 41793 | Tonsils or tonsils and adenoids, removal of, in a patient 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.) | $755.00 |
| 41797 | TONSILS OR TONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general anaesthesia, following removal of (Anaes.) | $297.20 |
| 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.) | $351.40 |
| 41804 | Removal of lingual tonsil (H) (Anaes.) | $195.50 |
| 41807 | Peritonsillar abscess (quinsy), incision of (Anaes.) | $149.10 |
| 41810 | Uvulotomy or uvulectomy (Anaes.) | $78.00 |
| 41813 | VALLECULAR OR PHARYNGEAL CYSTS, removal of (Anaes.) (Assist.) | $733.50 |
| 41822 | Oesophagoscopy, with rigid oesophagoscope, with or without biopsy, other than a service associated with a service to which item 30473 or 30478 applies (H) (Anaes.) | $490.80 |
| 41825 | Removal of a foreign body from the pharynx, larynx or oesophagus, by any means, other than a service associated with a service to which item 30478 applies (H) (Anaes.) (Assist.) | $733.30 |
| 41828 | Oesophageal stricture, dilatation of, without oesophagoscopy (Anaes.) | $111.00 |
| 41831 | Oesophagus, endoscopic pneumatic dilatation of, for treatment of achalasia (Anaes.) (Assist.) | $734.40 |
| 41832 | OESOPHAGUS, balloon dilatation of, using interventional imaging techniques (Anaes.) | $461.30 |
| 41834 | Total laryngectomy, including cricopharyngeal myotomy and tracheo oesophageal puncture (H) (Anaes.) (Assist.) | $2742.70 |
| 41837 | Complete vertical hemi laryngectomy, involving removal of true and false vocal cords, including tracheostomy. Applicable only once per provider per patient per lifetime (H) (Anaes.) (Assist.) | $2654.10 |
| 41840 | Total supraglottic laryngectomy, involving removal of ventricular folds, epiglottis and aryepiglottic folds including tracheostomy. Applicable only once per provider per patient per lifetime(H) (Anaes.) (Assist.) | $3148.80 |
| 41843 | LARYNGOPHARYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUITY after laryngopharyngectomy USING STOMACH OR BOWEL (Anaes.) (Assist.) | $2761.70 |
| 41855 | Microlaryngoscopy, by any approach, with or without biopsy(H) (Anaes.) (Assist.) | $636.20 |
| 41861 | Microlaryngoscopy with complete removal of benign or malignant lesions of the larynx, including papillomata, by any approach or technique, unilateral, other than a service associated with a service to which item 41870 applies on the same side (H) (Anaes.) (Assist.) | $1235.00 |
| 41867 | Microlaryngoscopy, with partial or complete arytenoidectomy or arytenoid repositioning(H) (Anaes.) (Assist.) | $1273.00 |
| 41870 | Laryngeal augmentation or modification by injection techniques, other than a service associated with a service to which item 41879 applies or item 41861 applies on the same side (Anaes.) (Assist.) | $999.40 |
| 41873 | Larynx, fractured, operation for(H) (Anaes.) (Assist.) | $1207.50 |
| 41876 | LARYNX, external operation on, OR LARYNGOFISSURE with or without cordectomy (Anaes.) (Assist.) | $1293.10 |
| 41879 | Tracheoplasty, laryngoplasty or thyroplasty, not by injection techniques, including tracheostomy, other than a service associated with a service to which item 41870 applies(H) (Anaes.) (Assist.) | $1937.10 |
| 41880 | Tracheostomyby a percutaneous technique(H) (Anaes.) | $524.50 |
| 41881 | Tracheostomyby open exposure of the trachea(H) (Anaes.) (Assist.) | $862.50 |
| 41884 | Cricothyrostomy(H) (Anaes.) | $193.80 |
| 41885 | TRACHE-OESOPHAGEAL FISTULA, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Anaes.) (Assist.) | $614.00 |
| 41886 | Trachea, removal of foreign body in (Anaes.) | $366.70 |
| 41887 | Pituitary tumour, removal of, by trans-sphenoidal approach, including stereotaxy and dermis, dermofat or fascia grafting, as part of conjoint surgery, other than a service associated with a service to which item 40600 applies(H) (Anaes.) (Assist.) | $4705.10 |
| 41888 | Fractured skull, after trauma only, or spontaneous defects with cerebrospinal fluid rhinorrhoea or otorrhoea, repair of, including stereotaxy and dermofat graft(H) (Anaes.) (Assist.) | $3329.90 |
| 41890 | Orbit, decompression of, by fenestration of 2 or more walls, or by the removal of intraorbital peribulbar and retrobulbar fat from each quadrant of the orbit, one eye by endonasal approach(H) (Anaes.) (Assist.) | $2226.40 |
| 41907 | Nasal septum button, insertion of (Anaes.) | $253.70 |
| 41910 | DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.) | $804.90 |
| **Ophthalmology** | | |
| 42503 | OPHTHALMOLOGICAL EXAMINATION under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.) | $235.00 |
| 42504 | Glaucoma, implantation of a micro-bypass surgery stent system into the trabecular meshwork, if: (a) conservative therapies have failed, are likely to fail, or are contraindicated; and (b) the service is performed by a specialist with training that is recognised by the Conjoint Committee for the Recognition of Training in Micro-Bypass Glaucoma Surgery (Anaes.) | $562.40 |
| 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.) | $567.80 |
| 42506 | EYE, ENUCLEATION OF, with or without sphere implant (Anaes.) (Assist.) | $988.90 |
| 42509 | EYE, ENUCLEATION OF, with insertion of integrated implant (Anaes.) (Assist.) | $1325.00 |
| 42510 | EYE, enucleation of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes.) (Assist.) | $1480.00 |
| 42512 | GLOBE, EVISCERATION OF (Anaes.) (Assist.) | $976.40 |
| 42515 | GLOBE, EVISCERATION OF, AND INSERTION OF INTRASCLERAL BALL OR CARTILAGE (Anaes.) (Assist.) | $1258.80 |
| 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.) | $752.00 |
| 42521 | ANOPHTHALMIC SOCKET, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (Anaes.) (Assist.) | $2467.60 |
| 42524 | Orbit, skin graft to, as a delayed procedure (Anaes.) | $421.70 |
| 42527 | CONTRACTED SOCKET, RECONSTRUCTION INCLUDING MUCOUS MEMBRANE GRAFTING AND STENT MOULD (Anaes.) (Assist.) | $865.10 |
| 42530 | ORBIT, EXPLORATION with or without biopsy, requiring REMOVAL OF BONE (Anaes.) (Assist.) | $1325.00 |
| 42533 | ORBIT, EXPLORATION OF, with drainage or biopsy not requiring removal of bone (Anaes.) (Assist.) | $835.50 |
| 42536 | ORBIT, EXENTERATION OF, with or without skin graft and with or without temporalis muscle transplant (Anaes.) (Assist.) | $1719.50 |
| 42539 | ORBIT, EXPLORATION OF, with removal of tumour or foreign body, requiring removal of bone (Anaes.) (Assist.) | $2672.90 |
| 42542 | ORBIT, exploration of anterior aspect with removal of tumour or foreign body (Anaes.) (Assist.) | $1037.80 |
| 42543 | ORBIT, exploration of retrobulbar aspect with removal of tumour or foreign body (Anaes.) (Assist.) | $1822.20 |
| 42545 | ORBIT, decompression of, for dysthyroid eye disease, by fenestration of 2 or more walls, or by the removal of intraorbital peribulbar and retrobulbar fat from each quadrant of the orbit, 1 eye (Anaes.) (Assist.) | $2762.10 |
| 42548 | OPTIC NERVE MENINGES, incision of (Anaes.) (Assist.) | $1671.40 |
| 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.) | $1301.70 |
| 42554 | EYE, PENETRATING WOUND OR RUPTURE OF, with incarceration or prolapse of uveal tissue repair (Anaes.) (Assist.) | $1518.20 |
| 42557 | EYE, PENETRATING WOUND OR RUPTURE OF, with incarceration of lens or vitreous repair (Anaes.) (Assist.) | $2121.90 |
| 42563 | INTRAOCULAR FOREIGN BODY, removal from anterior segment (Anaes.) (Assist.) | $1143.10 |
| 42569 | INTRAOCULAR FOREIGN BODY, removal from posterior segment (Anaes.) (Assist.) | $2121.90 |
| 42572 | Orbital abscess or cyst, drainage of (Anaes.) | $236.90 |
| 42573 | DERMOID, periorbital, excision of, on a patient 10 years of age or over (Anaes.) | $468.20 |
| 42574 | DERMOID, orbital, excision of (Anaes.) (Assist.) | $1032.10 |
| 42575 | Tarsal cyst, extirpation of (Anaes.) | $170.30 |
| 42576 | DERMOID, periorbital, excision of, on a patient under 10 years of age (Anaes.) | $592.20 |
| 42581 | Ectropion or entropion, tarsal cauterisation of (Anaes.) | $253.80 |
| 42584 | TARSORRHAPHY (Anaes.) (Assist.) | $571.30 |
| 42587 | Trichiasis (due to causes other than trachoma), treatment of by cryotherapy, laser or electrolysis—each eyelid (Anaes.) | $106.30 |
| 42588 | Trichiasis (due to trachoma), treatment of by cryotherapy, laser or electrolysis—each eyelid (Anaes.) | $98.10 |
| 42590 | CANTHOPLASTY, medial or lateral (Anaes.) (Assist.) | $755.00 |
| 42593 | Lacrimal gland, excision of palpebral lobe (Anaes.) | $415.20 |
| 42596 | LACRIMAL SAC, excision of, or operation on (Anaes.) (Assist.) | $1038.30 |
| 42599 | LACRIMAL CANALICULAR SYSTEM, establishment of patency by closed operation using silicone tubes or similar, 1 eye (Anaes.) (Assist.) | $1346.00 |
| 42602 | LACRIMAL CANALICULAR SYSTEM, establishment of patency by open operation, 1 eye (Anaes.) (Assist.) | $1301.40 |
| 42605 | LACRIMAL CANALICULUS, immediate repair of (Anaes.) (Assist.) | $1021.10 |
| 42608 | LACRIMAL DRAINAGE by insertion of glass tube, as an independent procedure (Anaes.) (Assist.) | $624.30 |
| 42610 | NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, unilateral, with or without lavage—under general anaesthesia (Anaes.) | $206.00 |
| 42611 | NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, bilateral, with or without lavage—under general anaesthesia (Anaes.) | $297.60 |
| 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) | $99.50 |
| 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) | $154.90 |
| 42617 | Punctum snip operation (Anaes.) | $294.00 |
| 42620 | Punctum, occlusion of, by use of a plug (Anaes.) | $121.70 |
| 42622 | Punctum, permanent occlusion of, by use of electrical cautery (Anaes.) | $177.80 |
| 42623 | DACRYOCYSTORHINOSTOMY (Anaes.) (Assist.) | $1498.40 |
| 42626 | DACRYOCYSTORHINOSTOMY where a previous dacryocystorhinostomy has been performed (Anaes.) (Assist.) | $2324.70 |
| 42629 | CONJUNCTIVORHINOSTOMY including dacryocystorhinostomy and fashioning of conjunctival flaps (Anaes.) (Assist.) | $1814.10 |
| 42632 | CONJUNCTIVAL PERITOMY OR REPAIR OF CORNEAL LACERATION by conjunctival flap (Anaes.) | $241.70 |
| 42635 | CORNEAL PERFORATIONS, sealing of, with tissue adhesive (Anaes.) (Assist.) | $619.40 |
| 42638 | CONJUNCTIVAL GRAFT OVER CORNEA (Anaes.) (Assist.) | $777.70 |
| 42641 | AUTOCONJUNCTIVAL TRANSPLANT, or mucous membrane graft (Anaes.) (Assist.) | $1009.50 |
| 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.) | $154.00 |
| 42647 | CORNEAL SCARS, removal of, by partial keratectomy, not being a service associated with a service to which item 42686 applies (Anaes.) | $435.20 |
| 42650 | Cornea, epithelial debridement for corneal ulcer or corneal erosion (excluding aftercare) (Anaes.) | $148.80 |
| 42651 | Cornea, epithelial debridement for eliminating band keratopathy (Anaes.) | $332.90 |
| 42652 | Corneal collagen cross linking, on a patient with a corneal ectatic disorder, with evidence of progression per eye (Anaes.) | $2316.80 |
| 42653 | CORNEA transplantation of (Anaes.) (Assist.) | $2715.70 |
| 42656 | CORNEA, transplantation of, second and subsequent procedures (Anaes.) (Assist.) | $3555.60 |
| 42662 | SCLERA, transplantation of, full thickness, including collection of donor material (Anaes.) (Assist.) | $1921.10 |
| 42665 | SCLERA, transplantation of, superficial or lamellar, including collection of donor material (Anaes.) (Assist.) | $1280.40 |
| 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 | $290.00 |
| 42668 | CORNEAL SUTURES, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (Anaes.) | $154.90 |
| 42672 | CORNEAL INCISONS, to correct corneal astigmatism of more than 11/2 dioptres following anterior segment surgery, including appropriate measurements and calculations, performed as an independent procedure (Anaes.) (Assist.) | $1919.30 |
| 42673 | ADDITIONAL CORNEAL INCISIONS, to correct corneal astigmatism of more than 11/2 dioptres, including appropriate measurements and calculations, performed in conjunction with other anterior segment surgery (Anaes.) (Assist.) | $915.00 |
| 42676 | Conjunctiva, biopsy of, as an independent procedure | $238.30 |
| 42677 | CONJUNCTIVA, CAUTERY OF, INCLUDING TREATMENT OF Pannus each attendance at which treatment is given including any associated consultation (Anaes.) | $126.60 |
| 42680 | CONJUNCTIVA, cryotherapy to, for melanotic lesions or similar using CO&#178; or N&#178;0 (Anaes.) | $610.00 |
| 42683 | CONJUNCTIVAL CYSTS, removal of, requiring admission to hospital or approved day-hospital facility (Anaes.) | $257.40 |
| 42686 | Pterygium, removal of (Anaes.) | $582.70 |
| 42689 | PINGUECULA, removal of, not being a service associated with the fitting of contact lenses (Anaes.) | $251.90 |
| 42692 | LIMBIC TUMOUR, removal of, excluding Pterygium (Anaes.) (Assist.) | $569.60 |
| 42695 | LIMBIC TUMOUR, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes.) (Assist.) | $932.20 |
| 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.) | $1569.50 |
| 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.) | $1098.50 |
| 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.) | $2206.80 |
| 42703 | INTRAOCULAR LENS or IRIS PROSTHESIS insertion of, into the posterior chamber with fixation to the iris or sclera (Anaes.) (Assist.) | $1219.10 |
| 42704 | Intraocular lens, removal or repositioning of by open operation, not being a service associated with a service to which item 42701 applies (Anaes.) | $1029.80 |
| 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.) | $1468.60 |
| 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.) | $1716.50 |
| 42710 | INTRAOCULAR LENS, removal of, and replacement with a lens inserted into the posterior chamber and fixated to the iris or sclera (Anaes.) (Assist.) | $1887.80 |
| 42713 | IRIS SUTURING, McCannell technique or similar, for fixation of intraocular lens or repair of iris defect (Anaes.) (Assist.) | $773.70 |
| 42716 | CATARACT, JUVENILE, removal of, including subsequent needlings (Anaes.) (Assist.) | $2600.00 |
| 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.) | $1069.30 |
| 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.) | $2761.90 |
| 42731 | LIMBAL OR PARS PLANA LENSECTOMY combined with vitrectomy, not being a service associated with items 42698, 42702, 42719, or 42725 (Anaes.) (Assist.) | $3233.60 |
| 42734 | Capsulotomy, other than by laser, and other than a service associated with a service to which item 42725 or 42731 applies (Anaes.) (Assist.) | $618.50 |
| 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. | $637.50 |
| 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,one or more of, as an independent procedure, for a patient requiring the administration of anaesthetic by an anaesthetist. (Anaes.) | $637.50 |
| 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.) | $618.50 |
| 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.) | $654.20 |
| 42743 | ANTERIOR CHAMBER, IRRIGATION OF BLOOD FROM, as an independent procedure (Anaes.) (Assist.) | $1301.70 |
| 42744 | Needle revision of glaucoma filtration bleb, following glaucoma filtering procedure (Anaes.) | $619.90 |
| 42746 | GLAUCOMA, filtering operation for, where conservative therapies have failed, are likely to fail, or are contraindicated (Anaes.) (Assist.) | $1963.40 |
| 42749 | GLAUCOMA, filtering operation for, where previous filtering operation has been performed (Anaes.) (Assist.) | $2467.50 |
| 42752 | GLAUCOMA, insertion of drainage device incorporating an extraocular reservoir for, such as a Molteno device (Anaes.) (Assist.) | $2874.30 |
| 42755 | Glaucoma, removal of drainage device incorporating an extraocular reservoir for, such as a molteno device (Anaes.) | $342.50 |
| 42758 | Goniotomy for the treatment of primary congenital glaucoma, excluding the minimally invasive implantation of glaucoma drainage devices (Anaes.) (Assist.) | $1490.00 |
| 42761 | DIVISION OF ANTERIOR OR POSTERIOR SYNECHIAE, as an independent procedure, other than by laser (Anaes.) (Assist.) | $1069.30 |
| 42764 | IRIDECTOMY (including excision of tumour of iris) OR IRIDOTOMY, as an independent procedure, other than by laser (Anaes.) (Assist.) | $1067.70 |
| 42767 | TUMOUR, INVOLVING CILIARY BODY OR CILIARY BODY AND IRIS, excision of (Anaes.) (Assist.) | $2216.90 |
| 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.) | $595.00 |
| 42773 | DETACHED RETINA, pneumatic retinopexy for, not being a service associated with a service to which item 42776 applies (Anaes.) (Assist.) | $1855.20 |
| 42776 | DETACHED RETINA, buckling or resection operation for (Anaes.) (Assist.) | $2850.80 |
| 42779 | DETACHED RETINA, revision of scleral buckling operation for (Anaes.) (Assist.) | $3405.00 |
| 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.) | $787.30 |
| 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.) | $776.50 |
| 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.) | $776.50 |
| 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.) | $776.50 |
| 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.) | $138.80 |
| 42801 | EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, insertion of (Anaes.) (Assist.) | $2159.50 |
| 42802 | EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, removal of (Anaes.) (Assist.) | $1064.00 |
| 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.) | $1190.10 |
| 42806 | IRIS TUMOUR, laser photocoagulation of (Anaes.) (Assist.) | $730.40 |
| 42807 | Photomydriasis, laser | $737.50 |
| 42808 | Laser peripheral iridoplasty | $737.50 |
| 42809 | RETINA, photocoagulation of, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.) | $935.00 |
| 42810 | PHOTOTHERAPEUTIC KERATECTOMY, by laser, for corneal scarring or disease, excluding surgery for refractive error (Anaes.) | $1205.00 |
| 42811 | TRANSPUPILLARY THERMOTHERAPY, for treatment of choroidal and retinal tumours or vascular malformations (Anaes.) | $932.70 |
| 42812 | Removal of scleral buckling material, from an eye having undergone previous scleral buckling surgery (Anaes.) | $352.40 |
| 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.) | $1301.40 |
| 42818 | Retina, cryotherapy to, as an independent procedure, or when performed in conjunction with item 42809 or 42770 (Anaes.) | $1208.30 |
| 42821 | OCULAR TRANSILLUMINATION, for the diagnosis and measurement of intraocular tumours (Anaes.) | $185.60 |
| 42824 | Retrobulbar injection of alcohol or other drug, as an independent procedure | $144.70 |
| 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.) | $1325.00 |
| 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.) | $1548.10 |
| 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.) | $1530.00 |
| 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.) | $1870.00 |
| 42845 | READJUSTMENT OF ADJUSTABLE SUTURES, 1 or both eyes, as an independent procedure following an operation for correction of squint (Anaes.) | $388.90 |
| 42848 | SQUINT, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 15 years or over (Anaes.) (Assist.) | $1530.00 |
| 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.) | $1855.80 |
| 42854 | RUPTURED MEDIAL PALPEBRAL LIGAMENT or ruptured EXTRAOCULAR MUSCLE, repair of (Anaes.) (Assist.) | $891.50 |
| 42857 | RESUTURING OF WOUND FOLLOWING INTRAOCULAR PROCEDURES with or without excision of prolapsed iris (Anaes.) (Assist.) | $840.90 |
| 42860 | EYELID (upper or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid retractors (Anaes.) (Assist.) | $1843.30 |
| 42863 | EYELID, recession of (Anaes.) (Assist.) | $1598.70 |
| 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.) | $1601.40 |
| 42869 | EYELID closure in facial nerve paralysis, insertion of foreign implant for (Anaes.) (Assist.) | $1169.90 |
| 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.) | $515.00 |
| 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. | $970.20 |
| 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. | $1102.60 |
| 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. | $178.70 |
| **Operations for osteomyelitis** | | |
| 43521 | OPERATION ON SKULL (Anaes.) (Assist.) | $1007.20 |
| 43527 | Operation on sternum, clavicle, rib, metacarpus, carpus, phalanx, metatarsus, tarsus, mandible or maxilla (other than alveolar margins), by open or arthroscopic means, for septic arthritis or osteomyelitis one approach, inclusive of the adjoining joint (H) (Anaes.) (Assist.) | $772.80 |
| 43530 | Operation on scapula, ulna, radius, tibia, fibula, humerus or femur, by open or arthroscopic means, for septic arthritis or osteomyelitis one approach, inclusive of the adjoining joint (Anaes.) (Assist.) | $772.80 |
| 43533 | Operation on spine or pelvic bones, by open or arthroscopic means, for septic arthritis or osteomyelitis one approach, inclusive of the adjoining joint (Anaes.) (Assist.) | $1274.30 |
| **Paediatric** | | |
| 43801 | INTESTINAL MALROTATION with or without volvulus, laparotomy for, not involving bowel resection (Anaes.) (Assist.) | $1932.60 |
| 43804 | INTESTINAL MALROTATION with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (Anaes.) (Assist.) | $2057.80 |
| 43807 | DUODENAL ATRESIA or STENOSIS, duodenoduodenostomy or duodenojejunostomy for (Anaes.) (Assist.) | $2244.90 |
| 43810 | JEJUNAL ATRESIA, bowel resection and anastomosis for, with or without tapering (Anaes.) (Assist.) | $2619.10 |
| 43813 | MECONIUM ILEUS, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intesinal perforation with or without meconium peritonitis (Anaes.) (Assist.) | $2619.10 |
| 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.) | $2431.80 |
| 43819 | Agangliosis coli, laparotomy for, with or without frozen section biopsies and formation of stoma (Anaes.) (Assist.) | $1964.10 |
| 43822 | ANORECTAL MALFORMATION, laparotomy and colostomy for (Anaes.) (Assist.) | $1964.10 |
| 43825 | NEONATAL ALIMENTARY OBSTRUCTION, laparotomy for, not being a service to which any other item in this Subgroup applies (Anaes.) (Assist.) | $2244.90 |
| 43828 | ACUTE NEONATAL NECROTISING ENTEROCOLITIS, laparotomy for, with resection, including any anastomoses or stoma formation (Anaes.) (Assist.) | $2480.30 |
| 43831 | ACUTE NEONATAL NECROTISING ENTEROCOLITIS where no definitive procedure is possible, laparotomy for (Anaes.) (Assist.) | $1932.60 |
| 43834 | BOWEL RESECTION for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (Anaes.) (Assist.) | $2244.90 |
| 43837 | CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (Anaes.) (Assist.) | $2805.90 |
| 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.) | $2431.80 |
| 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.) | $3741.40 |
| 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.) | $4021.80 |
| 43849 | OESOPHAGEAL ATRESIA, gastrostomy for (Anaes.) (Assist.) | $1029.10 |
| 43852 | Oesophageal atresia, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (Anaes.) (Assist.) | $3273.40 |
| 43855 | OESOPHAGEAL ATRESIA, delayed primary anastomosis for (Anaes.) (Assist.) | $3461.00 |
| 43858 | Oesophageal atresia, cervical oesophagostomy for (Anaes.) (Assist.) | $1215.70 |
| 43861 | CONGENITAL CYSTADENOMATOID MALFORMATION OR CONGENITAL LOBAR EMPHYSEMA, thoracotomy and lung resection for (Anaes.) (Assist.) | $3367.30 |
| 43864 | GASTROSCHISIS, operation for (Anaes.) (Assist.) | $2525.40 |
| 43867 | Gastroschisis or exomphalos, secondary operation for, with removal of silo (Anaes.) (Assist.) | $1403.20 |
| 43870 | EXOMPHALOS containing small bowel only, operation for (Anaes.) (Assist.) | $1964.10 |
| 43873 | EXOMPHALOS containing small bowel and other viscera, operation for (Anaes.) (Assist.) | $2619.10 |
| 43876 | SACROCOCCYGEAL TERATOMA, excision of, by posterior approach (Anaes.) (Assist.) | $2244.90 |
| 43879 | SACROCOCCYGEAL TERATOMA, excision of, by combined posterior and abdominal approach (Anaes.) (Assist.) | $2619.10 |
| 43882 | Cloacal exstrophy, operation for (H) (Anaes.) (Assist.) | $3367.30 |
| 43900 | TRACHEO-OESOPHAGEAL FISTULA without atresia, division and repair of (Anaes.) (Assist.) | $2244.90 |
| 43903 | OESOPHAGEAL ATRESIA or CORROSIVE OESOPHAGEAL STRICTURE, oesophageal replacement for, utilizing gastric tube, jejunum or colon (Anaes.) (Assist.) | $3741.40 |
| 43906 | OESOPHAGUS, resection of congenital, anastomic or corrosive stricture and anastomosis, not being a service to which item 43903 applies (Anaes.) (Assist.) | $3273.40 |
| 43909 | TRACHEOMALACIA, aortopexy for (Anaes.) (Assist.) | $3273.40 |
| 43912 | THORACOTOMY and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal teratoma (Anaes.) (Assist.) | $3092.70 |
| 43915 | Eventration, plication of diaphragm for (Anaes.) (Assist.) | $2496.10 |
| 43930 | HYPERTROPHIC PYLORIC STENOSIS, pyloromyotomy for (Anaes.) (Assist.) | $899.10 |
| 43933 | IDIOPATHIC INTUSSUSCEPTION, laparotomy and manipulative reduction of (Anaes.) (Assist.) | $1052.50 |
| 43936 | INTUSSUSCEPTION, laparotomy and resection with anastomosis (Anaes.) (Assist.) | $1964.10 |
| 43939 | VENTRAL HERNIA following neonatal closure of exomphalos or gastroschisis, repair of (Anaes.) (Assist.) | $1496.70 |
| 43942 | Abdominal wall vitello intestinal remnant, excision of (Anaes.) | $477.50 |
| 43945 | PATENT VITELLO INTESTINAL DUCT, excision of (Anaes.) (Assist.) | $1964.10 |
| 43948 | Umbilical granuloma, excision of, under general anaesthesia (Anaes.) | $280.90 |
| 43951 | GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (Anaes.) (Assist.) | $1758.90 |
| 43954 | GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (Anaes.) (Assist.) | $2151.30 |
| 43957 | GASTRO-OESOPHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or without hiatus hernia, in child with neurological disease, with gastrostomy (Anaes.) (Assist.) | $2338.20 |
| 43960 | ANORECTAL MALFORMATION, perineal anoplasty of (Anaes.) (Assist.) | $822.60 |
| 43963 | ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of (Anaes.) (Assist.) | $3273.40 |
| 43966 | ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes.) (Assist.) | $3741.40 |
| 43969 | PERSISTENT CLOACA, total correction of, with genital repair using posterior sagittal approach, with or without laparotomy (Anaes.) (Assist.) | $5144.40 |
| 43972 | CHOLEDOCHAL CYST, resection of, with 1 duct anastomosis (Anaes.) (Assist.) | $3801.60 |
| 43975 | CHOLEDOCHAL CYST, resection of, with 2 duct anastomoses (Anaes.) (Assist.) | $4396.20 |
| 43978 | BILIARY ATRESIA, portoenterostomy for (Anaes.) (Assist.) | $3741.40 |
| 43981 | NEPHROBLASTOMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.) | $1029.10 |
| 43984 | NEPHROBLASTOMA, radical nephrectomy for (Anaes.) (Assist.) | $2619.10 |
| 43987 | NEUROBLASTOMA, radical excision of (Anaes.) (Assist.) | $2899.60 |
| 43990 | Aganglionosis coli, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends to sigmoid colon (Anaes.) (Assist.) | $3554.30 |
| 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.) | $3834.80 |
| 43996 | Aganglionosis coli, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or without side to side ileocolic anastomosis (Anaes.) (Assist.) | $4302.60 |
| 43999 | Aganglionosis coli, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.) | $538.00 |
| 44102 | RECTUM, examination of, on a patient 2 years of age or over, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.) | $532.80 |
| 44105 | RECTAL PROLAPSE, SUBMUCOSAL or perirectal injection for, on a patient 2 years of age or over, under general anaesthesia (Anaes.) | $90.90 |
| 44108 | Inguinal hernia, laparoscopic or open repair of, at age less than 12 months (H) (Anaes.) (Assist.) | $1089.80 |
| 44111 | Obstructed or strangulated inguinal hernia,laparoscopic or open repair of, at age less than 12 months, including orchidopexy when performed (H) (Anaes.) (Assist.) | $1276.30 |
| 44114 | Inguinal hernia, laparoscopic or open repair of, at age less than 12 months when orchidopexy also required (H) (Anaes.) (Assist.) | $1276.30 |
| 44130 | LYMPHADENECTOMY, for atypical mycobacterial infection or other granulomatous disease (Anaes.) (Assist.) | $999.20 |
| 44133 | TORTICOLLIS, open division of sternomastoid muscle for (Anaes.) (Assist.) | $763.00 |
| 44136 | Ingrown toe nail, operation for, under general anaesthesia (Anaes.) | $364.40 |
| **Amputations** | | |
| 44325 | Amputation of hand, transcarpal (H) (Anaes.) (Assist.) | $610.50 |
| 44328 | Amputation of hand, proximal to wrist radiocarpal joint, through forearm (H) (Anaes.) (Assist.) | $723.10 |
| 44331 | AMPUTATION AT SHOULDER (Anaes.) (Assist.) | $1192.40 |
| 44334 | INTERSCAPULOTHORACIC AMPUTATION (Anaes.) (Assist.) | $2439.60 |
| 44338 | Amputation of one digit of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma; (c) skin cover with homodigital flaps (H) (Anaes.) (Assist.) | $296.80 |
| 44342 | Amputation of 2 digits of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma; (c) skin cover with homodigital flaps (H) (Anaes.) (Assist.) | $484.50 |
| 44346 | Amputation of 3 digits of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma; (c) skin cover with homodigital flaps (H) (Anaes.) (Assist.) | $545.50 |
| 44350 | Amputation of 4 digits of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma; (c) skin cover with homodigital flaps (H) (Anaes.) (Assist.) | $584.80 |
| 44354 | Amputation of 5 digits of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma; (c) skin cover with homodigital flaps (H) (Anaes.) (Assist.) | $708.30 |
| 44358 | Amputation of one ray of one foot, proximal to the metatarsal head, including any of the following (if performed): (a) resection of bone; (b) excision of neuromas; (c) skin cover or recontouring with homodigital flaps (H) (Anaes.) (Assist.) | $432.90 |
| 44359 | Amputation of one or more toes of one foot, or amputation at midfoot or hindfoot of one foot, for diabetic or other microvascular disease; (a) including any of the following (if performed): (i) resection of bone; (ii) excision of neuromas; (iii) excision of one or more bones of the foot; (iv) treatment of underlying infection; (v) skin cover or recontouring with homodigital flaps; and (b) excluding aftercare; applicable only once per foot per occasion on which the service is performed (H) (Anaes.) (Assist.) | $542.20 |
| 44361 | Amputation of foot, at ankle or hindfoot, including any of the following (if performed): (a) resection of bone; (b) excision of neuromas; (c) skin cover; (H) (Anaes.) (Assist.) | $794.20 |
| 44364 | Amputation of foot, transtarsal, including any of the following (if performed): (a) resection of bone; (b) excision of neuromas; (c) skin cover; (H) (Anaes.) (Assist.) | $608.70 |
| 44367 | Amputation through thigh, at knee or below knee (H) (Anaes.) (Assist.) | $1080.60 |
| 44370 | AMPUTATION AT HIP (Anaes.) (Assist.) | $1461.30 |
| 44373 | HINDQUARTER, amputation of (Anaes.) (Assist.) | $2999.90 |
| 44376 | Amputation stump, reamputation of, to provide adequate skin and muscle cover (Assist.) Derived fee: 75% of the original amputation fee. | DF |
| **Plastic and reconstructive surgery** | | |
| 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 31383 (Anaes.) | $1163.10 |
| 45003 | Single stage local myocutaneous flap repair to one defect, simple and small not in association with any of items 31356 to 31383 (Anaes.) | $1236.20 |
| 45006 | Single stage large myocutaneous flap repair to one defect (pectoralis major, latissimus dorsi, or similar large muscle), other than a service associated with a service to which any of items 45524 to 45542 apply (H) (Anaes.) (Assist.) | $2151.60 |
| 45009 | Single stage local muscle flap repair to 1 defect, simple and small, other than a service associated with a service to which item 30278, 30281 or 41722 applies (H) (Anaes.) (Assist.) | $822.90 |
| 45012 | Single stage large muscle flap repair to one defect (pectoralis major, gastrocnemius, gracilis or similar large muscle), other than a service associated with a service to which any of items 45524 to 45542 apply (H) (Anaes.) (Assist.) | $1364.00 |
| 45015 | Muscle or myocutaneous flap, delay of (Anaes.) | $735.00 |
| 45018 | Dermis, dermofat or fascia graft (other than transfer of fat by injection): (a) if the service is not associated with neurosurgical services for spinal disorders mentioned in any of items 51011 to 51171; and (b) other than a service associated with a service to which item 39615, 39715, 40106 or 40109 applies (Anaes.) (Assist.) | $1168.00 |
| 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.) | $875.10 |
| 45021 | Abrasive therapy for severely disfiguring scarring of face resulting from trauma, burns or acne, if sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes limited to one claim per patient per episode (Anaes.) | $380.00 |
| 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.) | $380.00 |
| 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.) | $850.00 |
| 45027 | Vascular anomaly, cauterisation of or injection into, if undertaken in the operating theatre of a hospital (H) (Anaes.) | $256.70 |
| 45030 | Vascular anomaly, of skin, mucous membrane and/or subcutaneous tissue, small, excision and suture of (Anaes.) | $290.70 |
| 45033 | Vascular anomaly, large or involving deeper tissue including facial muscle, excision and suture of (Anaes.) (Assist.) | $495.90 |
| 45035 | Vascular anomaly, large, deep, and involving major neurovascular structures, excision of, including dissection of muscles, nerves or major vessels (H) (Anaes.) (Assist.) | $1508.40 |
| 45036 | Vascular anomaly, of neck, deep and involving major neurovascular structures, excision of, including dissection of cranial nerves and major vessels (H) (Anaes.) (Assist.) | $2328.40 |
| 45045 | Vascular anomaly on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.) | $635.80 |
| 45048 | LYMPHOEDEMATOUS tissue or lymphangiectasis, of lower leg and foot, or thigh, or upper arm, or forearm and hand, major excision of (Anaes.) (Assist.) | $1722.10 |
| 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.) | $1125.00 |
| 45054 | Limb or chest, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (H) (Anaes.) (Assist.) | $546.60 |
| 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.) | $2400.50 |
| 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.) | $2400.50 |
| 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.) | $1737.00 |
| 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 31383 (Anaes.) | $585.90 |
| 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, 31376, 31378, 31380 or 31383)-may be claimed only once per defect (Anaes.) | $811.80 |
| 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.) | $811.80 |
| 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 31383 (Anaes.) (Assist.) | $836.50 |
| 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 31383 (Anaes.) | $789.30 |
| 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 31383 (Anaes.) | $783.70 |
| 45209 | Pedicled flap repair (forehead, cross arm, cross leg, abdominal or similar), first stage of a multistage procedure (H) (Anaes.) (Assist.) | $976.70 |
| 45212 | Pedicled flap repair (forehead, cross arm, cross leg, abdominal or similar), subsequent stage of a multistage procedure (Anaes.) (Assist.) | $484.70 |
| 45221 | Direct flap repair, small (cross finger or similar), first stage (Anaes.) | $536.60 |
| 45224 | Direct flap repair, small (cross finger or similar), second stage (Anaes.) | $254.40 |
| 45227 | INDIRECT FLAP OR TUBED PEDICLE, formation of (Anaes.) (Assist.) | $948.50 |
| 45230 | Direct or indirect flap or tubed pedicle, delay of (Anaes.) | $470.20 |
| 45233 | INDIRECT FLAP OR TUBED PEDICLE, preparation of intermediate or final site and attachment to the site (Anaes.) (Assist.) | $964.80 |
| 45239 | Direct, indirect, free or local flap, revision of, by incision and suture and/or liposuction, applicable once per flap, not being a service associated with a service to which item 45497 applies (Anaes.) | $540.20 |
| 45440 | Split thickness skin graft to a small defect that is:(a) less than 40 mm in diameter: (i) on areas below the knee; or(ii) distal to the ulnar styloid; or(iii) on the genital area; or(iv) on areas above the clavicle; or (b) less than 80 mm in diameter on any other part of the body (Anaes.) (Assist.) | $513.10 |
| 45443 | Split thickness skin graft to a large defect that is:(a) 40 mm or more in diameter: (i) on areas below the knee; or(ii) distal to the ulnar styloid; or(iii) on the genital area; or(iv) on areas above the clavicle; or (b) 80 mm or more in diameter on any other part of the body (Anaes.) (Assist.) | $1058.20 |
| 45451 | Full thickness skin graft to one defect, with an average diameter of 5 mm or more (Anaes.) (Assist.) | $976.60 |
| 45496 | FLAP, free tissue transfer using microvascular techniques—revision of, by open operation (Anaes.) | $889.90 |
| 45497 | Flap, free tissue transfer using microvascular techniques or any autologous breast reconstruction, revision of, by liposuction, other than a service associated with a service to which item 45239 applies (H) (Anaes.) | $695.90 |
| 45500 | Microvascular repair using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit; cannot be claimed by the same provider for both artery and vein (H) (Anaes.) (Assist.) | $2243.70 |
| 45501 | Microvascular anastomosis of artery or vein using microsurgical techniques, for replantation or revascularisation of limb or digit, if the limb or digit is devitalised and the repair is critical for restoration of blood supply, other than a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies (H) (Anaes.) (Assist.) | $3782.80 |
| 45502 | Microvascular anastomoses of artery and vein using microsurgical techniques, for replantation or revascularisation of limb or digit, if the limb or digit is devitalised and the repair is critical for restoration of blood supply, including anastomoses of all required vessels for that extremity or digit, unless a micro-arterial or micro-venous graft is being used, other than a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies (H) (Anaes.) (Assist.) | $4398.50 |
| 45503 | Micro-arterial or micro-venous graft using microsurgical techniques, if the graft is critical for restoration of blood supply, including harvest of graft and suturing of all related anastomoses (not to be claimed in the context of cardiac surgery) (H) (Anaes.) (Assist.) | $4202.10 |
| 45504 | Microvascular anastomosis of artery, vein or veins, using microsurgical techniques, for free transfer of tissue, including setting in of free flap, other than:(a) a service for the purpose of breast reconstruction; or(b) a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies(H) (Anaes.) (Assist.) | $3671.90 |
| 45505 | Microvascular anastomoses of artery and vein or veins, using microsurgical techniques, for free transfer of tissue, including setting in of free flap, other than:(a) a service for the purpose of breast reconstruction; or(b) a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies(H) (Anaes.) (Assist.) | $4017.10 |
| 45507 | Microvascular repair using microsurgical techniques, with restoration of continuity of artery and vein of distal extremity or digit, including anastomoses of all required vessels for that extremity or digit, other than a service associated with a service to which item 45564, 45565 or 45567 applies (H) (Anaes.) (Assist.) | $2950.90 |
| 45510 | Scar, of face or neck, not more than 3 cm in length, revision of, if:(a) undertaken in the operating theatre of a hospital; or(b) performed by a specialist in the practice of the specialist s specialty (Anaes.) | $396.80 |
| 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.) | $638.00 |
| 45515 | Scar, other than on face or neck, not more than 7 cm in length, revision of, if:(a) the service is:(i) undertaken in the operating theatre of a hospital; or(ii) performed by a specialist in the practice of the specialist s specialty; and(b) the service is not performed in conjunction with the insertion of breast implants for cosmetic purposes; and(c) the incision made for revision of the scar is not used as an approach for another procedure (including a non rebatable procedure); and(d) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes (Anaes.) | $385.30 |
| 45518 | Scar, other than on face or neck, more than 7 cm in length, revision of, if:(a) the service is:(i) undertaken in the operating theatre of a hospital; or(ii) performed by a specialist in the practice of the specialist s specialty; and(b) the service is not performed in conjunction with the insertion of breast implants for cosmetic purposes; and(c) the incision made for revision of the scar is not used as an approach for another procedure (including a non rebatable procedure); and(d) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes (Anaes.) | $459.40 |
| 45520 | Reduction mammaplasty (unilateral) with surgical repositioning of nipple, in the context of breast cancer or developmental abnormality of the breast, other than a service associated with a service to which item 31512, 31513 or 31514 applies on the same side (H) (Anaes.) (Assist.) | $2200.00 |
| 45522 | Reduction mammaplasty (unilateral) without surgical repositioning of the nipple:(a) excluding the treatment of gynaecomastia; and(b) not with insertion of any prosthesis; other than a service associated with a service to which item 31512, 31513 or 31514 applies on the same side (H) (Anaes.) (Assist.) | $1545.00 |
| 45523 | Reduction mammaplasty (bilateral) with surgical repositioning of the nipple:(a) for patients with macromastia who are experiencing pain in the neck or shoulder region; and(b) not with insertion of any prosthesis; other than a service associated with a service to which item 31512, 31513 or 31514 applies (H) (Anaes.) (Assist.) | $2550.40 |
| 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, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) | $1605.00 |
| 45527 | Breast reconstruction (unilateral), following mastectomy, using a permanent prosthesis, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) | $1768.20 |
| 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 or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) | $2415.00 |
| 45530 | Post-mastectomy breast reconstruction, autologous (unilateral), using a large muscle or myocutaneous flap, isolated on its vascular pedicle, excluding repair of muscular aponeurotic layer, other than a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45006 or 45012 applies (H) (Anaes.) (Assist.) | $2375.00 |
| 45539 | Breast reconstruction (unilateral), following mastectomy, using tissue expansion insertion of tissue expansion unit and all attendances for subsequent expansion injections, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) | $2526.20 |
| 45542 | Breast reconstruction (unilateral), following mastectomy, using tissue expansion removal of tissue expansion unit and insertion of permanent prosthesis, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) | $1320.00 |
| 45545 | NIPPLE OR AREOLA or both, reconstruction of, by any surgical technique (Anaes.) (Assist.) | $1340.50 |
| 45546 | NIPPLE OR AREOLA or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple | $405.10 |
| 45548 | Breast prosthesis, removal of, as an independent procedure (Anaes.) | $680.00 |
| 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.) | $1085.00 |
| 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.) | $1440.00 |
| 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.) | $1715.00 |
| 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, other than a service associated with a service to which item 31512, 31513 or 31514 applies on the same side (H) (Anaes.) (Assist.) | $1870.00 |
| 45558 | Correction of bilateral breast ptosis by mastopexy, if: (a) at least two thirds of the breast tissue, including the nipple, lies inferior to the inframammary fold where the nipple is located at the most dependent, inferior part of the breast contour; and (b) 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, other than a service associated with a service to which item 31512, 31513 or 31514 applies (H) (Anaes.) (Assist.) | $2805.00 |
| 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.) | $1110.00 |
| 45561 | Microvascular anastomosis of artery and/or vein, if considered necessary to salvage a vascularly compromised pedicled or free flap, either during the primary procedure or at a subsequent return to theatre (H) (Anaes.) (Assist.) | $3830.20 |
| 45562 | Free transfer of tissue (microvascular free flap) for non-breast defect involving raising of tissue on vascular pedicle, including direct repair of secondary cutaneous defect (if performed), other than a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies (H) (Anaes.) (Assist.) | $2267.70 |
| 45563 | Neurovascular island flap for restoration of essential sensation in the digits or sole of the foot, or for genital reconstruction, including:(a) direct repair of secondary cutaneous defect (if performed); and(b) formal dissection of the neurovascular pedicle; other than a service performed on simple V-Y flaps or other standard flaps, such as rotation or keystone (H) (Anaes.) (Assist.) | $2265.30 |
| 45564 | Free transfer of tissue (reconstructive surgery) for the repair of major tissue defect of the head and neck or other non-breast defect, using microvascular techniques, all necessary elements of the operation including (but not limited to):(a) anastomoses of all required vessels; and(b) raising of tissue on a vascular pedicle; and(c) preparation of recipient vessels; and(d) transfer of tissue; and(e) insetting of tissue at recipient site; and(f) direct repair of secondary cutaneous defect, if performed; other than a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505, 45507, 45562 or 45567 applies conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) | $5510.20 |
| 45565 | Free transfer of tissue (reconstructive surgery) for the repair of major tissue defect of the head and neck or other non-breast defect, using microvascular techniques, all necessary elements of the operation including (but not limited to):(a) anastomoses of all required vessels; and(b) raising of tissue on a vascular pedicle; and(c) preparation of recipient vessels; and(d) transfer of tissue; and(e) insetting of tissue at recipient site; and(f) direct repair of secondary cutaneous defect, if performed; other than a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505, 45507, 45562 or 45567 applies conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.) | $3933.10 |
| 45566 | Insertion of a temporary prosthetic tissue expander which requires subsequent removal, including all attendances for subsequent expansion injections, other than a service for breast or post-mastectomy tissue expansion (H) (Anaes.) (Assist.) | $2302.40 |
| 45567 | Free transfer of tissue (reconstructive surgery) for the repair of major tissue defect of the head and neck or other non-breast defect, using microvascular techniques, all necessary elements of the operation including (but not limited to):(a) anastomoses of all required vessels; and(b) raising of tissue on a vascular pedicle; and(c) preparation of recipient vessels; and(d) transfer of tissue; and(e) insetting of tissue at recipient site; and(f) direct repair of secondary cutaneous defect, if performed; other than a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505, 45507, 45562, 45564 or 45565 applies single surgeon (H) (Anaes.) (Assist.) | $5298.90 |
| 45568 | Tissue expander, removal of, including complete excision of fibrous capsule if performed (H) (Anaes.) (Assist.) | $962.20 |
| 45571 | Closure of abdomen with reconstruction of umbilicus, with or without lipectomy, to be used following the harvest of an autologous flap, being a service associated with a service to which item 45530, 45531, 45562, 45564, 45565, 45567, 46080, 46082, 46084, 46086, 46088 or 46090 applies, including repair of the musculoaponeurotic layer of the abdomen (including insertion of prosthetic mesh if used) (H) (Anaes.) (Assist.) | $1867.40 |
| 45572 | Intra-operative tissue expansion using a prosthetic tissue expander, performed under general anaesthetic or intravenous sedation during an operation, if combined with a service to which another item in Group T8 applies (including expansion injections), not to be used for breast tissue expansion (Anaes.) | $621.30 |
| 45575 | FACIAL NERVE PARALYSIS, free fascia graft for (Anaes.) (Assist.) | $1581.90 |
| 45578 | FACIAL NERVE PARALYSIS, muscle transfer for (Anaes.) (Assist.) | $1722.50 |
| 45581 | Facial nerve paralysis, excision of tissue for (Anaes.) | $680.00 |
| 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.) | $1550.00 |
| 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 or 31526 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 (H) (Anaes.) | $1550.00 |
| 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.) | $1865.00 |
| 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.) | $2790.00 |
| 45589 | Autologous fat grafting (harvesting, preparation and injection of adipocytes) if: (a) the autologous fat grafting is for either or both of the following purposes: (i) the correction of asymmetry arising from volume and contour defects in craniofacial disorders up to a total of 4 services if each service is provided at least 3 months after the previous service; (ii) the treatment of burn scar or associated skin graft in the context of scar contracture, contour deformity or neuropathic pain, for patients who have undergone a minimum of 3 months of topical therapies, including silicone and pressure therapy, with an unsatisfactory or minimal level of improvement up to a total of 4 services per region of the body (upper or lower limbs, trunk, neck or face) if each service provided per region of the body is provided at least 3 months after the previous such service; and (b) both: (i) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes; and (ii) for craniofacial disorders, evidence of diagnosis of the qualifying craniofacial disorder is documented in the patient notes (H) (Anaes.) | $1199.30 |
| 45590 | Orbital cavity, reconstruction of wall or floor, with or without bone graft, cartilage graft or foreign implant, other than a service associated with a service to which item 45594 applies on the same side (H) (Anaes.) (Assist.) | $1015.00 |
| 45592 | Orbital cavity, reconstruction of wall and floor with bone graft, cartilage graft or foreign implant, other than a service associated with a service to which item 45594 applies on the same side (H) (Anaes.) (Assist.) | $1535.80 |
| 45594 | Orbital cavity, exploration of wall or floor without bone graft, cartilage graft or foreign implant, other than a service associated with a service to which item 45590 or 45592 applies on the same side (H) (Anaes.) (Assist.) | $719.80 |
| 45596 | Hemimaxillectomy (H) (Anaes.) (Assist.) | $1960.00 |
| 45597 | Total maxillectomy (bilateral) (H) (Anaes.) (Assist.) | $2445.70 |
| 45599 | Mandible, total resection of, other than a service associated with a service to which item 45608 applies (H) (Anaes.) (Assist.) | $1658.00 |
| 45602 | MANDIBLE, including lower border, OR MAXILLA, sub-total resection of (Anaes.) (Assist.) | $1452.30 |
| 45605 | MANDIBLE OR MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.) | $1210.70 |
| 45608 | Mandible, segmental mandibular or maxilla reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (H) (Anaes.) (Assist.) | $1686.50 |
| 45609 | Mandible, maxilla or skull base, reconstruction of, using bony free flap, all osteotomies, shaping, inset and fixation by any means, including all necessary 3 dimensional planning, if performed in conjunction with one or more services covered by items 46060 to 46068 (H) (Anaes.) (Assist.) | $1492.80 |
| 45611 | Mandible, condylectomy of (H) (Anaes.) (Assist.) | $1265.00 |
| 45614 | Eyelid, reconstruction of a defect (greater than one quarter of the length of the lid) involving all 3 layers of the eyelid, if unable to be closed by direct suture or wedge excision, including all flaps and grafts that may be required (H) (Anaes.) (Assist.) | $1327.10 |
| 45617 | Upper eyelid, reduction of, if: (a) the reduction is for any of the following: (i) history of a demonstrated visual impairment; (ii) intertriginous inflammation of the eyelid; (iii) herniation of orbital fat in exophthalmos; (iv) facial nerve palsy; (v) post traumatic scarring; (vi) the restoration of symmetry of contralateral upper eyelid in respect of one of the conditions mentioned in subparagraphs(i) to (v); and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) | $495.00 |
| 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.) | $685.00 |
| 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.) | $1558.70 |
| 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.) | $1927.50 |
| 45625 | PTOSIS of eyelid, correction of eyelid height by revision of levator sutures within one week of primary repair by levator resection or advancement, performed in the operating theatre of a hospital (Anaes.) | $402.70 |
| 45626 | Ectropion or entropion, not caused by trachoma, correction of (unilateral) (Anaes.) | $719.40 |
| 45627 | Ectropion or entropion, caused by trachoma, correction of (unilateral) (Anaes.) | $609.80 |
| 45629 | SYMBLEPHARON, grafting for (Anaes.) (Assist.) | $1110.00 |
| 45632 | Rhinoplasty, partial, involving correction of one or both lateral cartilages, one or both alar cartilages or one or both lateral cartilages and 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.) | $1215.00 |
| 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.) | $1440.00 |
| 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.) | $2550.00 |
| 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; other than a service associated with a service to which item 45718 applies (H) (Anaes.) (Assist.) | $2985.00 |
| 45645 | Choanal atresia, repair of by puncture and dilatation (Anaes.) | $453.90 |
| 45646 | CHOANAL ATRESIA—correction by open operation with bone removal (Anaes.) (Assist.) | $1952.30 |
| 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.) | $330.00 |
| 45652 | Rhinophyma of a moderate or severe degree, carbon dioxide laser or erbium laser excision—ablation of (Anaes.) | $745.00 |
| 45653 | Rhinophyma, shaving of (Anaes.) | $773.40 |
| 45656 | COMPOSITE GRAFT (Chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes.) (Assist.) | $1132.90 |
| 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.) | $1145.00 |
| 45660 | External ear, complex total reconstruction of, using 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 the specialist s specialty (H) (Anaes.) (Assist.) | $5931.70 |
| 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 skin graft to cover cartilage (second stage)—performed by a specialist in the practice of the specialist s specialty (H) (Anaes.) (Assist.) | $2630.20 |
| 45665 | Lip, eyelid or ear, full thickness wedge excision of, with repair by direct sutures, excluding eyelid wedge when performed in conjunction with a cosmetic eyelid procedure (Anaes.) | $669.80 |
| 45668 | Vermilionectomy, by surgical excision (Anaes.) | $671.90 |
| 45669 | Vermilionectomy for biopsy-confirmed cellular atypia, using carbon dioxide laser or erbium laser excision—ablation (Anaes.) | $709.90 |
| 45671 | Lip or eyelid reconstruction, single stage or first stage of a two-stage flap reconstruction of a defect involving all 3 layers of tissue, if the flap is switched from the opposing lip or eyelid respectively (H) (Anaes.) (Assist.) | $1728.00 |
| 45674 | Lip or eyelid reconstruction, second stage of a two-stage flap reconstruction, division of the pedicle and inset of flap and closure of the donor (Anaes.) | $530.90 |
| 45675 | MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.) | $994.30 |
| 45676 | MACROSTOMIA, operation for (Anaes.) (Assist.) | $1185.10 |
| 45677 | Cleft lip, unilateral primary repair of nasolabial complex, one stage, without anterior palate repair (H) (Anaes.) (Assist.) | $1153.20 |
| 45680 | Cleft lip, unilateral primary repair of nasolabial complex, one stage, with anterior palate repair (H) (Anaes.) (Assist.) | $1508.40 |
| 45683 | Cleft lip, bilateral primary repair of nasolabial complex, one stage, without anterior palate repair (H) (Anaes.) (Assist.) | $1675.70 |
| 45686 | Cleft lip, bilateral primary repair of nasolabial complex, one stage, with anterior palate repair (H) (Anaes.) (Assist.) | $1903.70 |
| 45689 | CLEFT LIP, lip adhesion procedure, unilateral or bilateral (Anaes.) (Assist.) | $600.00 |
| 45692 | CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.) | $619.20 |
| 45695 | CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.) | $1075.00 |
| 45698 | Cleft lip, primary columella lengthening procedure, bilateral (Anaes.) | $930.90 |
| 45701 | CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) | $2320.80 |
| 45704 | CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) | $618.70 |
| 45707 | CLEFT PALATE, primary repair (Anaes.) (Assist.) | $1613.90 |
| 45710 | Cleft palate, secondary repair, closure of fistula using local flaps (Anaes.) | $1010.80 |
| 45713 | CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.) | $1146.70 |
| 45714 | Oro-nasal fistula, repair of, including a local flap for closure (H) (Anaes.) (Assist.) | $1668.30 |
| 45716 | VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.) | $1768.80 |
| 45718 | Face, contour restoration of one region, for the correction of deformity using autogenous bone or cartilage, if the deformity:(a) is secondary to congenital absence of tissue; or(b) has arisen from:(i) trauma (other than from previous cosmetic surgery); or(ii) a diagnosed pathological process; other than a service associated with a service to which item 45644 or 45717 (alveolar bone grafting) applies (H) (Anaes.) (Assist.) | $2308.40 |
| 45761 | Genioplasty, including transposition of nerves and vessels and bone grafts taken from the same site, if:(a) the deformity: (i) is secondary to congenital absence of tissue; or(ii) has arisen from trauma (other than from previous cosmetic surgery) or a diagnosed pathological process; and (b) the service is required for maintaining lip competency; and(c) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes(H) (Anaes.) (Assist.) | $1580.00 |
| 45767 | Hypertelorism,correction of,using intracranial approach (H) (Anaes.) (Assist.) | $5096.20 |
| 45773 | Syndromic orbital dystopia, such as Treacher Collins Syndrome, bilateral facial or periorbital reconstruction, with bone grafts from a distant site (H) (Anaes.) (Assist.) | $3558.00 |
| 45776 | ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, intracranial (Anaes.) (Assist.) | $3638.00 |
| 45779 | ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, extracranial (Anaes.) (Assist.) | $2616.00 |
| 45782 | Fronto-orbital advancement (H) (Anaes.) (Assist.) | $2028.20 |
| 45785 | Cranial vault reconstruction for single suture synostosis (H) (Anaes.) (Assist.) | $3384.70 |
| 45788 | Glenoid fossa, construction of, from bone and cartilage graft, and creation of condyle and ascending ramus of mandible, in hemifacial microsomia, not including harvesting of graft material (H) (Anaes.) (Assist.) | $3419.60 |
| 45791 | Absent condyle and ascending ramus in craniofacial microsomia, construction of, not including harvesting of graft material (H) (Anaes.) (Assist.) | $1807.50 |
| 45794 | Osseo integration procedure, first stage, implantation of fixture, following congenital absence, tumour or trauma, other than a service associated with a service to which item 41603 applies (Anaes.) | $1235.00 |
| 45797 | Osseo integration procedure, second stage, fixation of transcutaneous abutment, following congenital absence, tumour or trauma, other than a service associated with a service to which item 41603 applies (Anaes.) | $408.10 |
| 45801 | Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), in the oral cavity, removal from mucosa or submucosal tissues, if the removal is by surgical excision and suture (Anaes.) | $290.80 |
| 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.) | $524.30 |
| 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.) | $764.40 |
| 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.) | $1035.90 |
| 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.) | $1210.60 |
| 45815 | Operation on:(a) mandible or maxilla (other than alveolar margins) for chronic osteomyelitis with radiological and laboratory evidence of osteomyelitis; or(b) mandible or maxilla for necrosis of the jaw from any cause including medication or radiation that requires debridement of the alveolar bone or beyond (Anaes.) (Assist.) | $738.30 |
| 45823 | Arch bars or similar, one or more, that were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia, if the service is undertaken in the operating theatre of a hospital (H) (Anaes.) | $265.00 |
| 45825 | MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) | $699.50 |
| 45827 | MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.) | $687.80 |
| 45829 | Maxillary tuberosity, reduction of (Anaes.) | $525.00 |
| 45831 | Papillary hyperplasia of the palate, surgical reduction of cannot be claimed more than once per occasion of service (Anaes.) (Assist.) | $687.80 |
| 45837 | VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed—unilateral or bilateral (Anaes.) (Assist.) | $1247.60 |
| 45841 | ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both—unilateral (Anaes.) (Assist.) | $977.80 |
| 45845 | Osseo-integration procedure, intra-oral implantation of titanium or similar fixture to facilitate restoration of the dentition following:(a) resection of part of the maxilla or mandible for a benign or a malignant tumour; or(b) segmental loss from trauma or congenital absence of a segment of the maxilla or mandible (multiple adjacent teeth)Fixture must be placed at site of the missing segment following appropriate reconstructive procedures (Anaes.) | $1038.20 |
| 45847 | Osseo-integration procedure, fixation of transmucosal abutment to fixtures that are placed following:(a) resection of part of the maxilla or mandible for a benign or a malignant tumour; or(b) segmental loss from trauma or congenital absence of a segment of the maxilla or mandible (multiple adjacent teeth)Fixture must be placed at site of the missing segment following appropriate reconstructive procedures (Anaes.) | $397.00 |
| 45849 | Maxillary sinus, allograft, bone graft or both, to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), unilateral (Anaes.) (Assist.) | $1206.50 |
| 45851 | Temporomandibular joint, manipulation of, as an independent procedure performed in the operating theatre of a hospital, other than a service associated with a service to which any other item in this Group applies (H) (Anaes.) | $297.10 |
| 45855 | Temporomandibular joint, arthroscopy of, with or without biopsy, other than a service associated with another arthroscopic procedure of that joint (H) (Anaes.) (Assist.) | $829.20 |
| 45857 | Temporomandibular joint, arthroscopy of, removal of loose bodies, debridement, or lysis and lavage or biopsy (including repositioning of meniscus where indicated) one or more such procedures of that joint, other than a service associated with any other arthroscopic or open procedure of the temporomandibular joint (H) (Anaes.) (Assist.) | $1326.70 |
| 45865 | ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.) | $602.30 |
| 45871 | TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.) | $3260.00 |
| 45873 | Temporomandibular joint, surgery of, involving procedures to which item 45871 applies and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes.) (Assist.) | $3096.60 |
| 45874 | Temporomandibular joint, including condylar head and glenoid fossa, total alloplastic replacement (H) (Anaes.) (Assist.) | $2377.70 |
| 45882 | The treatment of a premalignant lesion of the oral mucosa by a treatment using cryotherapy, diathermy or carbon dioxide laser. | $87.30 |
| 45888 | FOREIGN BODY, in the oral and maxillofacial region, deep, removal of using interventional imaging techniques (Anaes.) (Assist.) | $875.00 |
| 45891 | SINGLE-STAGE LOCAL FLAP where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.) | $1288.20 |
| 45894 | Grafting (mucosa or split skin), in the oral cavity of a mucosal defect (Anaes.) | $446.90 |
| 45939 | PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.) | $951.20 |
| 46050 | Perforator flap, raising on a named source vessel, for pedicled transfer for head or neck or other non-breast reconstruction (H) (Anaes.) (Assist.) | $1419.30 |
| 46052 | Perforator Flap, such as anterolateral thigh flap or similar, raising in preparation for microsurgical transfer of a free flap for head or neck or other non-breast reconstruction (H) (Anaes.) (Assist.) | $448.00 |
| 46060 | Free transfer of tissue with a vascularised bone component (including chimeric/composite flap), for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to):(a) anastomoses of all required vessels using microvascular techniques; and(b) harvesting of flap (including osteotomies); and(c) raising of tissue on a vascular pedicle; and(d) preparation of recipient vessels; and(e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and(f) direct repair of secondary cutaneous defect, if performed; other than the following:(g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base;(h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 appliesSingle surgeon (H) (Anaes.) (Assist.) | $4803.00 |
| 46062 | Free transfer of tissue with a vascularised bone component (including chimeric/composite flap), for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to):(a) anastomoses of all required vessels using microvascular techniques; and(b) harvesting of flap (including osteotomies); and(c) raising of tissue on a vascular pedicle; and(d) preparation of recipient vessels; and(e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and(f) direct repair of secondary cutaneous defect, if performed; other than the following:(g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base;(h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) | $4594.30 |
| 46064 | Free transfer of tissue with a vascularised bone component (including chimeric/composite flap), for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to):(a) anastomoses of all required vessels using microvascular techniques; and(b) harvesting of flap (including osteotomies); and(c) raising of tissue on a vascular pedicle; and(d) preparation of recipient vessels; and(e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and(f) direct repair of secondary cutaneous defect, if performed; other than the following:(g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base;(h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.) | $3445.90 |
| 46066 | Double free flap, including one free transfer of tissue with a vascularized bone component, for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to):(a) anastomoses of all required vessels using microvascular techniques; and(b) harvesting of flap (including osteotomies); and(c) raising of tissue on a vascular pedicle; and(d) preparation of recipient vessels; and(e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and(f) direct repair of secondary cutaneous defect, if performed; other than the following:(g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base;(h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) | $6891.30 |
| 46068 | Double free flap, including one free transfer of tissue with a vascularized bone component, for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to):(a) anastomoses of all required vessels using microvascular techniques; and(b) harvesting of flap (including osteotomies); and(c) raising of tissue on a vascular pedicle; and(d) preparation of recipient vessels; and(e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and(f) direct repair of secondary cutaneous defect, if performed; other than the following:(g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base;(h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.) | $5168.80 |
| 46070 | Double free flap, including 2 free transfers of tissue (reconstructive surgery) for the repair of major tissue defect, involving anastomoses of all required vessels using microvascular techniques, all necessary elements of the operation, including (but not limited to):(a) raising each flap of tissue on a separate vascular pedicle; and(b) preparation of recipient vessels; and(c) transfer of tissue; and(d) inset of tissue at recipient site; and(e) direct repair of secondary cutaneous defect, if performed; other than a service:(f) performed in the context of breast reconstruction; or(g) associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) | $6891.30 |
| 46072 | Double free flap, including 2 free transfers of tissue (reconstructive surgery) for the repair of major tissue defect, involving anastomoses of all required vessels using microvascular techniques, all necessary elements of the operation including (but not limited to):(a) raising each flap of tissue on a separate vascular pedicle; and(b) preparation of recipient vessels; and(c) transfer of tissue; and(d) inset of tissue at recipient site; and(e) direct repair of secondary cutaneous defect, if performed; other than a service:(f) performed in the context of breast reconstruction; or(g) associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.) | $5168.80 |
| 46100 | Excision of burnt tissue, or definitive burn wound closure, if:(a) the area of burn excised involves more than 1% of hands, face or anterior neck; and(b) the service is performed in conjunction with a service (the co-claimed service) to which any of items 46101 to 46135 (other than item 46112 or 46124) apply; other than a service to which item 46136 applies | DF |
| 46101 | Excision of burnt tissue, if the area of burn excised involves not more than 1% of the total body surface (Anaes.) (Assist.) | $609.00 |
| 46102 | Excision of burnt tissue, if the area of burn excised involves more than 1% but less than 3% of the total body surface (H) (Anaes.) (Assist.) | $966.70 |
| 46103 | Excision of burnt tissue, if the area of burn excised involves 3% or more but less than 10% of the total body surface (H) (Anaes.) (Assist.) | $1060.40 |
| 46104 | Excision of burnt tissue, if the area of burn excised involves 10% or more but less than 20% of the total body surface, excluding aftercare (H) (Anaes.) (Assist.) | $1617.60 |
| 46105 | Excision of burnt tissue, if the area of burn excised involves 20% or more but less than 30% of total body surface, excluding aftercare (H) (Anaes.) (Assist.) | $2175.60 |
| 46106 | Excision of burnt tissue, if the area of burn excised involves 30% or more but less than 40% of total body surface, excluding aftercare (H) (Anaes.) (Assist.) | $2734.30 |
| 46107 | Excision of burnt tissue, if the area of burn excised involves 40% or more but less than 50% of total body surface, excluding aftercare (H) (Anaes.) (Assist.) | $3292.30 |
| 46108 | Excision of burnt tissue, if the area of burn excised involves 50% or more but less than 60% of total body surface, excluding aftercare (H) (Anaes.) (Assist.) | $3849.20 |
| 46109 | Excision of burnt tissue, if the area of burn excised involves 60% or more but less than 70% of total body surface, excluding aftercare (H) (Anaes.) (Assist.) | $4407.10 |
| 46110 | Excision of burnt tissue, if the area of burn excised involves 70% or more but less than 80% of total body surface, excluding aftercare (H) (Anaes.) (Assist.) | $5021.40 |
| 46111 | Excision of burnt tissue, if the area of burn excised involves 80% or more of total body surface, excluding aftercare (H) (Anaes.) (Assist.) | $5623.70 |
| 46112 | Excision of burnt tissue, if the area of burn excised involves whole of face (excluding ears) may be claimed with any one of items 46101 to 46111, based on the percentage total body surface (excluding the face), other than a service associated with a service to which item 46100 applies and excluding aftercare (H) (Anaes.) (Assist.) | $3104.60 |
| 46113 | Excised burn wound closure, or closure of skin defect secondary to burns contracture release, if the defect area is not more than 1% of total body surface and if the service:(a) is performed at the same time as the procedure for the primary burn wound excision or contracture release; and(b) involves: (i) autologous skin grafting for definitive closure; or(ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound (Anaes.) (Assist.) | $609.00 |
| 46114 | Excised burn wound closure, or closure of skin defect secondary to burns contracture release, if the defect area is more than 1% but not more than 3% of total body surface and if the service:(a) is performed at the same time as the procedure for the primary burn wound excision or contracture release; and(b) involves: (i) autologous skin grafting for definitive closure; or(ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound (H) (Anaes.) (Assist.) | $966.70 |
| 46115 | Excised burn wound closure or closure of skin defect secondary to burns contracture release, if the defect area is more than 3% but not more than 10% of total body surface and if the service:(a) is performed at the same time as the procedure for the primary burn wound excision or contracture release; and(b) involves: (i) autologous skin grafting for definitive closure; or(ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound (H) (Anaes.) (Assist.) | $1060.40 |
| 46116 | Excised burn wound closure or closure of skin defect secondary to burns contracture release, if the defect area is more than 10% but less than 20% of total body surface and if the service:(a) is performed at the same time as the procedure for the primary burn wound excision or contracture release; and(b) involves: (i) autologous skin grafting for definitive closure; or(ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) | $1617.60 |
| 46117 | Excised burn wound closure, if the defect area is 20% or more but less than 30% of total body surface and if the service:(a) is performed at the same time as the procedure for the primary burn wound excision; and(b) involves: (i) autologous skin grafting for definitive closure; or(ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) | $2175.60 |
| 46118 | Excised burn wound closure, if the defect area is 30% or more but less than 40% of total body surface and if the service:(a) is performed at the same time as the procedure for the primary burn wound excision; and(b) involves: (i) autologous skin grafting for definitive closure; or(ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) | $2734.30 |
| 46119 | Excised burn wound closure, if the defect area is 40% or more but less than 50% of total body surface and if the service:(a) is performed at the same time as the procedure for the primary burn wound excision; and(b) involves: (i) autologous skin grafting for definitive closure; or(ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) | $3292.30 |
| 46120 | Excised burn wound closure, if the defect area is 50% or more but less than 60% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) | $3849.20 |
| 46121 | Excised burn wound closure, if the defect area is 60% or more but less than 70% of total body surface and if the service:(a) is performed at the same time as the procedure for the primary burn wound excision; and(b) involves: (i) autologous skin grafting for definitive closure; or(ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) | $4407.10 |
| 46122 | Excised burn wound closure, if the defect area is 70% or more but less than 80% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) | $5021.40 |
| 46123 | Excised burn wound closure, if the defect area is 80% or more of total body surface and if the service:(a) is performed at the same time as the procedure for the primary burn wound excision; and(b) involves: (i) autologous skin grafting for definitive closure; or(ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) | $5623.70 |
| 46124 | Excised burn wound closure of whole of face, if the service:(a) is performed at the same time as the procedure for the primary burn wound excision; and(b) involves: (i) autologous skin grafting for definitive closure; or(ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare, other than a service associated with a service to which item 46100 applies (H) (Anaes.) (Assist.) | $3104.60 |
| 46125 | Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves less than 1% of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements) (Anaes.) (Assist.) | $609.00 |
| 46126 | Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves 1% or more but less than 3% of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements) (Anaes.) (Assist.) | $966.70 |
| 46127 | Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves 3% or more but less than 10% of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements) (H) (Anaes.) (Assist.) | $1339.20 |
| 46128 | Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves 10% or more but less than 30% of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements), excluding aftercare (H) (Anaes.) (Assist.) | $2455.10 |
| 46129 | Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves 30% or more of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements), excluding aftercare (H) (Anaes.) (Assist.) | $4492.70 |
| 46130 | Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, if the defect area involves less than 1% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure or simple dressings (Anaes.) (Assist.) | $609.00 |
| 46131 | Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, if the defect area involves 1% or more but less than 3% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure or simple dressings (H) (Anaes.) (Assist.) | $966.70 |
| 46132 | Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, if the defect area involves 3% or more but less than 10% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure or simple dressings (H) (Anaes.) (Assist.) | $1060.40 |
| 46133 | Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, if the defect area involves 10% or more but less than 20% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure or simple dressings, excluding aftercare (H) (Anaes.) (Assist.) | $1617.60 |
| 46134 | Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis, if the defect area involves 20% or more but less than 30% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure, excluding aftercare (H) (Anaes.) (Assist.) | $3580.00 |
| 46135 | Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis, if the defect area involves 30% or more of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure, excluding aftercare (H) (Anaes.) (Assist.) | $5623.70 |
| 46136 | Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis, of whole of face, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure, excluding aftercare, other than a service associated with a service to which item 46100 applies (H) (Anaes.) (Assist.) | $3104.60 |
| 46140 | Burns contracture, release of, by excision or incision of scar, if the defect resulting from surgery is less than 1% of total body surface, including direct repair if performed (Anaes.) (Assist.) | $464.50 |
| 46141 | Burns contracture, release of, by excision or incision of scar, if the defect resulting from surgery is 1% or more but less than 3% of total body surface (H) (Anaes.) (Assist.) | $696.80 |
| 46142 | Burns contracture, release of, by excision or incision of scar, if the defect resulting from surgery is 3% or more but less than 10% of total body surface (H) (Anaes.) (Assist.) | $836.00 |
| 46143 | Burns contracture, release of, by excision or incision of scar, if the defect resulting from surgery is 10% or more but less than 20% of total body surface (H) (Anaes.) (Assist.) | $1083.70 |
| 46150 | Mandible or maxilla, procedure for advancement, retrusion or alteration of tilt, by osteotomy in standard planes, including fixation by any means (including application of distractors if used) one service per patient on the same occasion (H) (Anaes.) (Assist.) | $2399.30 |
| 46151 | Mandible and maxilla (bimaxillary), procedure for advancement, retrusion or alteration of tilt, or combination of these, by osteotomies in standard planes, including fixation by any means (including application of distractors if used) conjoint surgery, principal specialist surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.) | $2616.10 |
| 46152 | Mandible and maxilla (bimaxillary), procedure for advancement, retrusion or alteration of tilt, or combination of these, by osteotomies in standard planes, including fixation by any means (including application of distractors if used) conjoint surgery, conjoint specialist surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.) | $1962.00 |
| 46153 | Mandible and maxilla (bimaxillary), procedure for advancement, retrusion or alteration of tilt, or combination of these, by osteotomies in standard planes, including fixation by any means (including application of distractors if used) single surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.) | $3270.00 |
| 46154 | Maxilla, procedure for reshaping arch of, by complex segmental osteotomies, including fixation by any means (including application of distractors if used), one service per patient on the same occasion (H) (Anaes.) (Assist.) | $2738.30 |
| 46155 | Mandible, procedure for reshaping arch of, by complex segmental osteotomies, including genioplasty (if performed) and fixation by any means (including application of distractors if used), one service per patient on the same occasion (H) (Anaes.) (Assist.) | $2738.30 |
| 46156 | Mandible and maxilla (bimaxillary), procedure for any combination of arch reshaping, advancement, retrusion or tilting of, involving complex segmental osteotomies, with or without standard osteotomies, including genioplasty (if performed) and fixation by any means (including application of distractors if used) conjoint surgery, principal specialist surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.) | $3126.10 |
| 46157 | Mandible and maxilla (bimaxillary), procedure for any combination of arch reshaping, advancement, retrusion or tilting of, involving complex segmental osteotomies, with or without standard osteotomies, including genioplasty (if performed) and fixation by any means (including application of distractors if used) conjoint surgery, conjoint specialist surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.) | $2344.60 |
| 46158 | Mandible and maxilla (bimaxillary), procedure for any combination of arch reshaping, advancement, retrusion or tilting of, involving complex segmental osteotomies, with or without standard osteotomies, including genioplasty (if performed) and fixation by any means (including application of distractors if used) single surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.) | $3907.50 |
| 46159 | Midfacial osteotomies, Le Fort II or Le Fort III conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) | $3457.10 |
| 46160 | Midfacial osteotomies, Le Fort II or Le Fort III conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.) | $2592.90 |
| 46161 | Midfacial osteotomies, Le Fort II or Le Fort III single surgeon (H) (Anaes.) (Assist.) | $4321.30 |
| 46170 | Decompression of thoracic outlet, primary, for thoracic outlet syndrome, using any approach, including (if performed) division of scalene muscles, cervical rib and/or first rib resection (H) (Anaes.) (Assist.) | $1804.30 |
| 46171 | Decompression of thoracic outlet, repeat (revision) procedure, for thoracic outlet syndrome, using any approach, including (if performed) division of scalene muscles, cervical rib and/or first rib resection (H) (Anaes.) (Assist.) | $3067.30 |
| 46172 | Removal or debulking of brachial plexus tumour, involving intraneural dissection, either supraclavicular or infraclavicular dissection (H) (Anaes.) (Assist.) | $4510.70 |
| 46173 | Removal or debulking of brachial plexus tumour, involving intraneural dissection, both supraclavicular and infraclavicular dissection (H) (Anaes.) (Assist.) | $6315.00 |
| 46174 | Exploration of the brachial plexus, either supraclavicular or infraclavicular, including any neurolyses performed and intraoperative neurophysiological recordings, but excluding reconstruction of elements(H) (Anaes.) (Assist.) | $4510.70 |
| 46175 | Exploration of the brachial plexus, both supraclavicular and infraclavicular, including any neurolyses performed and intraoperative neurophysiological recordings, but excluding reconstruction of elements(H) (Anaes.) (Assist.) | $7217.10 |
| 46176 | Exploration of the brachial plexus, posterior subscapular approach, all necessary elements of the operation including (but not limited to):(a) resection of the first rib and/or second rib; and(b) vertebral laminectomies or facetectomies, if performed; and(c) any neurolyses performed; and(d) intraoperative neurophysiological recordings; excluding the following:(e) reconstruction of elements of the plexus;(f) spinal instrumentation(H) (Anaes.) (Assist.) | $1804.30 |
| 46177 | Reconstruction of deficit of the brachial plexus, single cord or trunk, by any appropriate method, single surgeon (H) (Anaes.) (Assist.) | $3067.30 |
| 46178 | Reconstruction of deficit of the brachial plexus, single cord or trunk, by any appropriate method, conjoint surgery, principal surgeon (H) (Anaes.) (Assist.) | $3067.30 |
| 46179 | Reconstruction of deficit of the brachial plexus, single cord or trunk, by any appropriate method, conjoint surgery, conjoint surgeon (H) (Anaes.) (Assist.) | $2553.00 |
| 46180 | Reconstruction of deficit of the brachial plexus, more than a single cord or trunk, but less than the whole plexus, by any appropriate method, single surgeon (H) (Anaes.) (Assist.) | $4510.70 |
| 46181 | Reconstruction of deficit of the brachial plexus, more than a single cord or trunk, but less than the whole plexus, by any appropriate method, conjoint surgery, principal surgeon (H) (Anaes.) (Assist.) | $4510.70 |
| 46182 | Reconstruction of deficit of the brachial plexus, more than a single cord or trunk, but less than the whole plexus, by any appropriate method, conjoint surgery, conjoint surgeon (H) (Anaes.) (Assist.) | $3761.90 |
| 46183 | Reconstruction of deficit of the brachial plexus, whole plexus, by any appropriate method, single surgeon (H) (Anaes.) (Assist.) | $5412.80 |
| 46184 | Reconstruction of deficit of the brachial plexus, whole plexus, by any appropriate method, conjoint surgery, principal surgeon (H) (Anaes.) (Assist.) | $5412.80 |
| 46185 | Reconstruction of deficit of the brachial plexus, whole plexus, by any appropriate method, conjoint surgery, conjoint surgeon (H) (Anaes.) (Assist.) | $4510.70 |
| **Hand surgery** | | |
| 46300 | Arthrodesis of interphalangeal or metacarpophalangeal joint of hand, including either or both of the following (if performed): (a) joint debridement; (b) synovectomy one joint (H) (Anaes.) (Assist.) | $861.00 |
| 46303 | Arthrodesis of carpometacarpal joint of hand, including either or both of the following (if performed): (a) joint debridement; (b) synovectomy one joint (H) (Anaes.) (Assist.) | $905.80 |
| 46308 | Volar plate or soft tissue interposition arthroplasty of interphalangeal or metacarpophalangeal joint of hand, including either or both of the following (if performed): (a) realignment procedures; (b) tendon transfer one joint (Anaes.) (Assist.) | $1141.80 |
| 46309 | Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy; (d) tendon transfer one joint (H) (Anaes.) (Assist.) | $1128.10 |
| 46312 | Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy; (d) tendon transfer 2 joints of one hand (H) (Anaes.) (Assist.) | $1394.20 |
| 46315 | Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy; (d) tendon transfer 3 joints of one hand (H) (Anaes.) (Assist.) | $1873.00 |
| 46318 | Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy; (d) tendon transfer 4 joints of one hand (H) (Anaes.) (Assist.) | $2354.00 |
| 46321 | Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy; (d) tendon transfer; 5 joints of one hand (H) (Anaes.) (Assist.) | $2794.20 |
| 46322 | Revision of prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpal joint of hand, including any of the following (if performed): (a) bone grafting; (b) ligament reconstruction; (c) ligament realignment; (d) synovectomy; (e) tendon or ligament reconstruction; (f) tendon transfer; one joint (H) (Anaes.) (Assist.) | $1712.70 |
| 46324 | Prosthetic interpositional replacement of carpometacarpal joint, including either or both of the following (if performed): (a) ligament and tendon transfers; (b) rebalancing procedures (H) (Anaes.) (Assist.) | $1892.90 |
| 46325 | Excisional arthroplasty of carpometacarpal joint, including any of the following (if performed): (a) ligament and tendon transfers; (b) realignment procedures; (c) excision of adjacent trapezoid (H) (Anaes.) (Assist.) | $1899.80 |
| 46330 | Ligamentous or capsular repair or reconstruction of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) arthrotomy; (b) joint stabilisation; (c) synovectomy; one joint (H) (Anaes.) (Assist.) | $766.40 |
| 46333 | Ligamentous or capsular repair or reconstruction of interphalangeal or metacarpophalangeal joint of hand with graft, using graft or implant, including any of the following (if performed): (a) arthrotomy; (b) harvest of graft; (c) joint stabilisation; (d) synovectomy; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 apply one joint (H) (Anaes.) (Assist.) | $1237.40 |
| 46335 | Synovectomy of digital extensor tendons of hand, distal to wrist, for diagnosed inflammatory arthritis, including any of the following (if performed): (a) reconstruction of extensor retinaculum; (b) removal of tendon nodules; (c) tenolysis; (d) tenoplasty; other than a service associated with: (e) a service to which item 39330 applies; or (f) a service to which item 30023 applies that is performed at the same site Applicable once per hand per occasion on which the service is performed (Anaes.) (Assist.) | $1011.10 |
| 46336 | Synovectomy of interphalangeal, metacarpophalangeal or carpometacarpal joint of hand, including any of the following (if performed): (a) capsulectomy; (b) debridement; (c) ligament or tendon realignment (or both); other than a service combined with a service to which item 46495 applies one joint (Anaes.) (Assist.) | $669.40 |
| 46339 | Synovectomy of digital flexor tendons at wrist level, for diagnosed inflammatory arthritis, including either or both of the following (if performed): (a) tenolysis; (b) release of median nerve and carpal tunnel; other than a service associated with: (c) a service to which item 39330 or 39331 applies; or (d) a service to which item 30023 applies that is performed at the same site Applicable once per wrist per occasion on which the service is performed (H) (Anaes.) (Assist.) | $1009.60 |
| 46340 | Synovectomy of wrist flexor or extensor tendons of hand or wrist, for diagnosed inflammatory tenosynovitis, including any of the following (if performed): (a) reconstruction of flexor or extensor retinaculum; (b) removal of tendon nodules; (c) tenolysis; (d) tenoplasty; other than a service associated with: (e) a service to which item 39330 applies; or (f) if this service is performed on the wrist flexor tendons a service to which item 39331 applies; or (g) a service to which item 30023 applies that is performed at the same site one or more compartments per limb (H) (Anaes.) (Assist.) | $859.40 |
| 46341 | Synovectomy of wrist flexor or extensor tendons of hand or wrist, for non-inflammatory tenosynovitis or post traumatic synovitis, including any of the following (if performed): (a) reconstruction of flexor or extensor retinaculum; (b) removal of tendon nodules; (c) tenolysis; (d) tenoplasty; other than a service associated with: (e) a service to which item 39330 applies; or (f) if this service is performed on the wrist flexor tendons a service to which item 39331 applies; or (g) a service to which item 30023 applies that is performed at the same site one or more compartments per limb (H) (Anaes.) (Assist.) | $551.10 |
| 46342 | Synovectomy of distal radioulnar or carpometacarpal joint of hand one or more joints (H) (Anaes.) (Assist.) | $1009.60 |
| 46345 | Resection arthroplasty of distal radioulnar joint of hand, partial or complete, including any of the following (if performed): (a) ligament or tendon reconstruction; (b) joint stabilisation; (c) synovectomy (H) (Anaes.) (Assist.) | $1237.10 |
| 46348 | Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with: (d) a service to which item 30023 applies that is performed at the same site; or (e) a service to which item 46363 applies that is performed on the same ray one ray (H) (Anaes.) (Assist.) | $532.70 |
| 46351 | Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with: (d) a service to which item 30023 applies that is performed at the same site; or (e) a service to which item 46363 applies that is performed on one of the same rays 2 rays of one hand (H) (Anaes.) (Assist.) | $753.20 |
| 46354 | Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with: (d) a service to which item 30023 applies that is performed at the same site; or (e) a service to which item 46363 applies that is performed on one of the same rays 3 rays of one hand (H) (Anaes.) (Assist.) | $1001.60 |
| 46357 | Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with: (d) a service to which item 30023 applies that is performed at the same site; or (e) a service to which item 46363 applies that is performed on one of the same rays 4 rays of one hand (H) (Anaes.) (Assist.) | $1250.00 |
| 46360 | Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with: (d) a service to which item 30023 applies that is performed at the same site; or (e) a service to which item 46363 applies that is performed on one of the same rays 5 rays of one hand (H) (Anaes.) (Assist.) | $1498.40 |
| 46363 | Trigger finger release, for stenosing tenosynovitis, including either or both of the following (if performed): (a) synovectomy; (b) synovial biopsy; one ray (Anaes.) (Assist.) | $461.40 |
| 46364 | Digital sympathectomy of hand, using microsurgical techniques, other than a service associated with: (a) a service to which item 46363 applies; or (b) a service to which item 30023 applies that is performed at the same site one digit or palmer arch (or both) or radial or ulnar artery (or both) (Anaes.) (Assist.) | $1011.10 |
| 46365 | Excision of rheumatoid nodules of hand one lesion (Anaes.) (Assist.) | $571.00 |
| 46367 | De Quervain’s release, including any of the following (if performed): (a) synovectomy of extensor pollicis brevis; (b) synovectomy of abductor pollicis longus tendons; (c) retinaculum reconstruction; other than a service associated with a service to which item 46339 applies (Anaes.) (Assist.) | $862.20 |
| 46370 | Percutaneous fasciotomy for Dupuytren s contracture, by needle or chemical method, including either or both of the following (if performed): (a) immediate or delayed manipulation; (b) local or regional nerve block; one ray (Anaes.) (Assist.) | $277.40 |
| 46372 | Fasciectomy for Dupuytren s contracture, including dissection of nerves (if performed) one ray (H) (Anaes.) (Assist.) | $933.50 |
| 46375 | Fasciectomy for Dupuytren s contracture, including dissection of nerves (if performed) 2 rays (H) (Anaes.) (Assist.) | $1107.30 |
| 46378 | Fasciectomy for Dupuytren s contracture, including dissection of nerves (if performed) 3 rays (H) (Anaes.) (Assist.) | $1471.90 |
| 46379 | Fasciectomy for Dupuytren s contracture, including dissection of nerves (if performed) 4 rays (H) (Anaes.) (Assist.) | $1849.50 |
| 46380 | Fasciectomy for Dupuytren s contracture, including dissection of nerves (if performed) 5 rays (H) (Anaes.) (Assist.) | $2330.20 |
| 46381 | Release of interphalangeal joint of hand, by open procedure, when performed in conjunction with an operation for Dupuytren s contracture one joint (H) (Anaes.) (Assist.) | $652.10 |
| 46384 | Z-plasty or similar local flap procedure, when performed in conjunction with an operation for Dupuytren s contracture, including raising, transfer in-setting and suturing of both components (flaps) one Z-plasty or local flap procedure (H) (Anaes.) (Assist.) | $652.10 |
| 46387 | Fasciectomy for recurrence of Dupuytren s contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site one ray (H) (Anaes.) (Assist.) | $1342.00 |
| 46390 | Fasciectomy for recurrence of Dupuytren s contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site 2 rays (H) (Anaes.) (Assist.) | $1806.00 |
| 46393 | Fasciectomy for recurrence of Dupuytren s contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site 3 rays (H) (Anaes.) (Assist.) | $2086.00 |
| 46394 | Fasciectomy for recurrence of Dupuytren s contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site 4 rays (H) (Anaes.) (Assist.) | $2591.60 |
| 46395 | Fasciectomy for recurrence of Dupuytren s contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site 5 rays (H) (Anaes.) (Assist.) | $3229.60 |
| 46399 | Osteotomy of phalanx or metacarpal of hand, with internal fixation one bone (H) (Anaes.) (Assist.) | $1064.10 |
| 46401 | Operative treatment of non-union of phalanx or metacarpal of hand, including internal fixation (if performed) (Anaes.) (Assist.) | $901.30 |
| 46408 | Reconstruction of tendon of hand or wrist, by tendon graft, including either or both of the following (if performed): (a) harvest of graft; (b) tenolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.) | $1423.80 |
| 46411 | Reconstruction of complete flexor tendon pulley of hand or wrist, with graft, including harvest of graft (if performed) one pulley (H) (Anaes.) (Assist.) | $835.60 |
| 46414 | Insertion of artificial tendon prosthesis in preparation for grafting of tendon of hand or wrist, including tenolysis (if performed), other than a service associated with a service to which item 30023 applies that is performed at the same site (Anaes.) (Assist.) | $1086.50 |
| 46417 | Transfer of tendon of hand or wrist, for restoration of hand or digit motion, including harvest of donor motor unit (if performed) one transfer (H) (Anaes.) (Assist.) | $1001.60 |
| 46420 | Primary repair of extensor tendon of hand or wrist one tendon (Anaes.) (Assist.) | $414.50 |
| 46423 | Delayed repair of extensor tendon of hand or wrist, including tenolysis (if performed), other than a service associated with a service to which item 30023 applies that is performed at the same site (Anaes.) (Assist.) | $669.40 |
| 46426 | Primary repair of flexor tendon of hand or wrist, proximal to A1 pulley one tendon (H) (Anaes.) (Assist.) | $748.10 |
| 46432 | Primary repair of flexor tendon of hand, distal to A1 pulley, other than a service to repair a tendon of a digit if 2 tendons of the same digit have been repaired during the same procedure one tendon (H) (Anaes.) (Assist.) | $1120.20 |
| 46434 | Delayed repair of flexor tendon of hand or wrist, including tenolysis (if performed), other than a service associated with a service to which item 30023 applies that is performed at the same site (Anaes.) (Assist.) | $1054.20 |
| 46438 | Closed pin fixation of mallet finger (Anaes.) | $350.00 |
| 46441 | Open reduction of mallet finger, including any of the following (if performed): (a) joint release; (b) pin fixation; (c) tenolysis (Anaes.) (Assist.) | $680.80 |
| 46442 | MALLET FINGER with intra articular fracture involving more than one third of base of terminal phalanx—open reduction (Anaes.) (Assist.) | $581.50 |
| 46444 | Reconstruction of Boutonniere or swan neck deformity of hand, including either or both of the following (if performed): (a) tendon graft harvest; (b) tendon transfer one joint (H) (Anaes.) (Assist.) | $994.40 |
| 46450 | Tenolysis of extensor tendon of hand or wrist, following tendon injury or graft, other than a service: (a) for acute, traumatic injury; or (b) associated with a service to which item 30023 applies that is performed at the same site; one ray (H) (Anaes.) | $468.90 |
| 46453 | Tenolysis of flexor tendon of hand or wrist, following tendon injury, repair or graft, other than a service: (a) for acute, traumatic injury; or (b) associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.) | $758.90 |
| 46456 | Percutaneous tenotomy of digit of hand (Anaes.) | $201.70 |
| 46464 | Amputation of a supernumerary complete digit of hand (H) (Anaes.) (Assist.) | $466.50 |
| 46465 | Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone; (c) skin cover with local flaps one ray (H) (Anaes.) (Assist.) | $472.60 |
| 46468 | Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone; (c) skin cover with local flaps 2 rays (H) (Anaes.) (Assist.) | $1010.00 |
| 46471 | Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone; (c) skin cover with local flaps 3 rays (H) (Anaes.) (Assist.) | $1237.10 |
| 46474 | Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone; (c) skin cover with local flaps 4 rays (H) (Anaes.) (Assist.) | $1488.00 |
| 46477 | Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone; (c) skin cover with local flaps 5 rays (H) (Anaes.) (Assist.) | $1831.40 |
| 46480 | Amputation of ray of hand, proximal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) recontouring; (c) resection of bone; (d) skin cover with local flaps one ray (H) (Anaes.) (Assist.) | $819.90 |
| 46483 | Revision of amputation stump of hand to provide adequate cover, including any of the following (if performed): (a) bone shortening; (b) excision of nail bed remnants; (c) excision of neuroma (H) (Anaes.) (Assist.) | $652.10 |
| 46486 | Accurate reconstruction of acute nail bed laceration using magnification (H) (Anaes.) | $476.70 |
| 46489 | Secondary reconstruction of nail bed deformity using magnification, including removal of nail (if performed), other than a service associated with a service to which item 46513 or 45451 applies (H) (Anaes.) (Assist.) | $544.60 |
| 46492 | Surgical correction of contracture of joint of hand, flexor or extensor tendon, involving tissues deeper than skin and subcutaneous tissue one joint (H) (Anaes.) (Assist.) | $769.30 |
| 46493 | Resection of boss of metacarpal base of hand, including either or both of the following (if performed): (a) excision of ganglion; (b) synovectomy (Anaes.) (Assist.) | $714.60 |
| 46495 | Complete excision of one or more ganglia or mucous cysts of interphalangeal, metacarpophalangeal or carpometacarpal joint of hand, including any of the following (if performed): (a) arthrotomy; (b) osteophyte resections (c) synovectomy other than a service associated with a service to which item 30107 or 46336 applies one joint (H) (Anaes.) (Assist.) | $440.50 |
| 46498 | Excision of ganglion of flexor tendon sheath of hand, including any of the following (if performed): (a) flexor tenosynovectomy; (b) sheath excision; (c) skin closure by any method; other than a service associated with: (d) a service to which item 30107 applies; or (e) a service to which item 46363 applies that is performed on the same ray (Anaes.) (Assist.) | $451.60 |
| 46500 | Excision of ganglion of dorsal wrist joint of hand, including any of the following (if performed): (a) arthrotomy; (b) capsular or ligament repair (or both); (c) synovectomy other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.) | $538.10 |
| 46501 | Excision of ganglion of volar wrist joint of hand, including any of the following (if performed): (a) arthrotomy; (b) capsular or ligament repair (or both); (c) synovectomy; other than a service associated with a service to which item 30107 or 46325 applies (Anaes.) (Assist.) | $723.30 |
| 46502 | Excision of recurrent ganglion of dorsal wrist joint of hand, including any of the following (if performed): (a) arthrotomy; (b) capsular or ligament repair (or both); (c) synovectomy (Anaes.) (Assist.) | $718.60 |
| 46503 | Excision of recurrent ganglion of volar wrist joint of hand, including any of the following (if performed): (a) arthrotomy; (b) capsular or ligament repair (or both); (c) synovectomy; other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.) | $782.20 |
| 46504 | Neurovascular island flap, heterodigital, for pulp re-innervation and soft tissue cover (Anaes.) (Assist.) | $2396.90 |
| 46507 | Transposition or transfer of digit or ray on vascular pedicle of hand, including any of the following (if performed): (a) nerve transfer; (b) skin closure, by any means; (c) rebalancing procedures (H) (Anaes.) (Assist.) | $3024.60 |
| 46510 | Surgical reduction of enlarged elements resulting from macrodactyly, including any of the following (if performed): (a) nerve transfer; (b) skin closure, by any means; (c) rebalancing procedures one digit (H) (Anaes.) (Assist.) | $902.90 |
| 46513 | Removal of nail of finger or thumb one nail (Anaes.) | $114.60 |
| 46519 | Drainage of midpalmar, thenar or hypothenar spaces or dorsum of hand, excluding aftercare (Anaes.) (Assist.) | $300.80 |
| 46522 | Open operation and drainage of infection for flexor tendon sheath of finger or thumb, including either or both of the following (if performed): (a) synovectomy; (b) tenolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site one digit (H) (Anaes.) (Assist.) | $848.60 |
| 46525 | Incision for pulp space infection of hand: (a) other than a service: (i) to which another item in this Group applies; or (ii) associated with a service to which item 30023 applies that is performed at the same site; and (b) excluding aftercare (H) (Anaes.) | $116.00 |
| 46528 | Wedge resection for ingrowing nail of finger or thumb: (a) including each of the following: (i) excision and partial ablation of germinal matrix; (ii) removal of segment of nail; (iii) removal of ungual fold; and (b) including phenolisation (if performed) (Anaes.) | $343.80 |
| 46531 | Partial resection of ingrowing nail of finger or thumb,including phenolisation (Anaes.) | $172.80 |
| 46534 | Complete ablation of nail germinal matrix (H) (Anaes.) (Assist.) | $500.90 |
| **Orthopaedic** | | |
| 47000 | Mandible, treatment of dislocation of, by closed reduction, requiring general anaesthesia or intravenous sedation, if performed in the operating theatre of a hospital (H) (Anaes.) | $132.80 |
| 47003 | Treatment of dislocation of clavicle, by closed reduction (Anaes.) | $151.00 |
| 47007 | Repair of acromioclavicular or sternoclavicular joint dislocation (acute or chronic), by open, mini-open or arthroscopic technique, including either or both of the following (if performed): (a) ligament augmentation; (b) tendon transfers (Anaes.) (Assist.) | $765.60 |
| 47009 | Treatment of dislocation of shoulder, requiring general anaesthesia, other than a service to which item 47012 applies (Anaes.) | $364.80 |
| 47012 | Treatment of dislocation of shoulder, requiring general anaesthesia, by open reduction (H) (Anaes.) (Assist.) | $728.90 |
| 47015 | Treatment of dislocation of shoulder, not requiring general anaesthesia | $151.00 |
| 47018 | Treatment of dislocation of elbow, by closed reduction (Anaes.) | $376.80 |
| 47021 | Treatment of dislocation of elbow, by open reduction (H) (Anaes.) (Assist.) | $545.20 |
| 47024 | Treatment of dislocation of distal or proximal radioulnar joint, by closed reduction, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of treating fracture or dislocation in the same region (Anaes.) | $406.60 |
| 47027 | Treatment of dislocation of distal or proximal radioulnar joint, by open reduction, including either or both of the following (if performed): (a) styloid fracture; (b) triangular fibrocartilage complex repair; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of treating fracture or dislocation in the same region (Anaes.) (Assist.) | $630.30 |
| 47030 | Treatment of dislocation of carpus, carpus on radius and ulna or carpometacarpal joint, by closed reduction (Anaes.) | $421.50 |
| 47033 | Treatment of dislocation of carpus, carpus on radius and ulna or carpometacarpal joint, by open reduction, including ligament repair (if performed) (Anaes.) (Assist.) | $623.40 |
| 47042 | Treatment of dislocation of interphalangeal or metacarpophalangeal joint, by closed reduction (Anaes.) | $203.80 |
| 47045 | Treatment of dislocation of interphalangeal or metacarpophalangeal joint, by open reduction, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) ligament repair; (d) volar plate repair (Anaes.) (Assist.) | $358.50 |
| 47047 | Treatment of dislocation of prosthetic hip, by closed reduction (Anaes.) (Assist.) | $704.30 |
| 47049 | Treatment of dislocation of prosthetic hip, by open reduction (Anaes.) (Assist.) | $938.90 |
| 47052 | Treatment of dislocation of native hip, by closed reduction (Anaes.) (Assist.) | $915.70 |
| 47053 | Treatment of dislocation of native hip, by open reduction, with internal fixation (if performed) (Anaes.) (Assist.) | $1220.60 |
| 47054 | Treatment of dislocation of knee, by closed reduction, including application of external fixator (if performed) (Anaes.) (Assist.) | $673.70 |
| 47057 | Treatment of dislocation of patella, by closed reduction (Anaes.) | $225.70 |
| 47060 | Treatment of dislocation of patella, by open reduction (Anaes.) (Assist.) | $302.60 |
| 47063 | Treatment of dislocation of ankle or tarsus, by closed reduction (Anaes.) (Assist.) | $451.80 |
| 47066 | Treatment of dislocation of ankle or tarsus, by open reduction, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint (H) (Anaes.) (Assist.) | $696.70 |
| 47069 | Treatment of dislocation of toe, by closed reduction one toe (Anaes.) | $126.00 |
| 47301 | Treatment of fracture of middle or proximal phalanx, by closed reduction, requiring anaesthesia one bone (Anaes.) | $170.30 |
| 47304 | Treatment of fracture of metacarpal, by closed reduction, requiring anaesthesia onebone (H) (Anaes.) | $194.20 |
| 47307 | Treatment of fracture of phalanx or metacarpal, by closed reduction, including percutaneous K wire fixation (if performed) one bone (H) (Anaes.) (Assist.) | $392.30 |
| 47310 | Treatment of fracture of phalanx or metacarpal, by open reduction, with internal fixation (H) (Anaes.) (Assist.) | $647.20 |
| 47313 | Treatment of intra-articular fracture of phalanx or metacarpal, by closed reduction, including: (a) percutaneous K-wire fixation; and (b) external or dynamic fixation (if performed) (H) (Anaes.) (Assist.) | $627.80 |
| 47316 | Treatment of intra articular fracture of phalanx or metacarpal, by open reduction with fixation, other than a service provided on the same occasion as a service to which item 47319 applies (H) (Anaes.) (Assist.) | $1245.40 |
| 47319 | Treatment of intra-articular fracture of proximal end of middle phalanx, by open reduction, with fixation, other than a service provided on the same occasion as a service to which item 47316 applies (H) (Anaes.) (Assist.) | $1275.00 |
| 47348 | Treatment of fracture of carpus (excluding scaphoid), by cast immobilisation, other than a service associated with a service to which item 47351 applies (Anaes.) | $190.80 |
| 47351 | Treatment of fracture of carpus (excluding scaphoid), by open reduction, with internal fixation (Anaes.) (Assist.) | $502.00 |
| 47354 | Treatment of fracture of carpal scaphoid, by cast immobilisation, other than a service associated with a service to which item 47357 applies (Anaes.) | $343.80 |
| 47357 | Treatment of fracture of carpal scaphoid, by reduction, with fixation by any means (Anaes.) (Assist.) | $847.50 |
| 47361 | Treatment of fracture of distal end of radius or ulna (or both), by cast immobilisation, other than a service associated with a service to which item 47362, 47364, 47367, 47370 or 47373 applies | $258.60 |
| 47362 | Treatment of fracture of distal end of radius or ulna (or both), 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.) | $387.50 |
| 47364 | Treatment of fracture of distal end of radius or ulna (not involving joint surface), by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (H) (Anaes.) (Assist.) | $549.40 |
| 47367 | Treatment of fracture of distal end of radius, by closed reduction with percutaneous fixation, other than a service associated with a service to which item 47361 or 47362 applies (H) (Anaes.) (Assist.) | $438.80 |
| 47370 | Treatment of intra articular fracture of distal end of radius, by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (H) (Anaes.) (Assist.) | $796.20 |
| 47373 | Treatment of intra articular fracture of distal end of ulna, by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (H) (Anaes.) (Assist.) | $568.90 |
| 47381 | Treatment of fracture of shaft of radius or ulna, by closed reduction (H) (Anaes.) | $523.90 |
| 47384 | Treatment of fracture of shaft of radius or ulna, by open reduction with internal fixation (H) (Anaes.) (Assist.) | $697.50 |
| 47385 | Treatment of: (a) fracture of shaft of radius or ulna; and (b) dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury); by closed reduction (H) (Anaes.) (Assist.) | $601.30 |
| 47386 | Treatment of: (a) fracture of shaft of radius or ulna; and (b) dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury); by open reduction, with internal fixation, including reduction of dislocation (if performed) (H) (Anaes.) (Assist.) | $1011.50 |
| 47387 | Treatment of fracture of distal or shaft of radius or ulna (or both), by cast immobilisation, other than a service to which item 47390 or 47393 applies (Anaes.) (Assist.) | $553.70 |
| 47390 | Treatment of fracture of shafts of radius and ulna, by closed reduction (H) (Anaes.) | $844.90 |
| 47393 | Treatment of fracture of shafts of radius and ulna, by open reduction, with internal fixation (H) (Anaes.) (Assist.) | $1127.40 |
| 47396 | Treatment of fracture of olecranon, by closed reduction (Anaes.) | $381.80 |
| 47399 | Treatment of fracture of olecranon, by open reduction (H) (Anaes.) (Assist.) | $762.00 |
| 47402 | Treatment of fracture of olecranon, with excision of olecranon fragment and reimplantation of tendon (Anaes.) (Assist.) | $705.00 |
| 47405 | Treatment of fracture of head or neck of radius, by closed reduction (Anaes.) | $381.80 |
| 47408 | Treatment of fracture of head or neck of radius, by open reduction, including internal fixation and excision (if performed) (H) (Anaes.) (Assist.) | $797.30 |
| 47411 | Treatment of fracture of tuberosity of humerus, other than a service to which item 47417 applies (Anaes.) | $229.00 |
| 47414 | Treatment of fracture of tuberosity of humerus, by open reduction (Anaes.) | $530.80 |
| 47417 | Treatment of fracture of tuberosity of humerus and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) | $543.40 |
| 47420 | Treatment of fracture of tuberosity of humerus and associated dislocation of shoulder, by open reduction (H) (Anaes.) (Assist.) | $1288.40 |
| 47423 | Humerus, proximal, treatment of fracture of, other than a service to which item 47426, 47429 or 47432 applies (Anaes.) | $445.00 |
| 47426 | Humerus, proximal, treatment of fracture of, by closed reduction (H) (Anaes.) | $820.00 |
| 47429 | Humerus, proximal, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.) | $940.40 |
| 47432 | Humerus, proximal, treatment of intra articular fracture of, by open reduction (H) (Anaes.) (Assist.) | $1117.40 |
| 47435 | HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) | $881.20 |
| 47438 | Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (H) (Anaes.) (Assist.) | $1368.20 |
| 47441 | Humerus, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction (H) (Anaes.) (Assist.) | $1804.30 |
| 47444 | Humerus, shaft of, treatment of fracture of, other than a service to which item 47447 or 47450 applies (Anaes.) | $489.80 |
| 47447 | Humerus, shaft of, treatment of fracture of, by closed reduction (H) (Anaes.) | $703.70 |
| 47450 | Humerus, shaft of, treatment of fracture of, by internal or external fixation (H) (Anaes.) (Assist.) | $968.70 |
| 47451 | Humerus, shaft of, treatment of fracture of, by intramedullary fixation (H) (Anaes.) (Assist.) | $1159.90 |
| 47453 | Humerus, distal, (supracondylar or condylar), treatment of fracture of, other than a service to which item 47456 or 47459 applies (Anaes.) (Assist.) | $534.80 |
| 47456 | Humerus, distal (supracondylar or condylar), treatment of fracture of, by closed reduction (H) (Anaes.) (Assist.) | $820.30 |
| 47459 | Humerus, distal (supracondylar or condylar), treatment of fracture of, by open reduction (H) (Anaes.) (Assist.) | $1091.90 |
| 47462 | Clavicle, treatment of fracture of, other than a service to which item 47465 applies (Anaes.) | $229.00 |
| 47465 | CLAVICLE, treatment of fracture of, by open reduction (Anaes.) (Assist.) | $693.30 |
| 47466 | Sternum, treatment of fracture of, other than a service to which item 47467 applies (Anaes.) | $229.00 |
| 47467 | Sternum, treatment of fracture of, by open reduction (H) (Anaes.) | $480.50 |
| 47468 | SCAPULA, neck or glenoid region of, treatment of fracture of, by open reduction (Anaes.) (Assist.) | $918.40 |
| 47471 | RIBS (one or more), treatment of fracture of—each attendance | $87.30 |
| 47474 | Pelvic ring, treatment of fracture of, not involving disruption of pelvic ring or acetabulum | $390.70 |
| 47477 | PELVIC RING, treatment of fracture of, with disruption of pelvic ring or acetabulum | $488.60 |
| 47480 | PELVIC RING, treatment of fracture of, requiring traction (H) (Anaes.) (Assist.) | $1094.10 |
| 47483 | PELVIC RING, treatment of fracture of, requiring control by external fixation (H) (Anaes.) (Assist.) | $1203.60 |
| 47486 | Treatment of fracture of anterior pelvic ring or sacroiliac joint disruption (or both), by open reduction, with internal fixation (H) (Anaes.) (Assist.) | $1935.60 |
| 47489 | Treatment of fracture of posterior pelvic ring or sacroiliac joint disruption (or both), by open reduction, with internal fixation (H) (Anaes.) (Assist.) | $3004.00 |
| 47491 | Combined anterior and posterior pelvic ring disruption, including sacroiliac joint disruption, treatment of fracture by open reduction and internal fixation of both anterior and posterior ring segments (H) (Anaes.) (Assist.) | $3368.70 |
| 47495 | Treatment of fracture of acetabulum and associated dislocation of hip, including the application and management of traction (if performed), excluding aftercare (Anaes.) (Assist.) | $1010.40 |
| 47498 | Treatment of isolated posterior wall fracture of acetabulumand associated dislocation of hip, by open reduction, with internal fixation, including the application and management of traction (if performed) (H) (Anaes.) (Assist.) | $1502.00 |
| 47501 | Treatment of anterior or posterior column fracture of acetabulum, by open reduction, with internal fixation, including any of the following (if performed): (a) capsular stabilisation; (b) capsulotomy; (c) osteotomy (H) (Anaes.) (Assist.) | $1919.90 |
| 47511 | Treatment of combined column T-Type, transverse, anterior column or posterior hemitransverse fractures of acetabulum, by open reduction, with internal fixation, performed through single or dual approach (including fixation of the posterior wall fracture), including any of the following (if performed): (a) capsular stabilisation; (b) capsulotomy; (c) osteotomy (H) (Anaes.) (Assist.) | $3062.50 |
| 47514 | Treatment of posterior wall fracture of acetabulum and associated femoral head fracture, by open reduction, with internal fixation (H) (Anaes.) (Assist.) | $1786.40 |
| 47516 | FEMUR, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.) | $923.90 |
| 47519 | FEMUR, treatment of trochanteric or subcapital fracture of, by internal fixation (H) (Anaes.) (Assist.) | $1783.30 |
| 47528 | FEMUR, treatment of fracture of, by internal fixation or external fixation (H) (Anaes.) (Assist.) | $1602.40 |
| 47531 | FEMUR, treatment of fracture of shaft, by intramedullary fixation and cross fixation (H) (Anaes.) (Assist.) | $2043.40 |
| 47534 | Femur, condylar region of, treatment of intra articular (T shaped condylar) fracture of, requiring internal fixation, with or without internal fixation of one or more osteochondral fragments (H) (Anaes.) (Assist.) | $2334.40 |
| 47537 | Femur, condylar region of, treatment of fracture of, requiring internal fixation of one or more osteochondral fragments, other than a service associated with a service to which item 47534 applies (Anaes.) (Assist.) | $893.40 |
| 47540 | HIP SPICA OR SHOULDER SPICA, application of, as an independent procedure (Anaes.) | $446.90 |
| 47543 | Tibia, plateau of, treatment of medial or lateral fracture of, other than a service to which item 47546 or 47549 applies (Anaes.) | $458.60 |
| 47546 | TIBIA, plateau of, treatment of medial or lateral fracture of, by closed reduction (Anaes.) | $721.30 |
| 47549 | Treatment of medial or lateral fracture of plateau of tibia, by open reduction, with internal fixation, including any of the following (if performed): (a) arthroscopy; (b) arthrotomy; (c) meniscal repair (H) (Anaes.) (Assist.) | $1085.60 |
| 47552 | Tibia, plateau of, treatment of both medial and lateral fractures of, other than a service to which item 47555 or 47558 applies (Anaes.) (Assist.) | $802.30 |
| 47555 | Tibia, plateau of, treatment of both medial and lateral fractures of, by closed reduction (H) (Anaes.) | $1203.60 |
| 47558 | Treatment of medial and lateral fractures of tibia, by open reduction, with internal fixation, including any of the following (if performed): (a) arthroscopy; (b) arthrotomy; (c) meniscal repair (H) (Anaes.) (Assist.) | $1838.80 |
| 47559 | Treatment of medial or lateral (or both) fracture of plateau of tibia, with application of a bridging external fixator to the plateau (Anaes.) (Assist.) | $1657.50 |
| 47561 | Treatment of fracture of shaft of tibia, by cast immobilisation, other than a service to which item 47570 or 47573 applies (Anaes.) | $553.70 |
| 47565 | Tibia, shaft of, treatment of fracture of, by internal fixation or external fixation (H) (Anaes.) (Assist.) | $1479.20 |
| 47566 | Tibia, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (H) (Anaes.) (Assist.) | $1877.40 |
| 47568 | Closed reduction of proximal tibia, distal tibia or shaft of tibia, with or without treatment of fibular fracture (Anaes.) (Assist.) | $888.20 |
| 47570 | TIBIA, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (Anaes.) (Assist.) | $1161.90 |
| 47573 | Treatment of proximal or distal intra-articular fracture of shaft of tibia, by open reduction, with or without treatment of fibular fracture, including any of the following (if performed): (a) arthroscopy; (b) arthrotomy; (c) capsule repair; (d) removal of intervening soft tissue; (e) removal of loose fragments; (f) washout of joint; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of treating a medial malleolus fracture of the distal tibia (H) (Anaes.) (Assist.) | $1466.00 |
| 47577 | Treatment of fracture of fibula proximal to ankle, by open reduction, with internal fixation, including any of the following (if performed): (a) internal fixation; (b) arthrotomy; (c) capsule repair; (d) removal of loose fragments or intervening soft tissue; (e) washout of joint (H) (Anaes.) (Assist.) | $932.60 |
| 47579 | Treatment of fracture of patella, other than a service to which item 47582 or 47585 applies (Anaes.) | $324.80 |
| 47582 | Treatment of fracture of patella, with internal fixation, including bone grafting (if performed), other than a service associated with a service to which item 47579 or 47585 applies (H) (Anaes.) (Assist.) | $802.50 |
| 47585 | Treatment of proximal or distal fracture of patella, by open reduction, with internal fixation, including any of the following (if performed): (a) arthrotomy; (b) excision of patellar pole, with reattachment of tendon; (c) removal of loose fragments; (d) repair of quadriceps or patellar tendon (or both); (e) stabilisation of patello-femoral joint (H) (Anaes.) (Assist.) | $946.40 |
| 47588 | Knee joint, treatment of fracture of, by internal fixation of intra articular fractures of femoral condylar or tibial articular surfaces and requiring repair or reconstruction of one or more ligaments (H) (Anaes.) (Assist.) | $2806.00 |
| 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 one or more ligaments (H) (Anaes.) (Assist.) | $3411.00 |
| 47592 | Repair or reconstruction (or both) of acute traumatic chondral injury to the distal femoral or proximal tibial articular surfaces of the knee, when chondral or osteochondral implants or transfers are utilised (H) (Anaes.) (Assist.) | $707.00 |
| 47593 | Repair or reconstruction (or both) of acute traumatic chondral injury to the distal femoral and proximal tibial articular surfaces of the knee, using chondral or osteochondral implants or transfers (H) (Anaes.) (Assist.) | $1730.50 |
| 47595 | Treatment of fracture of ankle joint, hindfoot, midfoot, metatarsals or toes, by non-surgical management one leg (Anaes.) | $349.40 |
| 47597 | Treatment of fracture of ankle joint, by closed reduction (Anaes.) (Assist.) | $667.50 |
| 47600 | Treatment of fracture of ankle joint: (a) by internal fixation of the malleolus, fibula or diastasis; and (b) including any of the following (if performed): (i) arthrotomy; (ii) capsule repair; (iii) removal of loose fragments or intervening soft tissue; (iv) washout of joint (H) (Anaes.) (Assist.) | $1043.70 |
| 47603 | Treatment of fracture of ankle joint: (a) by internal fixation of 2 or more of the malleolus, fibula, diastasis and medial tissue interposition; and (b) including any of the following (if performed): (i) arthrotomy; (ii) capsule repair; (iii) removal of loose fragments or intervening soft tissue; (iv) washout of joint (H) (Anaes.) (Assist.) | $1331.10 |
| 47612 | Treatment of intra-articular fracture of hindfoot, by closed reduction, with or without dislocation one foot (Anaes.) (Assist.) | $894.30 |
| 47615 | Treatment of fracture of hindfoot, by open reduction, with or without dislocation, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint one hindfoot bone (Anaes.) (Assist.) | $1010.40 |
| 47618 | Treatment of intra-articular fracture of hindfoot, by open reduction, with or without dislocation, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint one hindfoot bone (H) (Anaes.) (Assist.) | $1226.50 |
| 47621 | Treatment of intra-articular fracture of midfoot, by closed reduction, with or without dislocation one foot (Anaes.) (Assist.) | $842.00 |
| 47624 | Treatment of fracture of tarso-metatarsal, by open reduction, with or without dislocation, including any of the following (if performed): (a) arthrotomy; (b) capsule or ligament repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint one joint (H) (Anaes.) (Assist.) | $1219.20 |
| 47630 | Treatment of fracture of cuneiform, by open reduction, with or without dislocation, including any of the following (if performed): (a) arthrotomy; (b) capsule or ligament repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint one bone (Anaes.) (Assist.) | $698.30 |
| 47637 | Treatment of fractures of metatarsal, by closed reduction one or more metatarsals of one foot (Anaes.) (Assist.) | $416.00 |
| 47639 | Treatment of fracture of metatarsal, by open reduction, including removal of loose fragments or intervening soft tissue (if performed) one metatarsal of one foot (Anaes.) (Assist.) | $494.00 |
| 47648 | Treatment of fracture of metatarsal, by open reduction, including removal of loose fragments or intervening soft tissue (if performed) 2 metatarsals of one foot (H) (Anaes.) (Assist.) | $609.10 |
| 47657 | Treatment of fracture of metatarsal, by open reduction, including removal of loose fragments or intervening soft tissue (if performed) 3 or more metatarsals of one foot (H) (Anaes.) (Assist.) | $1001.00 |
| 47663 | Treatment of fracture of phalanx of toe, by closed reduction one toe (Anaes.) | $286.80 |
| 47666 | Treatment of fracture or dislocation of phalanx of great toe, by open reduction, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments; (d) removal of intervening soft tissue; (e) washout of joint one great toe (Anaes.) | $581.10 |
| 47672 | Treatment of fracture or dislocation of phalanx of toe, by open reduction, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments; (d) removal of intervening soft tissue; (e) washout of joint one toe (other than great toe) of one foot (Anaes.) | $244.80 |
| 47678 | Treatment of fracture or dislocation of phalanx of toe, by open reduction, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments; (d) removal of intervening soft tissue; (e) washout of joint 2 or more toes (other than great toe) of one foot (Anaes.) | $349.70 |
| 47735 | Nasal bones, treatment of fracture of, other than a service to which item 47738 or 47741 applies each attendance | $92.10 |
| 47738 | Nasal bones, treatment of fracture of, by reduction (Anaes.) | $600.40 |
| 47741 | Nasal bones, treatment of fracture of, by open reduction involving osteotomies (H) (Anaes.) (Assist.) | $1066.10 |
| 47753 | Maxilla or mandible, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (H) (Anaes.) (Assist.) | $1020.00 |
| 47762 | Zygomatic arch, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach, other than a service associated with a service to which another item in this Group applies (Anaes.) | $562.40 |
| 47765 | Zygomaticomaxillary complex/malar, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at one or more sites (H) (Anaes.) (Assist.) | $938.90 |
| 47766 | Naso-orbital-ethmoidal complex, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at one or more sites (H) (Anaes.) (Assist.) | $1084.30 |
| 47786 | Maxilla, treatment of fracture of, requiring open reduction and internal fixation involving one or more plates (H) (Anaes.) (Assist.) | $1800.00 |
| 47789 | Mandible, treatment of fracture of, requiring open reduction and internal fixation involving one or more plates (H) (Anaes.) (Assist.) | $1555.10 |
| 47790 | Tendon, large, lengthening of, as an independent procedure (Anaes.) (Assist.) | $527.70 |
| 47791 | Tenosynovectomy, not being a service associated with a service to which another item in this Group applies (Anaes.) (Assist.) | $492.70 |
| 47792 | Joint stabilisation procedure of acromioclavicular joint orsternoclavicular joint, including any of the following (if performed): (a) arthrotomy; (b) osteotomy, with or without fixation; (c) local tendon transfer; (d) local tendon lengthening or release; (e) ligament repair; (f) joint debridement; not being a service associated with a service to which another item in this Group applies (H) (Anaes.) (Assist.) | $879.80 |
| 47795 | Joint stabilisation procedure of scapulothoracic joint, other than a service associated with a service to which another item in this Group (other than item 38828 or 48406) applies (H) (Anaes.) (Assist.) | $777.20 |
| 47900 | Injection into, or aspiration of, unicameral bone cyst (Anaes.) | $350.00 |
| 47903 | Epicondylitis, open operation for (Anaes.) | $573.90 |
| 47904 | DIGITAL NAIL OF TOE, removal of, not being a service to which item 47906 applies (Anaes.) | $114.60 |
| 47906 | Digital nail of toe, removal of, in the operating theatre of a hospital(H) (Anaes.) | $234.30 |
| 47915 | Wedge resection for ingrowing nail of toe: (a) including each of the following: (i) removal of segment of nail; (ii) removal of ungual fold; (iii) excision and partial ablation of germinal matrix and portion of nail bed; and (b) including phenolisation (if performed) (Anaes.) (Assist.) | $348.00 |
| 47916 | Partial resection for ingrowing nail of toe, including phenolisation (Anaes.) | $172.80 |
| 47918 | Complete ablation of nail germinal matrix: (a) including each of the following: (i) removal of segment of nail; (ii) removal of ungual fold; (iii) excision and ablation of germinal matrix and portion of nail bed; and (b) including phenolisation (if performed) (Anaes.) (Assist.) | $487.70 |
| 47921 | Orthopaedic pin or wire, insertion of, as an independent procedure (Anaes.) | $250.30 |
| 47924 | Removal of one or more buried wires, pins or screws (inserted for internal fixation purposes), with incision, other than a service associated with a service to which item 47927 or 47929 applies one bone (Anaes.) | $77.60 |
| 47927 | Removal of one or more buried wires, pins or screws (inserted for internal fixation purposes) one bone (H) (Anaes.) | $288.20 |
| 47929 | Removal of fixation elements (including plate, rod or nail and associated wires, pins, screws or external fixation), other than a service associated with a service to which item 47924 or 47927 applies one bone (H) (Anaes.) (Assist.) | $816.60 |
| 47953 | Repair of distal biceps brachii tendon, by any method, performed as an independent procedure (Anaes.) (Assist.) | $938.90 |
| 47954 | Repair of traumatic tear or rupture of tendon, other than a service associated with: (a) a service to which item 39330 applies; or (b) a service to which another item in this Schedule applies if the service described in the other item is for the purpose of repairing peripheral nerve items in the same region (Anaes.) (Assist.) | $792.40 |
| 47955 | Repair of gluteal or rectus femoris tendon, by open or arthroscopic means, when performed as an independent procedure, including either or both of the following (if performed): (a) bursectomy; (b) preparation of greater trochanter; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the hip (H) (Anaes.) (Assist.) | $1413.10 |
| 47956 | Repair of proximal hamstring tendon, performed as an independent procedure, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the hip (H) (Anaes.) (Assist.) | $2119.80 |
| 47960 | TENOTOMY, SUBCUTANEOUS, not being a service to which another item in this Group applies (Anaes.) | $280.00 |
| 47964 | Iliopsoas tenotomy, by open or arthroscopic means, when performed as an independent procedure, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the hip (H) (Anaes.) (Assist.) | $469.50 |
| 47967 | Restoration of shoulder or elbow function by major muscle tendon transfer, including associated dissection of neurovascular pedicle, excluding micro-anastomosis and biceps tenodesis one transfer (H) (Anaes.) (Assist.) | $938.90 |
| 47968 | Open tenotomy of one or more tendons of shoulder, with or without tenoplasty, to restore shoulder function, other than a service to which another item in this Group applies applicable once per joint per occasion on which this service is performed (Anaes.) | $357.50 |
| 47970 | Open tenotomy of one or more tendons of scapula, with or without tenoplasty, to restore scapula function, other than a service to which another item in this Group applies applicable once per joint per occasion on which this service is performed (Anaes.) | $357.50 |
| 47973 | Open tenotomy of one or more tendons of elbow, with or without tenoplasty, to restore elbow function, other than a service to which another item in this Group applies applicable once per joint per occasion on which this service is performed (Anaes.) | $357.50 |
| 47975 | Forearm or calf, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue(H) (Anaes.) (Assist.) | $798.00 |
| 47978 | Forearm or calf, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue(H) (Anaes.) | $558.10 |
| 47981 | Forearm, calf or interosseous muscle space of hand, decompression fasciotomy of, other than a service to which another item in this Group applies (Anaes.) | $371.30 |
| 47982 | Forage (Drill decompression), of neck or head of femur, or both (H) (Anaes.) (Assist.) | $779.30 |
| 47983 | Stabilisation of slipped capital femoral epiphysis, by internal fixation (H) (Anaes.) (Assist.) | $1878.50 |
| 47984 | Open subcapital realignment of slipped capital femoral epiphysis, other than a service associated with a service to which item 48427 applies (H) (Anaes.) (Assist.) | $1878.50 |
| 48245 | Harvesting and insertion of bone graft (autograft) via separate incisions and at separate surgical fields (H) (Anaes.) (Assist.) | $678.30 |
| 48248 | Harvesting and insertion of bone graft (autograft) via separate incisions, including internal fixation of the graft or fusion fixation (or both) (H) (Anaes.) (Assist.) | $1050.40 |
| 48251 | Harvesting and insertion of osteochondral graft (autograft) via separate incisions at the same joint or joint complex (H) (Anaes.) (Assist.) | $864.40 |
| 48254 | Harvesting and insertion of pedicled bone flap (autograft), including internal fixation of the bone flap (if performed), other than a service associated with a service to which item 45562, 45504 or 45505 applies (H) (Anaes.) (Assist.) | $1980.50 |
| 48257 | Preparation and insertion of metallic, cortical or other graft substitute (allograft), where substitute is structural cortico-cancellous bone or structural bone (or both), including internal fixation (if performed) (H) (Anaes.) (Assist.) | $864.40 |
| 48400 | Operation on foot: (a) with either or both of the following: (i) osteotomy of phalanx or metatarsal for correction of deformity; (ii) excision of accessory bone or sesamoid bone; and (b) including any of the following (if performed): (i) removal of bone; (ii) excision of surrounding osteophytes; (iii) synovectomy; (iv) joint release; one bone (H) (Anaes.) (Assist.) | $726.50 |
| 48403 | Osteotomy of phalanx of first toe or metatarsal, for correction of deformity, with internal fixation, including any of the following (if performed): (a) removal of bone; (b) excision of surrounding osteophytes; (c) synovectomy; (d) joint release; one bone (H) (Anaes.) (Assist.) | $1075.00 |
| 48406 | Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, for correction of deformity, including any of the following (if performed): (a) removal of bone; (b) excision of surrounding osteophytes; (c) synovectomy; (d) joint release; one bone (H) (Anaes.) (Assist.) | $680.80 |
| 48409 | Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, for correction of deformity, with internal fixation, including any of the following (if performed): (a) removal of bone; (b) excision of surrounding osteophytes; (c) synovectomy; (d) joint release; one bone (H) (Anaes.) (Assist.) | $1113.70 |
| 48412 | Osteotomy of humerus, without internal fixation (H) (Anaes.) (Assist.) | $1310.20 |
| 48415 | Osteotomy of humerus, with internal fixation (H) (Anaes.) (Assist.) | $1651.30 |
| 48419 | Osteotomy of distal tibia, for correction of deformity, without internal or external fixation, including any of the following (if performed): (a) excision of surrounding osteophytes; (b) release of joint; (c) removal of bone; (d) synovectomy; one bone (H) (Anaes.) (Assist.) | $1367.70 |
| 48420 | Osteotomy of distal tibia, for correction of deformity, with internal or external fixation by any method, including any of the following (if performed): (a) excision of surrounding osteophytes; (b) release of joint; (c) removal of bone; (d) synovectomy; one bone (H) (Anaes.) (Assist.) | $1735.40 |
| 48421 | Osteotomy of proximal tibia, to alter lower limb alignment or rotation (or both), with internal or external fixation (or both) (H) (Anaes.) (Assist.) | $1984.70 |
| 48422 | Osteotomy of distal femur, to alter lower limb alignment or rotation (or both), with internal or external fixation (or both) (H) (Anaes.) (Assist.) | $1980.50 |
| 48423 | Osteotomy of pelvis, in a patient aged 18 years or over, including any of the following (if performed): (a) associated intra-articular procedures; (b) bone grafting; (c) internal fixation (H) (Anaes.) (Assist.) | $1633.60 |
| 48424 | Osteotomy of pelvis, in a patient aged less than 18 years, with application of hip spica, including internal fixation (if performed), other than a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) | $1718.10 |
| 48426 | Osteotomy of femur, in a patient aged 18 years or over, including either or both of the following (if performed): (a) bone grafting; (b) internal fixation (H) (Anaes.) (Assist.) | $1980.50 |
| 48427 | Osteotomy of femur, in a patient aged less than 18 years, including internal fixation (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) | $1964.70 |
| 48430 | Excision of one or more osteophytes of the foot or ankle, or simple removal of bunion, including any of the following (if performed): (a) capsulotomy; (b) excision of surrounding osteophytes; (c) release of ligaments; (d) removal of one or more associated bursae or ganglia; (e) removal of bone; (f) synovectomy; each incision (H) (Anaes.) (Assist.) | $581.90 |
| 48433 | Treatment of non-union or malunion, with preservation of the joint, for ankle or hindfoot fracture, with internal or external fixation by any method, including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) excision of surrounding osteophytes; (d) osteotomy; (e) release of joint; (f) removal of bone; (g) removal of hardware; (h) synovectomy; one bone (H) (Anaes.) (Assist.) | $2317.40 |
| 48435 | Treatment of non-union or malunion, with preservation of the joint, for midfoot or forefoot fracture, with internal or external fixation by any method, including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) excision of surrounding osteophytes; (d) osteotomy; (e) release of joint; (f) removal of bone; (g) removal of hardware; (h) synovectomy; one bone (H) (Anaes.) (Assist.) | $1225.00 |
| 48436 | Excision of one or more exostoses of the hand, distal to the wrist, including any of the following (if performed): (a) excision of surrounding osteophytes; (b) release of ligaments; (c) removal of one or more associated bursae or ganglia; (d) removal of bone; (e) synovectomy; other than a service associated with a service to which another item in this Schedule applies that: (f) is an arthroscopic procedure, arthrodesis, arthroplasty or osteotomy, or involves the removal of hardware; and (g) is performed on the same joint or bone; each incision (H) (Anaes.) (Assist.) | $443.00 |
| 48438 | Excision of one or more exostoses in the wrist including any of the following (if performed): (a) capsulotomy; (b) excision of surrounding osteophytes; (c) release of ligaments; (d) removal of one or more associated bursae or ganglia; (e) removal of bone; (f) synovectomy; other than: (g) a service to which 48436 applies; or (h) a service associated with a service to which another item in this Schedule applies that: (i) is an arthroscopic procedure, arthrodesis, arthroplasty or osteotomy, or involves the removal of hardware; and (ii) is performed on the same joint or bone; each incision (H) (Anaes.) (Assist.) | $443.00 |
| 48440 | Excision of one or more exostoses in the arm or shoulder, including the radius, ulna, humerus, acromion, clavicle, or scapula, including any of the following (if performed): (a) capsulotomy; (b) excision of surrounding osteophytes; (c) release of ligaments; (d) removal of one or more associated bursae or ganglia; (e) removal of bone; (f) synovectomy; other than: (g) a service to which 48438 applies; or (h) a service associated with a service to which another item in this Schedule applies that: (i) is an arthroscopic procedure, arthrodesis, arthroplasty or osteotomy, or involves the removal of hardware; and (ii) is performed on the same joint or bone; each incision (H) (Anaes.) (Assist.) | $443.00 |
| 48442 | Excision of one or more exostoses in the hip, including pelvis and femur, including any of following (if performed): (a) capsulotomy; (b) excision of surrounding osteophytes; (c) release of ligaments; (d) removal of one or more associated bursae or ganglia; (e) removal of bone; (f) synovectomy; other than: (g) a service to which 48444 applies; or (h) a service associated with a service to which another item in this Schedule applies that: (i) is an arthroscopic procedure, arthrodesis, arthroplasty or osteotomy, or involves the removal of hardware; and (ii) is performed on the same joint or bone; each incision (H) (Anaes.) (Assist.) | $443.00 |
| 48444 | Excision of one or more exostoses in the knee, tibia or fibula, including any of following (if performed): (a) capsulotomy; (b) excision of surrounding osteophytes; (c) release of ligaments; (d) removal of one or more associated bursae or ganglia; (e) removal of bone; (f) synovectomy; other than: (g) a service to which item 48430 applies; or (h) a service associated with a service to which another item in this Schedule applies that: (i) is an arthroscopic procedure, arthrodesis, arthroplasty or osteotomy, or involves the removal of hardware; and (ii) is performed on the same joint or bone; each incision (H) (Anaes.) (Assist.) | $443.00 |
| 48446 | Treatment of non-union or malunion of fracture of pelvis, including bone graft, and including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) osteotomy; (d) removal of hardware; (e) internal fixation; other than a service associated with a service to which item 48245, 48248, 48251, 48254, 48257 or 47929 applies that is performed on the same bone one bone (H) (Anaes.) (Assist.) | $1992.30 |
| 48448 | Treatment of non-union or malunion of fracture of femur, including bone graft, and including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) osteotomy; (d) removal of hardware; (e) internal fixation; other than a service associated with a service to which item 48245, 48248, 48251, 48254, 48257 or 47929 applies that is performed on the same bone one bone (H) (Anaes.) (Assist.) | $1992.30 |
| 48450 | Treatment of non-union or malunion of fracture of tibia or fibula, proximal to ankle, including bone graft, and including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) osteotomy; (d) removal of hardware; (e) internal fixation; other than a service associated with a service to which item 48245, 48248, 48251, 48254, 48257 or 47929 applies that is performed on the same bone one bone (H) (Anaes.) (Assist.) | $1805.70 |
| 48452 | Treatment of non-union or malunion of fracture of humerus, including bone graft, and including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) osteotomy; (d) removal of hardware; (e) internal fixation; other than a service associated with a service to which item 48245, 48248, 48251, 48254, 48257 or 47929 applies that is performed on the same bone one bone (H) (Anaes.) (Assist.) | $1805.70 |
| 48454 | Treatment of non-union or malunion of fracture of radius, ulna, or carpus including bone graft, and including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) osteotomy; (d) removal of hardware; (e) internal fixation; other than a service associated with a service to which item 48245, 48248, 48251, 48254, 48257 or 47929 applies that is performed on the same bone one bone (H) (Anaes.) (Assist.) | $1339.40 |
| 48456 | Treatment of non-union or malunion of fracture of hand, distal to wrist, including bone graft, and including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) osteotomy; (d) removal of hardware; (e) internal fixation; other than a service associated with a service to which item 48245, 48248, 48251, 48254, 48257 or 47929 applies that is performed on the same bone one bone (H) (Anaes.) (Assist.) | $1339.40 |
| 48507 | Epiphysiodesis of a long bone, in a patient less than 18 years of age (H) (Anaes.) (Assist.) | $794.20 |
| 48509 | Hemiepiphysiodesis, partial growth plate arrest using internal fixation, in a patient less than 18 years of age (H) (Anaes.) (Assist.) | $525.00 |
| 48512 | Epiphysiolysis, release of focal growth plate closure, in a patient less than 18 years of age (H) (Anaes.) (Assist.) | $1921.20 |
| 48900 | Shoulder, excision of coraco acromial ligament or removal of calcium deposit from cuff or both (Anaes.) (Assist.) | $605.40 |
| 48903 | Shoulder, decompression of subacromial space by acromioplasty, excision of coraco acromial ligament and distal clavicle, or any combination (H) (Anaes.) (Assist.) | $1241.70 |
| 48906 | Shoulder, repair of rotator cuff, including excision of coraco acromial ligament or removal of calcium deposit from cuff, or both other than a service associated with a service to which item 48900 applies (H) (Anaes.) (Assist.) | $1162.60 |
| 48909 | Shoulder, repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco acromial ligament and distal clavicle, or any combination, other than a service associated with a service to which item 48903 applies (H) (Anaes.) (Assist.) | $1686.20 |
| 48915 | Shoulder, hemi arthroplasty of (H) (Anaes.) (Assist.) | $1656.70 |
| 48918 | Anatomic or reverse total shoulder replacement, including any of the following (if performed): (a) associated rotator cuff repair; (b) biceps tenodesis; (c) tuberosity osteotomy; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose ofperforming a procedure on the shoulder region by open or arthroscopic means (H) (Anaes.) (Assist.) | $3127.70 |
| 48919 | Anatomic or reverse total shoulder replacement with bone graft, including any of the following (if performed): (a) associated rotator cuff repair; (b) biceps tenodesis; (c) tuberosity osteotomy; other than a service associated with: (d) a service to which another item in this Schedule applies that is performed on the shoulder region by open or arthroscopic means; or (e) a service to which item 48245, 48248, 48251, 48254 or 48257 applies that is performed on the same joint (H) (Anaes.) (Assist.) | $2816.40 |
| 48921 | Shoulder, total replacement arthroplasty, revision of (H) (Anaes.) (Assist.) | $3311.80 |
| 48924 | Revision of total shoulder replacement, including either or both of the following (if performed): (a) bone graft to humerus; (b) bone graft to scapula (H) (Anaes.) (Assist.) | $3955.80 |
| 48925 | Arthroplasty of shoulder, other than: (a) a service to which another item applies; or (b) a service associated with a service to which any of items 48900 to 48909, 48948, 48951, or 48960 applies that is performed on the same joint (H) (Anaes.) (Assist.) | $1159.90 |
| 48927 | Shoulder prosthesis, removal of (H) (Anaes.) (Assist.) | $744.90 |
| 48932 | Arthroplasty of acromioclavicular joint or sternoclavicular joint, other than: (a) a service to which another item applies; or (b) a service associated with a service to which another item in this Schedule applies that is performed on the same joint by arthroscopic means one joint (H) (Anaes.) (Assist.) | $1159.90 |
| 48939 | Shoulder, arthrodesis of, with synovectomy if performed (H) (Anaes.) (Assist.) | $2225.00 |
| 48942 | Arthrodesis of shoulder, with bone grafting or internal fixation, including either or both of the following (if performed): (a) removal of prosthesis; (b) synovectomy; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) | $3008.40 |
| 48943 | Arthrodesis of acromioclavicular or sternoclavicular joint, including either or both of the following (if performed): (a) joint debridement; (b) synovectomy; one joint (H) (Anaes.) (Assist.) | $777.20 |
| 48944 | Arthrodesis of scapulothoracic joint, including either or both of the following (if performed): (a) joint debridement; (b) synovectomy; one joint (H) (Anaes.) (Assist.) | $777.20 |
| 48945 | SHOULDER, diagnostic arthroscopy of (including biopsy)—not being a service associated with any other arthroscopic procedure of the shoulder region (H) (Anaes.) (Assist.) | $583.40 |
| 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(H) (Anaes.) (Assist.) | $1325.60 |
| 48951 | SHOULDER, arthroscopic division of coraco-acromial ligament including acromioplasty—not being a service associated with any other arthroscopic procedure of the shoulder region(H) (Anaes.) (Assist.) | $1902.70 |
| 48952 | Surgery of acromioclavicular joint or sternoclavicular joint, by arthroscopic means, including any of the following (if performed): (a) cartilage treatment; (b) removal of loose bodies; (c) synovectomy; (d) excision of joint osteophytes; other than a service associated with a service to which another item in this Group applies that is performed on the same joint by arthroscopic means (H) (Anaes.) (Assist.) | $1010.40 |
| 48953 | Surgery of scapulothoracic joint, by arthroscopic means, including any of the following (if performed): (a) cartilage treatment; (b) removal of loose bodies; (c) synovectomy; (d) excision of joint osteophytes; other than a service associated with a service to which another item in this Group applies that is performed on the same joint by arthroscopic means (H) (Anaes.) (Assist.) | $1010.40 |
| 48954 | Synovectomy of shoulder, performed as an independent procedure, including release of contracture (if performed), other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by arthroscopic means (H) (Anaes.) (Assist.) | $1941.70 |
| 48958 | Joint stabilisation procedure for multi-directional instability of shoulder, anterior or posterior repair, by open or arthroscopic means, including labral repair or reattachment (if performed), excluding bone grafting and removal of hardware, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by arthroscopic means (H) (Anaes.) (Assist.) | $2348.00 |
| 48959 | Latarjet procedure by open or arthroscopic means, including any of the following (if performed) but excluding removal of hardware: (a) labral repair or reattachment; (b) bone grafting; (c) tendon transfer; other than a service associated with a service to which another item in this Schedule applies that is performed on the shoulder region by arthroscopic means (H) (Anaes.) (Assist.) | $2496.20 |
| 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(H) (Anaes.) (Assist.) | $1977.70 |
| 48972 | Tenodesis of biceps, by open or arthroscopic means, performed as an independent procedure (H) (Anaes.) (Assist.) | $938.90 |
| 48980 | Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the shoulder girdle (H) (Anaes.) (Assist.) | $1735.40 |
| 48983 | Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the elbow (H) (Anaes.) (Assist.) | $1272.70 |
| 48986 | Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the forearm (H) (Anaes.) (Assist.) | $1735.40 |
| 49100 | ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture(H) (Anaes.) (Assist.) | $666.10 |
| 49104 | Repair of one or more ligaments of the elbow, for acute instability within 6 weeks after the time of injury (H) (Anaes.) (Assist.) | $1148.30 |
| 49105 | Stabilisation of one or more ligaments of the elbow, for chronic instability, including harvesting of tendon graft 6 weeks or more after the time of injury (H) (Anaes.) (Assist.) | $1684.30 |
| 49106 | ELBOW, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) | $2007.70 |
| 49109 | ELBOW, total synovectomy of(H) (Anaes.) (Assist.) | $1488.20 |
| 49112 | Radial head replacement of elbow, other than a service associated with a service to which item 49115 applies (H) (Anaes.) (Assist.) | $1554.80 |
| 49113 | Removal of radial head prosthesis (H) (Anaes.) (Assist.) | $1159.90 |
| 49114 | Revision of radial head replacement (H) (Anaes.) (Assist.) | $1159.90 |
| 49115 | Total or hemi humeral arthroplasty of elbow, excluding isolated radial head replacement and ligament stabilisation procedures, other than a service associated with a service to which item 49112 applies (H) (Anaes.) (Assist.) | $2687.70 |
| 49116 | ELBOW, total replacement arthroplasty of, revision procedure, including removal of prosthesis(H) (Anaes.) (Assist.) | $3066.70 |
| 49117 | Revision of total replacement arthroplasty of elbow, including bone grafting and removal of prosthesis (H) (Anaes.) (Assist.) | $3646.70 |
| 49118 | ELBOW, diagnostic arthroscopy of, including biopsy and lavage, not being a service associated with any other arthroscopic procedure of the elbow(H) (Anaes.) (Assist.) | $556.10 |
| 49121 | Surgery of the elbow, by arthroscopic means, including any of the following (if performed): (a) chondroplasty; (b) drilling of defect; (c) osteoplasty; (d) removal of loose bodies; (e) release of contracture or adhesions; (f) treatment of epicondylitis; other than a service associated witha service to which another item in this Schedule applies if the service described in the other item is for the purpose of an arthroscopic procedure of the elbow (H) (Anaes.) (Assist.) | $1280.40 |
| 49124 | Excision of olecranon bursa, including bony prominence, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of an arthroscopic procedure of the elbow (Anaes.) (Assist.) | $805.70 |
| 49127 | Elbow joint, arthroplasty of, other than a service to which another item applies (H) (Anaes.) (Assist.) | $1159.90 |
| 49200 | Wrist, arthrodesis of, with synovectomy if performed, with or without internal fixation of the radiocarpal joint (H) (Anaes.) (Assist.) | $1750.50 |
| 49203 | Limited fusion of wrist, with or without bone graft, including each of the following: (a) ligament or tendon transfers; (b) partial or total excision of one or more carpal bones; (c) rebalancing procedures; (d) synovectomy (H) (Anaes.) (Assist.) | $1521.20 |
| 49206 | Proximal row carpectomy of wrist, including either or both of the following (if performed): (a) styloidectomy; (b) synovectomy (H) (Anaes.) (Assist.) | $1142.20 |
| 49209 | Prosthetic replacement of wrist or distal radioulnar joint, including either or both of the following (if performed): (a) ligament realignment; (b) tendon realignment (H) (Anaes.) (Assist.) | $1610.60 |
| 49210 | Revision of total replacement arthroplasty of wrist or distal radioulnar joint, including any of the following (if performed): (a) ligament rebalancing; (b) removal of prosthesis; (c) tendon rebalancing (H) (Anaes.) (Assist.) | $2117.60 |
| 49212 | Arthrotomy of wrist or distal radioulnar joint, including any of the following (if performed): (a) joint debridement; (b) removal of loose bodies; (c) synovectomy (H) (Anaes.) (Assist.) | $511.90 |
| 49213 | Sauve-Kapandji procedure of distal radioulnar joint, including any of the following (if performed): a) radioulnar fusion; b) osteotomy; c) soft tissue reconstruction (Anaes.) (Assist.) | $1827.10 |
| 49215 | Reconstruction of single or multiple ligaments or capsules of wrist, including any of the following (if performed): (a) arthrotomy; (b) ligament harvesting and grafting; (c) synovectomy; (d) tendon harvesting and grafting; (e) insertion of synthetic ligament substitute (H) (Anaes.) (Assist.) | $1405.80 |
| 49218 | Wrist, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy) other than a service associated with another arthroscopic procedure of the wrist joint(H) (Anaes.) (Assist.) | $637.50 |
| 49219 | Diagnosis of carpometacarpal joint of thumb or joint of digit, by arthroscopic means, including biopsy (if performed) (H) (Anaes.) (Assist.) | $592.00 |
| 49220 | Treatment of carpometacarpal joint of thumb or joint of digit, by arthroscopic means one joint (H) (Anaes.) (Assist.) | $1327.10 |
| 49221 | Treatment of wrist, by arthroscopic means, including any of the following (if performed): (a) drilling of defect; (b) removal of loose bodies; (c) release of adhesions; (d) synovectomy; (e) debridement; (f) resection of dorsal or volar ganglia; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint (H) (Anaes.) (Assist.) | $1343.50 |
| 49224 | Osteoplasty of wrist, by arthroscopic means, including either or both of the following (if performed): (a) excision of the distal ulna; (b) total synovectomy; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint 2 or more distinct areas (H) (Anaes.) (Assist.) | $1557.60 |
| 49227 | Treatment of wrist by one of the following: (a) pinning of osteochondral fragment, by arthroscopic means; (b) stabilisation procedure for ligamentous disruption; (c) partial wrist fusion or carpectomy, by arthroscopic means; (d) fracture management; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint (H) (Anaes.) (Assist.) | $1444.40 |
| 49230 | Total, hemi or interpositional prosthetic replacement of carpal bone of wrist, including any of the following (if performed): (a) ligament and tendon rebalancing procedures; (b) limited wrist fusions; (c) limited bone grafting (H) (Anaes.) (Assist.) | $1997.90 |
| 49233 | Excisional arthroplasty of single (or part of) carpal bone of wrist, when transfers of ligaments or tendons, or rebalancing procedures, are not required, including any of the following (if performed): (a) radial styloidectomy; (b) ulnar styloidectomy; (c) proximal hamate; (d) partial scaphoid; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a distal radioulnar joint reconstruction, a proximal row carpectomy or a limited wrist fusion applicable once for a single operation (H) (Anaes.) (Assist.) | $841.20 |
| 49236 | Stabilisation of soft tissue of distal radioulnar joint, with or without ligament or tendon grafting, including either or both of the following (if performed): (a) graft harvest; (b) triangular fibrocartilage complex repair or reconstruction (H) (Anaes.) (Assist.) | $1268.20 |
| 49239 | Excision of pisiform or hook of hamate or sesamoid bone of hand, including release of ulnar nerve (if performed) (H) (Anaes.) (Assist.) | $630.80 |
| 49300 | Sacro-iliac joint arthrodesis of(H) (Anaes.) (Assist.) | $1300.00 |
| 49303 | Arthrotomy of hip, by open procedure, including any of the following (if performed): (a) lavage; (b) drainage; (c) biopsy (H) (Anaes.) (Assist.) | $1125.10 |
| 49306 | Hip, arthrodesis of, with synovectomy if performed(H) (Anaes.) (Assist.) | $2224.30 |
| 49309 | Arthrectomy or excision arthroplasty (Girdlestone) of hip, other than a service performed: (a) for the purpose of implant removal; or (b) as stage 1 of a 2-stage procedure (H) (Anaes.) (Assist.) | $1550.10 |
| 49315 | Hip, arthroplasty of, unipolar or bipolar(H) (Anaes.) (Assist.) | $1745.20 |
| 49318 | Total arthroplasty of hip, including minor bone grafting (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) | $2730.40 |
| 49319 | Bilateral total arthroplasty of hip, including minor bone grafting (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) | $5233.80 |
| 49321 | Complex primary arthroplasty of hip, with internal fixation, including either or both of the following (if performed): (a) structural bone graft; (b) insertion of synthetic substitutes or metal augments; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) | $3409.20 |
| 49360 | Diagnostic arthroscopy of hip, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure of the hip joint by arthroscopic means (H) (Anaes.) (Assist.) | $735.20 |
| 49363 | Diagnostic arthroscopy of hip, with synovial biopsy, other than a service associated with a service to which another item in this Schedule applies that is performed on the hip joint by arthroscopic means (H) (Anaes.) (Assist.) | $860.70 |
| 49366 | Treatment of hip, by arthroscopic means, including any procedures to treat bone or soft tissue in the same area (if performed), other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing: (a) a procedure of the hip joint by arthroscopic means; or (b) surgery for femoroacetabular impingement (H) (Anaes.) (Assist.) | $1515.30 |
| 49372 | Revision arthroplasty of hip, with exchange of head or liner (or both) (H) (Anaes.) (Assist.) | $2000.40 |
| 49374 | Revision arthroplasty of hip, with exchange of head and acetabular shell or cup, including minor bone grafting (if performed) (H) (Anaes.) (Assist.) | $3715.20 |
| 49376 | Revision arthroplasty of hip, with exchange of head and acetabular shell or cup, including major bone grafting (if performed) (H) (Anaes.) (Assist.) | $4572.60 |
| 49378 | Revision arthroplasty of hip, with revision of femoral component (if there is no requirement for femoral osteotomy), including minor bone grafting (if performed) (H) (Anaes.) (Assist.) | $4000.80 |
| 49380 | Revision arthroplasty of hip, with revision of femoral and acetabular components (if femoral osteotomy is not required), including minor bone grafting (if performed) (H) (Anaes.) (Assist.) | $4858.40 |
| 49382 | Revision arthroplasty of hip, with revision of femoral and acetabular components (if femoral osteotomy is not required), including major bone grafting (H) (Anaes.) (Assist.) | $6287.20 |
| 49384 | Revision arthroplasty of hip, for pelvic discontinuity, with revision of acetabular component (H) (Anaes.) (Assist.) | $7430.30 |
| 49386 | Revision arthroplasty of hip, with revision of femoral component with femoral osteotomy, including minor bone grafting (if performed) (H) (Anaes.) (Assist.) | $5144.00 |
| 49388 | Revision arthroplasty of hip, including: (a) revision of both of the following: (i) femoral component with femoral osteotomy; (ii) acetabular component; and (b) minor bone grafting (if performed) (H) (Anaes.) (Assist.) | $6001.70 |
| 49390 | Revision arthroplasty of hip, including: (a) revision of both of the following: (i) femoral component with femoral osteotomy; (ii) acetabular component; and (b) major bone grafting (H) (Anaes.) (Assist.) | $7144.60 |
| 49392 | Revision arthroplasty of hip, including: (a) either: (i) revision of femoral component with femoral osteotomy; or (ii) proximal femoral replacement; and (b) revision of acetabular component for pelvic discontinuity (H) (Anaes.) (Assist.) | $10002.40 |
| 49394 | Revision arthroplasty of hip, including: (a) replacement of proximal femur; and (b) revision of the acetabular component; and (c) bone grafting (if performed) (H) (Anaes.) (Assist.) | $8573.50 |
| 49396 | Revision arthroplasty of hip, including: (a) removal of prosthesis as stage 1 of a 2-stage revision arthroplasty or as a definitive stage procedure; and (b) insertion of temporary prosthesis (if performed) (H) (Anaes.) (Assist.) | $5715.60 |
| 49398 | Revision arthroplasty of hip, including: (a) revision of femoral component for periprosthetic fracture; and (b) internal fixation; and (c) bone grafting (if performed) (H) (Anaes.) (Assist.) | $4286.90 |
| 49500 | Knee, arthrotomy of, involving one or more of capsular release, biopsy or lavage, or removal of loose body or foreign body(H) (Anaes.) (Assist.) | $776.10 |
| 49503 | Arthrotomy of knee, including one of the following: (a) meniscal surgery; (b) repair of collateral or cruciate ligament; (c) patellectomy; (d) single transfer of ligament or tendon; (e) repair or replacement of chondral or osteochondral surface (excluding prosthetic replacement); other than a service associated with a service to which another item in this Group applies (H) (Anaes.) (Assist.) | $1046.60 |
| 49506 | Arthrotomy of knee, including 2 or more of the following: (a) meniscal surgery; (b) repair of collateral or cruciate ligament; (c) patellectomy; (d) single transfer of ligament or tendon; (e) repair or replacement of chondral or osteochondral surface (excluding prosthetic replacement); other than a service associated with a service to which another item in this Group applies (H) (Anaes.) (Assist.) | $1516.00 |
| 49509 | Total synovectomy of knee, by open procedure, other than a service performed in association with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing an arthroplasty (H) (Anaes.) (Assist.) | $1603.80 |
| 49512 | Primary or revision arthrodesis of knee, including arthrodesis (H) (Anaes.) (Assist.) | $2561.30 |
| 49515 | Removal of cemented or uncemented knee prosthesis, performed as the first stage of a 2-stage procedure; including: (a) removal of associated cement; and (b) insertion of spacer (if required) (H) (Anaes.) (Assist.) | $1833.50 |
| 49516 | Bilateral unicompartmental arthroplasty of femur and proximal tibia of knee (H) (Anaes.) (Assist.) | $4578.20 |
| 49517 | Unicompartmental arthroplasty of femur and proximal tibia of knee (H) (Anaes.) (Assist.) | $2625.20 |
| 49518 | Total arthroplasty of knee, including either or both of the following (if performed): (a) revision of patello-femoral joint replacement to total knee replacement; (b) patellar resurfacing; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) | $2727.00 |
| 49519 | Bilateral total arthroplasty of knee, including patellar resurfacing, other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) | $5145.30 |
| 49521 | Complex primary arthroplasty of knee, using revision femoral or tibial components, including either or both of the following (if performed): (a) ligament reconstruction; (b) patellar resurfacing; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) | $3291.50 |
| 49524 | Complex primary arthroplasty of knee: (a) using revision femoral and tibial components; or (b) using revision femoral or tibial components including anatomic specific allograft of femur or tibia; including either or both of the following (if performed): (c) ligament reconstruction; (d) patellar resurfacing; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) | $3875.70 |
| 49525 | Revision of uni-compartmental arthroplasty of the knee, with femoral or tibial components (or both) with uni-compartmental implants, other than a service associated with a service to which: (a) item 48245, 48248, 48251, 48254 or 48257 applies; or (b) another item in this Group applies if the service described in the other item is for the purpose of performing surgery on a knee (H) (Anaes.) (Assist.) | $3471.20 |
| 49527 | Minor revision of total or partial arthroplasty of knee, including either or both of the following: (a) exchange of polyethylene component (including uni); (b) insertion of patellar component; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) | $3101.20 |
| 49530 | Revision of total or partial arthroplasty of knee, with exchange of femoral or tibial component: (a) excluding revision of unicompartmental with unicompartmental implants; and (b) including patellar resurfacing (if performed); other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) | $4212.10 |
| 49533 | Revision of total or partial arthroplasty of knee, with exchange of femoral and tibial components, excluding revision of unicompartmental with unicompartmental implants, including patellar resurfacing (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) | $5317.60 |
| 49534 | Arthroplastyof patella and trochlea of patello-femoral joint of knee, performed as a primary procedure (H) (Anaes.) (Assist.) | $1398.90 |
| 49536 | Either: (a) repair of cruciate ligaments of knee; or (b) repair or reconstruction of collateral ligaments of knee; by open or arthroscopic means, including either or both of the following (if performed): (c) graft harvest; (d) intraarticular knee surgery; other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.) | $2043.30 |
| 49542 | Reconstruction of anterior or posterior cruciate ligament of knee, by open or arthroscopic means, including any of the following (if performed): (a) graft harvest; (b) donor site repair; (c) meniscal repair; (d) collateral ligament repair; (e) extra-articular tenodesis; (f) any other associated intra-articular surgery; other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.) | $2822.50 |
| 49544 | Reconstruction of 2 or more cruciate or collateral ligaments of knee, by open or arthroscopic means, including any of the following (if performed): (a) ligament repair; (b) graft harvest donor site repair; (c) meniscal repair; (d) any other associated intra-articular surgery; other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.) | $3327.30 |
| 49548 | Knee, revision of patello-femoral stabilisation(H) (Anaes.) (Assist.) | $1928.60 |
| 49551 | Knee, revision of procedures to which item 49536 or 49542 applies (H) (Anaes.) (Assist.) | $2821.20 |
| 49554 | Revision of total replacement of knee, by anatomic specific allograft of tibia or femur, other than a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.) | $3876.30 |
| 49564 | Stabilisation of patellofemoral joint of knee, by combined open and arthroscopic means, including either or both of the following (if performed): (a) medial soft tissue reconstruction and tendon transfer; (b) tibial tuberosity transfer with bone graft and internal fixation; other than a service associated a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.) | $1906.90 |
| 49565 | Reconstruction of patellofemoral joint of knee, by combined open and arthroscopic means, including: (a) both of the following: (i) medial soft tissue reconstruction; (ii) tibial tuberosity transfer; and (b) any of the following (if performed): (i) bone graft; (ii) internal fixation; (iii) trochleoplasty; other than a service associated a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.) | $2860.80 |
| 49569 | Knee, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty)(H) (Anaes.) (Assist.) | $1555.10 |
| 49570 | Diagnosis of knee, by arthroscopic means, when the pre-procedure diagnosis is undetermined, including either or both of the following (if performed): (a) biopsy; (b) lavage (H) (Anaes.) (Assist.) | $592.00 |
| 49572 | Partial meniscectomy of knee, by arthroscopic means, for atraumatic meniscus tear, other than a service to which another item of this Schedule applies if the service described in the other item is for the purpose of treating osteoarthritis (H) (Anaes.) (Assist.) | $1440.50 |
| 49574 | Removal of loose bodies of knee, by arthroscopic means one or more bodies (H) (Anaes.) (Assist.) | $1440.50 |
| 49576 | Repair of chondral lesion of knee, by arthroscopic means, including either or both of the following (if performed): (a) microfracture; (b) microdrilling; other than a service performed in combination with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing chondral or osteochondral grafts (H) (Anaes.) (Assist.) | $1440.50 |
| 49578 | Release of soft tissue, lateral release or osteoplasty of knee, by arthroscopic means, other than a service performed in combination with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of stabilising the patellofemoral joint of the knee (H) (Anaes.) (Assist.) | $1440.50 |
| 49580 | Partial meniscectomy of knee, by arthroscopic means, for traumatic meniscus tear (H) (Anaes.) (Assist.) | $1440.50 |
| 49582 | Meniscal repair of knee, by arthroscopic means (H) (Anaes.) (Assist.) | $1682.00 |
| 49584 | Chondral, osteochondral or meniscal graft of knee, by arthroscopic means (H) (Anaes.) (Assist.) | $1682.00 |
| 49586 | Synovectomy of knee, by arthroscopic means, for neoplasia or inflammatory arthropathy, other than a service to which another item of this Schedule applies if the service described in the other item is for the purpose of treating uncomplicated osteoarthritis (Anaes.) (Assist.) | $1682.00 |
| 49590 | Excision of ganglion, cyst or bursa of knee, by open or arthroscopic means, performed as an independent procedure, other than a service associated with a service to which another item in this Group applies (Anaes.) (Assist.) | $805.70 |
| 49592 | Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the hip, including pelvis and proximal femur (H) (Anaes.) (Assist.) | $1884.80 |
| 49594 | Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the knee, including distal femur, proximal fibula and proximal tibia (H) (Anaes.) (Assist.) | $1507.80 |
| 49596 | Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the lower leg, other than a service to which item 49594 applies (H) (Anaes.) (Assist.) | $1130.90 |
| 49703 | Surgery of ankle joint, by arthroscopic means, including any of the following (if performed): (a) cartilage treatment; (b) removal of loose bodies; (c) synovectomy; (d) excision of joint osteophytes; other than a service associated with a service to which another item in this Group applies if the service described in the other item is for the purpose of performing a procedure on the ankle by arthroscopic means (H) (Anaes.) (Assist.) | $1332.20 |
| 49706 | Arthrotomy of joint of ankle, including removal of loose bodies and joint debridement, including release of joint contracture (if performed) (H) (Anaes.) (Assist.) | $700.40 |
| 49709 | Stabilisation of ligament of ankle or subtalar joint (or both), including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) joint debridement; one ligament complex, each incision (H) (Anaes.) (Assist.) | $1514.10 |
| 49712 | Arthrodesis of ankle, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.) | $1963.40 |
| 49715 | Total replacement of ankle, with prosthetic replacement of ankle joint, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.) | $2491.20 |
| 49716 | Revision of total ankle replacement: (a) including either: (i) exchange of tibial or talar components (or both) or plastic inserts; or (ii) removal of tibial or talar components (or both) and plastic inserts; and (b) including any of the following (if performed): (i) insertion of cement spacer for infection; (ii) capsulotomy; (iii) joint release; (iv) neurolysis; (v) debridement of cysts; (vi) synovectomy; (vii) joint debridement other than a service associated with a service to which item 30023 applies (H) (Anaes.) (Assist.) | $3045.60 |
| 49717 | Revision of total ankle replacement: (a) including either: (i) exchange of tibial and talar components; or (ii) removal of tibial and talar components and conversion to ankle arthrodesis; and (b) including both of the following (iii) internal or external fixation, by any means; (iv) major bone grafting; and (c) including any of the following (if performed): (i) capsulotomy; (ii) joint release; (iii) neurolysis; (iv) debridement and extensive grafting of cysts; (v) synovectomy; (vi) joint debridement; other than a service associated with a service to which item 30023, 48245, 48248, 48251, 48254 or 48257 applies that is performed at the same site (H) (Anaes.) (Assist.) | $3811.90 |
| 49718 | Primary repair of major tendon of ankle, by any method, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy one tendon (H) (Anaes.) (Assist.) | $828.90 |
| 49724 | Reconstruction of major tendon of ankle, by any method, including any of the following (if performed): (a) synovial biopsy; (b) synovectomy; (c) adjacent tendon transfer; (d) turn down flaps; other than a service associated with a service to which item 49718 applies (H) (Anaes.) (Assist.) | $1655.00 |
| 49727 | Lengthening of major tendon of ankle, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy (H) (Anaes.) (Assist.) | $630.80 |
| 49728 | Lengthening of Achilles tendon, by any method, with gastro-soleus lengthening for the correction of equinous deformity, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy; other than a service associated with a service to which item 49727 applies (H) (Anaes.) (Assist.) | $1211.10 |
| 49730 | Surgery of joint of hindfoot (other than ankle) or first metatarsophalangeal joint, by arthroscopic means, including any of the following (if performed): (a) cartilage treatment; (b) removal of loose bodies; (c) synovectomy; (d) excision of joint osteophytes; other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the ankle by arthroscopic means one joint (H) (Anaes.) (Assist.) | $1327.10 |
| 49732 | Endoscopy of large tendons of foot, including any of the following (if performed): (a) debridement of tendon and sheath; (b) removal of loose bodies; (c) synovectomy; (d) excision of tendon impingement; other than a service associated with a service to which item 49718 or 49724 applies (H) (Anaes.) (Assist.) | $1327.10 |
| 49734 | Arthrotomy of hindfoot, midfoot or metatarsophalangeal joint, including: (a) removal of loose bodies; and (b) either or both of the following: (i) joint debridement; (ii) release of joint contracture; each incision (H) (Anaes.) (Assist.) | $714.60 |
| 49736 | Transfer of major tendon of foot and ankle, including: (a) split or whole transfer to contralateral side of foot; and (b) passage of posterior or anterior tendon to, or through, interosseous membrane; and (c) any of the following (if performed): (i) synovial biopsy; (ii) synovectomy; (iii) tendon lengthening; (iv) insetting of tendon (H) (Anaes.) (Assist.) | $1429.40 |
| 49738 | Stabilisation of ligament of talonavicular or metatarsophalangeal joint, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement (H) (Anaes.) (Assist.) | $1020.70 |
| 49740 | Revision of arthrodesis of ankle, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint; (e) removal of hardware; (f) neurolysis; (g) osteotomy of non-union or malunion; other than a service associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.) | $3062.70 |
| 49742 | Arthrodesis of extended ankle and hindfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.) | $2891.20 |
| 49744 | Revision of arthrodesis of extended ankle and hindfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint; (e) removal of hardware; (f) neurolysis; (g) osteotomy of non-union or malunion; other than a service associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.) | $4336.90 |
| 49760 | Arthroereisis of subtalar joint, including any of the following (if performed): (a) capsulotomy; (b) synovectomy; (c) joint debridement (H) (Anaes.) (Assist.) | $765.60 |
| 49761 | Stabilisation of metatarsophalangeal joint at metatarsal, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; one metatarsal (H) (Anaes.) (Assist.) | $1123.00 |
| 49762 | Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; 2 metatarsals (H) (Anaes.) (Assist.) | $1246.10 |
| 49763 | Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; 3 metatarsals (H) (Anaes.) (Assist.) | $1369.30 |
| 49764 | Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; 4 metatarsals (H) (Anaes.) (Assist.) | $1492.50 |
| 49765 | Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; 5 metatarsals (H) (Anaes.) (Assist.) | $1615.70 |
| 49766 | Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; 6 metatarsals (H) (Anaes.) (Assist.) | $1739.10 |
| 49767 | Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; 7 metatarsals (H) (Anaes.) (Assist.) | $1862.20 |
| 49768 | Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; 8 metatarsals (H) (Anaes.) (Assist.) | $1985.40 |
| 49769 | Unilateral correction of hallux valgus or varus deformity, by osteotomy of first metatarsal and proximal phalanx of first toe, with internal fixation of both bones, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.) | $1965.10 |
| 49770 | Bilateral correction of hallux valgus or varus deformity, by osteotomy of first metatarsal and proximal phalanx of first toe, with internal fixation of both bones, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.) | $3266.30 |
| 49771 | Synovectomy of major tendon of ankle, for extensive synovitis by any method, including any of the following (if performed): (a) tenolysis; (b) debridement of ligament or tendon (or both); (c) release of ligament or tendon (or both); (d) excision of tubercule or osteophyte; (e) reconstruction of tendon retinaculum; (f) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site each incision (H) (Anaes.) (Assist.) | $805.70 |
| 49772 | Excision of rheumatoid nodules or gouty tophi, excluding aftercare, including any of the following (if performed): (a) capsulotomy; (b) debridement of ligament or tendon (or both); (c) release of ligament or tendon (or both); (d) excision of tubercle or osteophyte; each incision (H) (Anaes.) (Assist.) | $711.00 |
| 49773 | Revision of excision of intermetatarsal or digital neuroma, including any of the following (if performed): (a) release of tissues; (b) excision of bursae; (c) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site one web space (H) (Anaes.) (Assist.) | $881.20 |
| 49774 | Release of tarsal tunnel, including any of the following (if performed): (a) release of ligaments; (b) synovectomy; (c) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site one foot (H) (Anaes.) (Assist.) | $600.20 |
| 49775 | Revision of release of tarsal tunnel, including any of the following (if performed): (a) release of ligaments; (b) synovectomy; (c) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site one foot (H) (Anaes.) (Assist.) | $810.40 |
| 49776 | Revision of arthrodesis of joint of hindfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint; (e) removal of hardware; (f) neurolysis; (g) osteotomy of non union or malunion; other than a service associated with a service to which item 30023 applies that is performed at the same site may only be claimed once per joint (H) (Anaes.) (Assist.) | $2549.00 |
| 49777 | Arthrodesis of joint of midfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint; one joint (H) (Anaes.) (Assist.) | $1509.20 |
| 49778 | Arthrodesis of joints of midfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints; 2 joints (H) (Anaes.) (Assist.) | $2264.00 |
| 49779 | Arthrodesis of joints of midfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints; 3 joints (H) (Anaes.) (Assist.) | $2641.20 |
| 49780 | Arthrodesis of joints of midfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints; 4 joints (H) (Anaes.) (Assist.) | $3018.60 |
| 49781 | Revision of arthrodesis of joint of midfoot, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of ostephytes at joint; (e) removal of hardware; (f) osteotomy of non-union or malunion; one joint (H) (Anaes.) (Assist.) | $2264.00 |
| 49782 | Revision of total ankle replacement, including: (a) bone grafting of perioperative cysts to the tibia or talus (or both); and (b) retention of implants; and (c) any of the following (if performed): (i) capsulotomy; (ii) joint release; (iii) neurolysis; (iv) debridement and grafting of cysts; (v) synovectomy; (vi) joint debridement; other than a service associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.) | $1226.20 |
| 49783 | Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; 3 joints (H) (Anaes.) (Assist.) | $1644.40 |
| 49784 | Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; 4 joints (H) (Anaes.) (Assist.) | $1879.10 |
| 49785 | Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; 5 joints (H) (Anaes.) (Assist.) | $2113.90 |
| 49786 | Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; 6 joints (H) (Anaes.) (Assist.) | $2348.60 |
| 49787 | Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; 7 joints (H) (Anaes.) (Assist.) | $2583.30 |
| 49788 | Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; 8 joints (H) (Anaes.) (Assist.) | $2818.10 |
| 49789 | Bilateral arthrodesis of first metatarsophalangeal joint, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.) | $2424.00 |
| 49790 | Revision of arthrodesis of first metatarsophalangeal joint, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of exostosis at joint; (e) removal of hardware; (f) osteotomy of non-union or malunion (H) (Anaes.) (Assist.) | $2105.50 |
| 49791 | Arthrodesis of hallux interphalangeal or lesser metatarsophalangeal joint, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.) | $954.60 |
| 49792 | Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; one or 2 toes (H) (Anaes.) (Assist.) | $1072.20 |
| 49793 | Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; 3 toes (H) (Anaes.) (Assist.) | $1250.90 |
| 49794 | Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; 4 toes (H) (Anaes.) (Assist.) | $1429.50 |
| 49795 | Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; 5 toes (H) (Anaes.) (Assist.) | $1608.30 |
| 49796 | Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; 6 toes (H) (Anaes.) (Assist.) | $1787.00 |
| 49797 | Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; 7 toes (H) (Anaes.) (Assist.) | $1965.60 |
| 49798 | Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; 8 toes (H) (Anaes.) (Assist.) | $2144.40 |
| 49800 | Primary repair of flexor or extensor tendon of foot, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy; one toe (Anaes.) (Assist.) | $268.80 |
| 49803 | Secondary repair of flexor or extensor tendon of foot, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy; one toe (Anaes.) (Assist.) | $356.00 |
| 49806 | Subcutaneous tenotomy of foot, by small percutaneous incisions one or more tendons (Anaes.) | $269.60 |
| 49809 | Open tenotomy or lengthening of foot, by open incision, with or without tenoplasty, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy; one toe (Anaes.) (Assist.) | $477.10 |
| 49812 | Advancement of tendon or ligament transfer of foot, including: (a) side to side transfer, harvesting and transfer for ligament or minor foot tendon reconstruction; and (b) either or both of the following (if performed): (i) synovial biopsy; (ii) synovectomy; one major tendon or toe (H) (Anaes.) (Assist.) | $897.00 |
| 49814 | Reconstruction of major tendon of ankle, by any method, including: (a) osteotomy of hindfoot, with internal fixation; and (b) lengthening of major tendon of ankle; and (c) any of the following (if performed): (i) synovial biopsy; (ii) synovectomy; (iii) adjacent tendon transfer; (iv) turn down flaps; other than a service associated with a service to which item 49718 applies (H) (Anaes.) (Assist.) | $2144.00 |
| 49815 | Triple arthrodesis of hindfoot joints, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints (H) (Anaes.) (Assist.) | $2041.90 |
| 49818 | Release of plantar fascia, including excision of calcaneal spur (if performed) (H) (Anaes.) (Assist.) | $654.70 |
| 49821 | Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joint, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement one joint (H) (Anaes.) (Assist.) | $941.10 |
| 49824 | Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joint, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; 2 joints (H) (Anaes.) (Assist.) | $1613.50 |
| 49827 | Unilateral correction of hallux valgus or varus deformity of the foot, by local tendon transfer, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.) | $948.50 |
| 49830 | Bilateral correction of hallux valgus or varus deformity of the foot, by local tendon transfer, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.) | $1809.00 |
| 49833 | Unilateral correction of hallux valgus or varus deformity of the foot, by osteotomy of first metatarsal, without internal fixation, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.) | $1083.60 |
| 49836 | Bilateral correction of hallux valgus or varus deformity of the foot by osteotomy of first metatarsal, without internal fixation, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.) | $1992.30 |
| 49837 | Unilateral correction of hallux valgus or varus deformity of the foot, by osteotomy of first metatarsal, with internal fixation, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.) | $1397.80 |
| 49838 | Bilateral correction of hallux valgus or varus deformity of the foot by osteotomy of first metatarsal, with internal fixation or arthrodesis of first metatarsophalangeal joint, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.) | $2387.60 |
| 49839 | Total replacement of first metatarsophalangeal joint, with replacement of both joint surfaces, including any of the following (if performed): (a) capsulotomy; (b) synovectomy; (c) joint debridement (H) (Anaes.) (Assist.) | $1136.50 |
| 49845 | Unilateral arthrodesis of first metatarsophalangeal joint, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints (H) (Anaes.) (Assist.) | $1276.00 |
| 49851 | Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal (or both) joints of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) tendon lengthening; (d) joint release; (e) synovectomy; (f) removal of osteophytes at joints; one toe (H) (Anaes.) (Assist.) | $573.70 |
| 49854 | Radical plantar fasciotomy or fasciectomy, with extensive incision into foot and excision of fascia, including excision of calcaneal spur (if performed), other than a service associated with a service to which 49818 applies (H) (Anaes.) (Assist.) | $774.00 |
| 49857 | Hemi joint replacement of first or lesser metatarsophalangeal joint, including any of the following (if performed): (a) capsulotomy; (b) synovectomy; (c) joint debridement (H) (Anaes.) (Assist.) | $838.40 |
| 49860 | Synovectomy of metatarsophalangeal joints, including any of the following (if performed): (a) capsulotomy; (b) debridement; (c) release of ligament or tendon (or both); one or more joints on one foot (H) (Anaes.) (Assist.) | $714.10 |
| 49866 | Excision of intermetatarsal or digital neuroma, including any of the following (if performed): (a) release of metatarsal or digital ligament; (b) excision of bursae; (c) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site one web space (H) (Anaes.) (Assist.) | $656.30 |
| 49878 | Talipes equinovarus, calcaneo valgus or metatarsus varus, treatment by cast, splint or manipulation each attendance (Anaes.) | $117.20 |
| 49881 | Complete excision of one or more ganglia or bursae: (a) including excision of bony prominence or mucinous cyst of interphalangeal or metatarsophalangeal joint and surrounding tissues; and (b) including any of the following (if performed): (i) arthrotomy; (ii) synovectomy; (iii) osteophyte resections; (iv) neurolysis; (v) skin closure, by any local method; other than a service associated with a service to which item 30023 applies that is performed at the same site each incision (H) (Anaes.) (Assist.) | $477.00 |
| 49884 | Complete excision of one or more ganglia or bursae: (a) including excision of bony prominence or mucinous cyst of ankle, hindfoot or midfoot joint and surrounding tissues; and (b) including any of the following (if performed): (i) arthrotomy; (ii) synovectomy; (iii) osteophyte resections; (iv) neurolysis; (v) capsular or ligament repair; (vi) skin closure, by any method; other than a service associated with a service to which item 30023 applies that is performed at the same site each incision (H) (Anaes.) (Assist.) | $805.70 |
| 49887 | Revision of complete excision of one or more ganglia or bursae: (a) including excision of bony prominence or mucinous cyst of interphalangeal or metatarsophalangeal joint and surrounding tissues; and (b) including any of the following (if performed): (i) arthrotomy; (ii) synovectomy; (iii) osteophyte resections; (iv) neurolysis; (v) skin closure, by any method; other than a service associated with: (c) a service to which item 49881 applies; or (d) a service to which item 30023 applies that is performed at the same site each incision (H) (Anaes.) (Assist.) | $644.00 |
| 49890 | Revision of complete excision of one or more ganglia or bursae: (a) including excision of bony prominence or mucinous cyst of ankle, hindfoot or midfoot joint and surrounding tissues; and (b) including any of the following (if performed): (i) arthrotomy; (ii) synovectomy; (iii) osteophyte resections; (iv) neurolysis; (v) capsular or ligament repair; (vi) skin closure, by any method; other than a service associated with: (c) a service to which item 49884 applies; or (d) a service to which item 30023 applies that is performed at the same site each incision (H) (Anaes.) (Assist.) | $1087.50 |
| 50107 | Stabilisation of joint of hip, by open means, including any of the following (if performed): (a) repair of capsule; (b) labrum; (c) capsulorraphy; (d) repair of ligament; (e) internal fixation; other than a service associated with a service to which another item in this Group applies (H) (Anaes.) (Assist.) | $1020.70 |
| 50112 | Cicatricial flexion or extension contraction of joint, correction of, involving tissues deeper than skin and subcutaneous tissue, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.) | $748.00 |
| 50115 | Manipulation of one or more joints, excluding spine, other than a service associated with a service to which another item in this Group applies (H) (Anaes.) | $294.00 |
| 50118 | Arthrodesis of joint of hindfoot, by any method, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints; one joint (H) (Anaes.) (Assist.) | $1144.00 |
| 50130 | Joint or joints, application of external fixator to, other than for treatment of fractures (H) (Anaes.) (Assist.) | $731.10 |
| 50200 | Core needle biopsy of aggressive or potentially malignant bone or soft tissue tumour, excluding aftercare (Anaes.) | $390.70 |
| 50201 | Incisional biopsy of aggressive or potentially malignant bone or soft tissue tumour, excluding aftercare (Anaes.) (Assist.) | $724.10 |
| 50203 | Intralesional or marginal excision of bone or soft tissue tumour (Anaes.) (Assist.) | $854.90 |
| 50206 | Intralesional or marginal excision of bone tumour, with at least one of the following: (a) autograft; (b) allograft; (c) cementation (H) (Anaes.) (Assist.) | $1340.20 |
| 50209 | Intralesional or marginal excision of bone tumour, with at least 2 of the following: (a) autograft; (b) allograft; (c) cementation (H) (Anaes.) (Assist.) | $1555.60 |
| 50212 | Wide excision of malignant or aggressive bone or soft tissue tumour (or both), affecting a limb, trunk or scapula (H) (Anaes.) (Assist.) | $3390.40 |
| 50215 | Wide excision of malignant or aggressive bone or soft tissue tumour (or both), with intercalary reconstruction of bone by prosthesis, allograft or autograft (H) (Anaes.) (Assist.) | $4258.10 |
| 50218 | Wide excision of malignant or aggressive bone or soft tissue tumour (or both), with reconstruction, replacement or arthrodesis of adjacent joint, by prosthesis, allograft or autograft (H) (Anaes.) (Assist.) | $5658.10 |
| 50221 | Wide excision of malignant or aggressive bone or soft tissue tumour (or both) of pelvis, sacrum or spine, without reconstruction (H) (Anaes.) (Assist.) | $5241.40 |
| 50224 | Wide excision of malignant or aggressive bone or soft tissue tumour (or both) of pelvis, sacrum or spine, with reconstruction of bone defect, or one or more joints, by any technique (Anaes.) (Assist.) | $5830.00 |
| 50233 | Treatment of malignant or aggressive bone or soft tissue tumour (or both) by hindquarter or forequarter amputation(H) (Anaes.) (Assist.) | $4455.20 |
| 50236 | Treatment of malignant or aggressive bone or soft tissue tumour (or both), by hip disarticulation, shoulder disarticulation or amputation through the proximal one third of the femur (H) (Anaes.) (Assist.) | $3456.10 |
| 50239 | Treatment of malignant or aggressive bone or soft tissue tumour (or both), by amputation, other than a service associated with a service to which item 50233 or 50236 applies (H) (Anaes.) (Assist.) | $2328.80 |
| 50242 | Revision of endoprosthetic replacement, if item 50218 or 50224, or an item that describes a service substantially similar to either of those items, applied to the initial procedure: (a) including any of the following: (i) rebushing; (ii) patella resurfacing; (iii) polyethylene exchange or similar; and (b) excluding removal of prosthetic from bone (H) (Anaes.) (Assist.) | $1837.50 |
| 50245 | Revision of reconstructive procedure, if item 50215, 50218 or 50224, or an item that describes a service substantially similar to any of those items, applied to the initial procedure, by any technique or combination of techniques (H) (Anaes.) (Assist.) | $5512.70 |
| 50300 | Gradual correction of joint deformity, with application of external fixator (H) (Anaes.) (Assist.) | $2386.80 |
| 50303 | Limb lengthening, by gradual distraction, with application of external fixator or intra-medullary device (H) (Anaes.) (Assist.) | $3263.40 |
| 50306 | Bipolar limb lengthening: (a) with application of external fixator or intra-medullary device; and (b) by any of the following: (i) gradual distraction; (ii) bone transport; (iii) fixator extension, to correct for an adjacent joint deformity (H) (Anaes.) (Assist.) | $5091.70 |
| 50309 | Ring fixator or similar device, adjustment of, with or without insertion or removal of fixation pins, performed under general anaesthesia, other than a service to which item 50303 or 50306 applies (H) (Anaes.) (Assist.) | $627.00 |
| 50310 | Major adjustment of ring fixator or similar device, other than a service associated with a service to which item 50303, 50306, or 50309 applies | $94.70 |
| 50312 | Synovectomy or debridement, and microfracture, of ankle joint for osteochondral large defect greater than 1.5cm2, by arthroscopic or open means, including any of the following (if performed): (a) capsulotomy; (b) debridement or release of ligament; (c) debridement or release of tendon; other than a service associated with a service to which any of the following apply: (d) item 49703; (e) another item in this Schedule if the service described in the other item is for the purpose of performing an arthroscopic procedure of the ankle (H) (Anaes.) (Assist.) | $1653.40 |
| 50321 | Release of soft tissue of talipes equinovarus, by open means (H) (Anaes.) (Assist.) | $1923.60 |
| 50324 | Revision of release of soft tissue of talipes equinovarus, by open means (H) (Anaes.) (Assist.) | $2686.70 |
| 50330 | Post operative manipulation, and change of plaster, of vertical, congenital talipes equinovarus or talus, other than a service to which item 50321 or 50324 applies (H) (Anaes.) | $504.00 |
| 50333 | Excision of tarsal coalition, with interposition of muscle, fat graft or similar graft, including any of the following (if performed): (a) capsulotomy; (b) synovectomy; (c) excision of osteophytes; one coalition (H) (Anaes.) (Assist.) | $1360.20 |
| 50335 | Treatment of vertical, congenital talus, by percutaneous or open stabilisation of talonavicular joint and Achilles tenotomy (H) (Anaes.) (Assist.) | $1337.70 |
| 50336 | Talus, vertical, congenital, combined anterior and posterior reconstruction (H) (Anaes.) (Assist.) | $1870.90 |
| 50339 | Tibialis anterior or tibialis posterior tendon transfer (split or whole) (H) (Anaes.) (Assist.) | $1206.60 |
| 50345 | Hyperextension deformity of toe, release incorporating V Y plasty of skin, lengthening of extensor tendons and release of capsule contracture (H) (Anaes.) (Assist.) | $737.90 |
| 50348 | Knee, deformity of, post operative manipulation and change of plaster, performed under general anaesthesia (H) (Anaes.) | $470.50 |
| 50351 | Treatment of developmental dislocation of hip, by open reduction, including application of hip spica (H) (Anaes.) (Assist.) | $3240.90 |
| 50352 | Treatment of developmental dysplasia of hip, including supervision of initial application of splint, harness or cast, other than a service to which another item in this Group applies (Anaes.) | $117.20 |
| 50354 | Resection and fixation of congenital pseudarthrosis of tibia (Anaes.) (Assist.) | $2658.10 |
| 50357 | Transfer of tendon of rectus femoris or medial or lateral hamstring (H) (Anaes.) (Assist.) | $1242.20 |
| 50360 | Combined medial and lateral hamstring tendon transfer (H) (Anaes.) (Assist.) | $1380.50 |
| 50369 | Unilateral posterior release of knee contracture, with multiple tendon lengthening or tenotomies, including release of joint capsule (if performed), other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of knee replacement (H) (Anaes.) (Assist.) | $1385.80 |
| 50372 | Bilateral posterior release of knee contracture, with multiple tendon lengthening or tenotomies, including release of joint capsule (if performed), other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of knee replacement (H) (Anaes.) (Assist.) | $2321.00 |
| 50375 | Unilateral medial release of hip contracture, with lengthening or division of the adductors and psoas, including division of obturator nerve (if performed) (H) (Anaes.) (Assist.) | $1155.00 |
| 50378 | Bilateral medial release of hip contracture, with lengthening or division of adductors and psoas, including division of obturator nerve (if performed) (H) (Anaes.) (Assist.) | $1940.40 |
| 50381 | Unilateral anterior release of hip contracture, with lengthening or division of hip flexors and psoas, including division of joint capsule (if performed) (H) (Anaes.) (Assist.) | $1340.80 |
| 50384 | Bilateral anterior release of hip contracture, with lengthening or division of hip flexors and psoas, including division of joint capsule (if performed) (H) (Anaes.) (Assist.) | $2374.70 |
| 50390 | Application of cast under general anaesthesia, for patient with perthes, cerebral palsy, or other neuromuscular conditions, affecting hips or knees (H) (Anaes.) | $487.30 |
| 50393 | Acetabular shelf procedure, other than a service associated with a service to which another item of this Schedule applies if the service in the other item is for the purpose of performing arthroplasty on the hip (H) (Anaes.) (Assist.) | $1744.50 |
| 50394 | Multiple peri-acetabular osteotomy, including internal fixation (if performed) (H) (Anaes.) (Assist.) | $5907.50 |
| 50395 | Osteotomy and distillation of greater trochanter, with internal fixation (H) (Anaes.) (Assist.) | $1980.50 |
| 50396 | Amputation of congenital abnormalities or duplication of digits of the hand or foot, including any of the following (if performed): (a) splitting of phalanx or phalanges; (b) ligament reconstruction; (c) joint reconstruction (H) (Anaes.) (Assist.) | $1005.40 |
| 50399 | Forearm, radial aplasia or dysplasia (radial club hand), centralisation or radialisation of (H) (Anaes.) (Assist.) | $1870.90 |
| 50411 | Lower limb deficiency, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion (Anaes.) (Assist.) | $2658.10 |
| 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.) | $3586.60 |
| 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.) | $2658.10 |
| 50420 | Patella, congenital dislocation of, reconstruction of the quadriceps (H) (Anaes.) (Assist.) | $2194.40 |
| 50423 | TIBIA, FIBULA OR BOTH, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (Anaes.) (Assist.) | $2285.90 |
| 50426 | Removal of one or more lesions from bone, for osteochondroma occurring solitary or in association with hereditary multiple exotoses, with histological examination one approach (H) (Anaes.) (Assist.) | $986.70 |
| 50428 | Percutaneous drilling of osteochondritis dessicans or other osteochondral lesion, for a patient: (a) with open growth plates; or (b) less than 18 years of age (H) (Anaes.) (Assist.) | $1682.00 |
| 50450 | Unilateral single event multilevel surgery, for a patient less than 18 years of age with hemiplegic cerebral palsy, comprising 3 or more of the following: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; (b) correction of muscle imbalance by transfer of a tendon or tendons; (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 (H) (Anaes.) (Assist.) | $2477.00 |
| 50451 | Unilateral single event multilevel surgery, for a patient less than 18 years of age with hemiplegic cerebral palsy, comprising 3 or more of the following: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; (b) correction of muscle imbalance by transfer of a tendon or tendons; (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 (H) (Anaes.) (Assist.) | $2477.00 |
| 50455 | Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.) | $2805.00 |
| 50456 | Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.) | $2805.00 |
| 50460 | Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery and bilateral femoral osteotomies, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of torsional abnormality of the femur by rotational osteotomy and internal fixation; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.) | $4187.60 |
| 50461 | Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery and bilateral femoral osteotomies, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of torsional abnormality of the femur by rotational osteotomy and internal fixation; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.) | $4187.60 |
| 50465 | Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.) | $5898.40 |
| 50466 | Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.) | $5898.40 |
| 50470 | Bilateral single event multilevel surgery, for a patient 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, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; and (e) correction of bilateral pes valgus by os calcis lengthening or subtalar fusion; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.) | $7480.60 |
| 50471 | Bilateral single event multilevel surgery, for a patient 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, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; and (e) correction of bilateral pes valgus by os calcis lengthening or subtalar fusion; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.) | $7480.60 |
| 50475 | Single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, for the correction of crouch gait, including: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation; and (d) correction of patella alta and quadriceps insufficiency by patella tendon shortening or reconstruction; and (e) correction of tibial torsion by rotational osteotomy of the tibia with internal fixation; and (f) correction of foot instability by os calcis lengthening or subtalar fusion; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.) | $8631.80 |
| 50476 | Single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, for the correction of crouch gait including: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation; and (d) correction of patella alta and quadriceps insufficiency by patella tendon shortening or reconstruction; and (e) correction of tibial torsion by rotational osteotomy of the tibia with internal fixation; and (f) correction of foot instability by os calcis lengthening or subtalar fusion; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.) | $8631.80 |
| 50508 | Treatment of fracture of distal end of radius or ulna (or both), by closed reduction, for a patient with open growth plates (Anaes.) | $842.30 |
| 50512 | Treatment of fracture of distal end of radius or ulna (or both), by open or closed reduction, with internal fixation, for a patient with open growth plates (H) (Anaes.) (Assist.) | $1087.40 |
| 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 (H) (Anaes.) (Assist.) | $828.80 |
| 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 (H) (Anaes.) (Assist.) | $1573.60 |
| 50532 | Treatment of fracture of shafts of radius or ulna (or both), by closed reduction, for a patient with open growth plate (H) (Anaes.) | $1640.00 |
| 50536 | Treatment of fracture of shafts of radius or ulna (or both), by open or closed reduction, with internal fixation, for a patient with open growth plate (H) (Anaes.) (Assist.) | $1628.00 |
| 50540 | Olecranon, with open growth plate, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.) | $1089.90 |
| 50544 | RADIUS, with open growth plate, treatment of fracture of head or neck of, by closed reduction of (Anaes.) | $534.80 |
| 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 (H) (Anaes.) (Assist.) | $1070.10 |
| 50552 | Humerus, proximal, with open growth plate, treatment of fracture of, by closed reduction (H) (Anaes.) | $936.70 |
| 50556 | Treatment of fracture of proximal humerus, by open or closed reduction, with internal fixation, for a patient with open growth plate (H) (Anaes.) (Assist.) | $1246.50 |
| 50560 | Humerus, shaft of, with open growth plate, treatment of fracture of, by closed reduction (H) (Anaes.) | $962.60 |
| 50564 | Treatment of fracture of shaft of humerus, by open or closed reduction, with internal or external fixation, for a patient with open growth plate (H) (Anaes.) (Assist.) | $1283.60 |
| 50568 | Humerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by closed reduction (H) (Anaes.) | $1144.70 |
| 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 (H) (Anaes.) (Assist.) | $1521.30 |
| 50576 | Treatment of fracture of femur, by closed reduction or traction, including application of hip spica (if performed), for a patient with open growth plate (Anaes.) (Assist.) | $1533.80 |
| 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 (H) (Anaes.) (Assist.) | $1292.10 |
| 50584 | Tibia, distal, with open growth plate, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.) | $1377.50 |
| 50588 | Tibia and fibula, with open growth plates, treatment of fracture of, by internal fixation (H) (Anaes.) (Assist.) | $1631.30 |
| 50592 | Treatment of fracture of shaft of femur, by open or closed reduction, with internal or external fixation, for a patient with open growth plate (H) (Anaes.) (Assist.) | $2082.40 |
| 50596 | Treatment of fracture of shaft of tibia, by open or closed reduction, including casting, for a patient with open growth plate (H) (Anaes.) (Assist.) | $651.10 |
| 50600 | Scoliosis or kyphosis, in a child, manipulation of deformity and application of a localiser cast, under general anaesthesia, in a hospital (H) (Anaes.) (Assist.) | $877.50 |
| 50604 | Scoliosis or kyphosis, in a child or adolescent, spinal fusion for (without instrumentation) (H) (Anaes.) (Assist.) | $3724.80 |
| 50608 | Scoliosis or kyphosis, in a child or adolescent, treatment by segmental instrumentation and fusion of the spine, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.) | $6995.00 |
| 50612 | Scoliosis or kyphosis, in a child or adolescent, with spinal deformity, treatment by segmental instrumentation, utilising separate anterior and posterior approaches, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.) | $10023.30 |
| 50616 | Scoliosis, in a child or adolescent, re-exploration for adjustment or removal of segmental instrumentation used for correction of spine deformity (H) (Anaes.) (Assist.) | $1273.50 |
| 50620 | Scoliosis, in a child or adolescent, revision of failed scoliosis surgery, involving more than one of osteotomy, fusion, removal of instrumentation or instrumentation, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.) | $7086.20 |
| 50624 | Scoliosis, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar)—not more than 4 levels (H) (Anaes.) (Assist.) | $7298.10 |
| 50628 | Scoliosis, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) more than 4 levels (H) (Anaes.) (Assist.) | $8696.60 |
| 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, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.) | $7322.60 |
| 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, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.) | $7982.60 |
| 50640 | Scoliosis, in a child or adolescent, congenital, resection and fusion of abnormal vertebra via an anterior or posterior approach, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.) | $4412.60 |
| 50644 | Spine, bone graft to, for a child or adolescent, associated with surgery for correction of scoliosis or kyphosis or both (H) (Anaes.) (Assist.) | $4658.90 |
| 50654 | Examination or closed reduction (or both) of hip for a patient under the age of 18 years, including any of the following (if performed): (a) diagnostic injection; (b) arthrography; (c) application or reapplication of a hip spica (H) (Anaes.) (Assist.) | $1002.60 |
| **Radiofrequency ablation** | | |
| 50950 | Unresectable primary malignant tumour of the liver, destruction of, by percutaneous ablation (including any associated imaging services), other than a service associated with a service to which item 30419 or 50952 applies (Anaes.) | $1772.60 |
| 50952 | Unresectable primary malignant tumour of the liver, destruction of, by open or laparoscopic ablation (including any associated imaging services), if a multi disciplinary team has assessed that percutaneous 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 percutaneousablationprocedure;(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 ablation; other than a service associated with a service to which item 30419 or 50950 applies (Anaes.) | $1688.30 |
| **Spinal Surgery** | | |
| 51011 | Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a posterior spinal release, one motion segment, not being a service associated with a service to which item 51012, 51013, 51014 or 51015 applies (H) (Anaes.) (Assist.) | $2710.00 |
| 51012 | Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a posterior spinal release, 2 motion segments, not being a service associated with a service to which item 51011, 51013, 51014 or 51015 applies (H) (Anaes.) (Assist.) | $3613.50 |
| 51013 | Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a posterior spinal release, 3 motion segments, not being a service associated with a service to which item 51011, 51012, 51014 or 51015 applies (H) (Anaes.) (Assist.) | $4516.90 |
| 51014 | Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a posterior spinal release, 4 motion segments, not being a service associated with a service to which item 51011, 51012, 51013 or 51015 applies (H) (Anaes.) (Assist.) | $5420.40 |
| 51015 | Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a 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 (H) (Anaes.) (Assist.) | $6323.60 |
| 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.) | $1445.30 |
| 51021 | Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, one motion segment, excluding vertebral body tethering for the treatment of scoliosis and not being a service associated with a service to which item 51020, 51022, 51023, 51024, 51025 or 51026 applies (H) (Anaes.) (Assist.) | $2419.00 |
| 51022 | Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 2 motion segments, excluding vertebral body tethering for the treatment of scoliosis and not being a service associated with a service to which item 51020, 51021, 51023, 51024, 51025 or 51026 applies (H) (Anaes.) (Assist.) | $3009.10 |
| 51023 | Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 3 or 4 motion segments, excluding vertebral body tethering for the treatment of scoliosis and not being a service associated with a service to which item 51020, 51021, 51022, 51024, 51025 or 51026 applies (H) (Anaes.) (Assist.) | $3581.10 |
| 51024 | Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 5 or 6 motion segments, excluding vertebral body tethering for the treatment of scoliosis and not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51025 or 51026 applies (H) (Anaes.) (Assist.) | $4134.20 |
| 51025 | Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 7 to 12 motion segments, excluding vertebral body tethering for the treatment of scoliosis and not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51024 or 51026 applies (H) (Anaes.) (Assist.) | $4832.00 |
| 51026 | Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, more than 12 motion segments, excluding vertebral body tethering for the treatment of scoliosis and not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51024 or 51025 applies (H) (Anaes.) (Assist.) | $5290.40 |
| 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.) | $1777.50 |
| 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.) | $2133.00 |
| 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.) | $2488.80 |
| 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.) | $2666.50 |
| 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.) | $2844.20 |
| 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.) | $3022.00 |
| 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.) | $2044.30 |
| 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.) | $2862.10 |
| 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.) | $3577.50 |
| 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.) | $3884.10 |
| 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.) | $4088.50 |
| 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.) | $3493.00 |
| 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.) | $4248.30 |
| 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.) | $4833.70 |
| 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.) | $2577.30 |
| 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.) | $3866.00 |
| 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.) | $4510.20 |
| 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.) | $4531.50 |
| 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.) | $5099.00 |
| 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.) | $6230.90 |
| 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.) | $5352.20 |
| 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.) | $6937.60 |
| 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.) | $8402.80 |
| 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.) | $9351.70 |
| 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.) | $10342.90 |
| 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.) | $10889.90 |
| 51071 | Removal of intradural lesion, or primary extradural tumour or lesion, where the pathology is confirmed by histology—not including removal of synovial or juxtafacet cyst and not being a service associated with a service to which item 51072 or 51073 applies (H) (Anaes.) (Assist.) | $4720.30 |
| 51072 | Craniocervical junction lesion, transoral approach for, not being a service associated with a service to which item 51071 or 51073 applies (Anaes.) (Assist.) | $4909.10 |
| 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.) | $6230.90 |
| 51102 | Thoracoplasty in combination with thoracic scoliosis correction 3 or more ribs (Anaes.) (Assist.) | $2234.40 |
| 51103 | Odontoid screw fixation (Anaes.) (Assist.) | $3926.80 |
| 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.) | $1422.30 |
| 51111 | Skull calipers or halo, insertion of, as an independent procedure (Anaes.) | $604.50 |
| 51112 | Plaster jacket, application of, as an independent procedure (Anaes.) | $408.90 |
| 51113 | Halo, application of, in addition to spinal fusion for scoliosis, or other conditions (Anaes.) | $453.30 |
| 51114 | Halo thoracic orthosis application of both halo and thoracic jacket (Anaes.) | $800.00 |
| 51115 | Halo femoral traction, as an independent procedure (Anaes.) | $800.00 |
| 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.) | $444.80 |
| 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.) | $3386.70 |
| 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.) | $2044.30 |
| 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.) | $835.30 |
| 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.) | $1545.50 |
| 51145 | Wound debridement or excision for post operative infection or haematoma following spinal surgery (Anaes.) (Assist.) | $835.30 |
| 51150 | Coccyx, excision of (Anaes.) (Assist.) | $840.90 |
| 51160 | Anterior exposure of thoracic or lumbar spine, one motion segment, not being a service to which item 51165 applies (Anaes.) (Assist.) | $2171.30 |
| 51165 | Anterior exposure of thoracic or lumbar spine, more than one motion segment, excluding vertebral body tethering for the treatment of scoliosis and not being a service to which item 51160 applies (H) (Anaes.) (Assist.) | $2737.80 |
| 51170 | Syringomyelia or hydromyelia, craniotomy for, with or without duraplasty, intradural dissection, plugging of obex or local cerebrospinal fluid shunt (Anaes.) (Assist.) | $4124.70 |
| 51171 | Syringomyelia or hydromyelia, treatment by direct cerebrospinal fluid shunt (for example, syringosubarachnoid shunt, syringopleural shunt or syringoperitoneal shunt) (Anaes.) (Assist.) | $1732.20 |
| **Ear, nose and throat** | | |
| 41527 | Myringoplasty, by transcanal approach, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.) | $1249.70 |
| 41530 | Myringoplasty, post-aural or endaural approach, with or without mastoid inspection, other than a service associated with a service to which another item in this Subgroup applies(H) (Anaes.) | $1986.00 |
| 41533 | Atticotomy without reconstruction of the bony defect, with or without myringoplasty, other than a service associated with a service to which another item in this Subgroup applies(H) (Anaes.) (Assist.) | $2351.10 |
| 41536 | Atticotomy with reconstruction of the bony defect, with or without myringoplasty, other than a service associated with a service to which another item in this Subgroup applies(H) (Anaes.) (Assist.) | $2652.80 |
| 41545 | Mastoidectomy (cortical),other than a service associated with a service to which another item in this Subgroup applies(H) (Anaes.) (Assist.) | $1108.90 |
| 41551 | Mastoidectomy, intact wall technique, with myringoplasty, other than a service associated with a service to which another item in this Subgroup applies(H) (Anaes.) (Assist.) | $3287.00 |
| 41554 | Mastoidectomy, intact wall technique, with myringoplasty and ossicular chain reconstruction, other than a service associated with a service to which item 41603 or another item in this Subgroup applies(H) (Anaes.) (Assist.) | $3807.60 |
| 41557 | Mastoidectomy (radical or modified radical),other than a service associated with a service to which another item in this Subgroup applies(H) (Anaes.) (Assist.) | $2350.30 |
| 41560 | Mastoidectomy (radical or modified radical) and myringoplasty, other than a service associated with a service to which another item in this Subgroup applies(H) (Anaes.) | $2545.40 |
| 41563 | Mastoidectomy (radical or modified radical), myringoplasty and ossicular chain reconstruction, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.) | $3250.90 |
| 41564 | Mastoidectomy (radical or modified radical), obliteration of the mastoid cavity, blind sac closure of external auditory canal and obliteration of eustachian tube, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.) | $4065.80 |
| 41566 | Revision of mastoidectomy(radical, modified radical or intact wall), including myringoplasty, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.) | $2244.60 |
| 41629 | Middle ear, exploration of, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.) | $1110.20 |
| 41635 | Clearance of middle ear for granuloma, cholesteatoma and polyp, one or more, with or without myringoplasty, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.) | $2434.20 |
| 41638 | Clearance of middle ear for granuloma, cholesteatoma and polyp, one or more, with or without myringoplasty with ossicular chain reconstruction other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.) | $2944.70 |
| 41671 | Septal surgery, including septoplasty, septal reconstruction, septectomy, closure of septal perforation or other modifications of the septum, not including cauterisation, by any approach, other than a service associated with a service to which item 41689, 41692 or 41693 applies (H) (Anaes.) (Assist.) | $1065.30 |
| 41689 | Turbinate reduction, partial or total, unilateral or bilateral, other than a service associated with a service to which item 41671, 41692 or 41693 applies (Anaes.) | $291.00 |
| 41692 | Turbinate, submucous resection with removal of bone, unilateral or bilateral, other than a service associated with a service to which item 41671, 41689 or 41693 applies (H) (Anaes.) | $395.40 |
| 41693 | Septal surgery with submucous resection of turbinates, unilateral or bilateral, other than a service associated with a service to which item 41671, 41689, 41692 or 41764 applies (H) (Anaes.) (Assist.) | $1335.90 |
| 41702 | Functional sinus surgery of the ostiomeatal unit, including ethmoid, unilateral, other than a service associated with a service to which item 41662, 41698, 41703, 41705, 41710 or 41764 applies on the same side(H) (Anaes.) (Assist.) | $1188.40 |
| 41703 | Functional sinus surgery, complete dissection of all 5 sinuses and creation of single sinus cavity, unilateral, other than a service associated with a service to which item 41662, 41698, 41702, 41705, 41710, 41734, 41737, 41752 or 41764 applies on the same side (H) (Anaes.) (Assist.) | $1757.00 |
| 41705 | Functional sinus surgery, complete dissection of all 5 sinuses to create a single sinus cavity, with extended drilling of frontal sinuses, unilateral, other than a service associated with a service to which item 41662, 41698, 41702, 41703, 41710, 41734, 41737, 41752 or 41764 applies on the same side(H) (Anaes.) (Assist.) | $2858.80 |
| 41710 | Antrostomyby any approach, other than a service associated with a service to which item 41702, 41703, 41705 or 41698 applies on the same side (H) (Anaes.) (Assist.) | $995.00 |
| 41734 | Endoscopic Lothrop procedure or radical external frontal sinusotomy with osteoplastic flap, unilateral, other than a service associated with a service to which item 41698, 41703, 41705 or 41764 applies on the same side(H) (Anaes.) (Assist.) | $2156.70 |
| 41737 | Frontal sinus, unilateral, intranasal operation on, including complete dissection of frontal recess and exposure of frontal sinus ostium (excludes simple probing, dilatation or irrigation of frontal sinus), other than a service associated with a service to which item 41698, 41703, 41705 or 41764 applies on the same side(H) (Anaes.) (Assist.) | $1003.20 |
| 41752 | Sphenoidal sinus, unilateral, intranasal operation on, other than a service associated with a service to which item 41703 or 41705 applies on the same side(H) (Anaes.) (Assist.) | $613.10 |
| **GROU T9—ASSISTANCE AT OPERATIONS** | | |
| 51300 | NOTE: Benefit in respect of assistance at an operation is not payable unless the assistance is rendered by a medical practitioner other than the anaesthetist or assistant anaesthetist. The amount specified is the amount payable whether the assistance is rendered by one or more than one medical practitioner. Assistance at any operation identified by the word Assist for which the fee does not exceed $1196.80 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 $1196.80. | $187.30 |
| 51303 | Assistance at any operation identified by the word Assist for which the fee exceeds $1196.80 or at a series of operations identified by the word Assist for which the aggregate fee exceeds $1196.80. Derived fee: One fifth of the established fee for the operation or combination of operations. | DF |
| 51306 | Assistance at a birth involving Caesarean section | $268.20 |
| 51309 | Assistance at a series or combination of operations which have been identified by the word “Assist.” and assistance at a delivery involving Caesarean section 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) | DF |
| 51312 | Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615, 16627 and 16633 Derived Fee: one fifth of the established fee for the procedure or combination of procedures. | DF |
| 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 | $555.30 |
| 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 | $370.30 |
| **GROUP O1—CONSULTATIONS** | | |
| 51700 | APPROVED DENTAL PRACTITIONER, REFERRED CONSULTATION—SURGERY, HOSPITAL OR RESIDENTIAL AGED CARE FACILITY 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 | $177.00 |
| 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 | $89.00 |
| **GROUP O2—ASSISTANCE OF OPERATIONS** | | |
| 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 $1196.80 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 $1196.80. | $187.30 |
| 51803 | Assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery at any operation identified by the word Assist for which the fee exceeds $1196.80 or at a series of combination of operations identified by the word Assist where the aggregate fee exceeds $1196.80. Derived fee: One fifth of the established fee for the operation or combination of operations. | DF |
| **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.) | $674.00 |
| 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.) | $152.70 |
| 51904 | LIPECTOMY—wedge excision of skin or fat—1 EXCISION (Anaes.) (Assist.) | $935.40 |
| 51906 | LIPECTOMY- wedge excision of skin or fat—2 OR MORE EXCISIONS (Anaes.) (Assist.) | $1403.60 |
| 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.) | $170.50 |
| 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.) | $243.10 |
| 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.) | $243.10 |
| 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.) | $403.60 |
| 52010 | FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.) | $569.60 |
| 52012 | SUPERFICIAL FOREIGN BODY, removal of, as an independent procedure (Anaes.) | $99.90 |
| 52015 | SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and suture, as an independent procedure (Anaes.) | $409.50 |
| 52018 | FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.) | $572.10 |
| 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.) | $69.60 |
| 52024 | Biopsy of skin or mucous membrane, as an independent procedure (Anaes.) | $162.20 |
| 52025 | Lymph node of neck, biopsy of (Anaes.) | $373.00 |
| 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.) | $307.90 |
| 52030 | Sinus, excision of, involving superficial tissue only (Anaes.) | $186.10 |
| 52033 | Sinus, excision of, involving muscle and deep tissue (Anaes.) | $373.00 |
| 52034 | PREMALIGNANT LESIONS of the oral mucous, treatment by cryotherapy, diathermy or carbon dioxide laser | $182.60 |
| 52035 | Endoscopic laser therapy for neoplasia and benign vascular lesions of the oral cavity (Anaes.) | $1079.60 |
| 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.) | $277.80 |
| 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.) | $674.00 |
| 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.) | $369.10 |
| 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.) | $510.60 |
| 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.) | $771.80 |
| 52051 | TUMOUR, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.) | $1040.30 |
| 52054 | TUMOUR, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.) | $1277.10 |
| 52055 | HAEMATOMA, SMALL ABSCESS OR CELLULITIS, not requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding after care) | $56.70 |
| 52056 | HAEMATOMA, aspiration of (Anaes.) | $56.70 |
| 52057 | LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.) | $336.90 |
| 52058 | PERCUTANEOUS DRAINAGE OF DEEP ABSCESS, using interventional imaging techniques—but not including imaging (Anaes.) | $491.50 |
| 52059 | ABSCESS, DRAINAGE TUBE, exchange of using interventional imaging techniques—but not including imaging (Anaes.) | $1137.80 |
| 52060 | MUSCLE, excision of (Anaes.) | $391.10 |
| 52061 | MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.) | $453.90 |
| 52062 | MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.) | $600.00 |
| 52063 | BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) | $764.90 |
| 52064 | BONE CYST, injection into or aspiration of (Anaes.) | $362.30 |
| 52066 | SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.) | $1303.70 |
| 52069 | Sublingual gland, extirpation of (Anaes.) | $460.70 |
| 52072 | Salivary gland, dilatation or diathermy of duct (Anaes.) | $145.50 |
| 52073 | Salivary gland, repair of cutaneous fistula of (Anaes.) | $303.50 |
| 52075 | SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures (Anaes.) | $326.80 |
| 52078 | TONGUE, partial excision of (Anaes.) (Assist.) | $630.10 |
| 52081 | Tongue tie, division or excision of frenulum (Anaes.) | $181.10 |
| 52084 | TONGUE TIE, MANDIBULAR FRENULUM OR MAXILLARY FRENULUM, division or excision of frenulum, in a patient aged not less than 2 years (Anaes.) | $240.70 |
| 52087 | Ranula or mucous cyst of mouth, removal of (Anaes.) | $422.50 |
| 52090 | OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis—1 bone or in combination with adjoining bones (Anaes.) (Assist.) | $736.70 |
| 52092 | OPERATION on SKULL for OSTEOMYELITIS (Anaes.) (Assist.) | $942.60 |
| 52094 | OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 52092 (Anaes.) (Assist.) | $1224.40 |
| 52095 | BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.) | $868.10 |
| 52096 | ORTHOPAEDIC PIN OR WIRE, insertion of, into maxilla or mandible or zygoma, as an independent procedure (Anaes.) | $346.60 |
| 52097 | EXTERNAL FIXATION, removal of, in the operating theatre of a hospital (Anaes.) | $330.90 |
| 52098 | EXTERNAL FIXATION, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.) | $387.00 |
| 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.) | $291.90 |
| 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.) | $303.30 |
| 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.) | $543.50 |
| 52106 | ARCH BARS, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia where undertaken in the operating theatre of a hospital (Anaes.) | $336.20 |
| 52108 | LIP, full thickness wedge excision of, with repair by direct sutures (Anaes.) (Assist.) | $674.00 |
| 52111 | VERMILIONECTOMY (Anaes.) (Assist.) | $752.70 |
| 52114 | MANDIBLE or MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.) | $1216.30 |
| 52117 | MANDIBLE, including lower border, or MAXILLA, sub-total resection of (Anaes.) (Assist.) | $1430.20 |
| 52120 | MANDIBLE, hemimandiblectomy of, including condylectomy where performed (Anaes.) (Assist.) | $3517.20 |
| 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.) | $3517.20 |
| 52123 | MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.) | $1900.20 |
| 52126 | MAXILLA, total resection of (Anaes.) (Assist.) | $1827.10 |
| 52129 | MAXILLA, total resection of both maxillae (Anaes.) (Assist.) | $2445.70 |
| 52130 | BONE GRAFT, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) | $915.00 |
| 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.) | $1638.40 |
| 52132 | Tracheostomy (Anaes.) | $1058.20 |
| 52133 | CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.) | $184.80 |
| 52135 | POST-OPERATIVE or POST-NASAL HAEMORRHAGE, or both, control of, where undertaken in the operating theatre of a hospital (Anaes.) | $298.60 |
| 52138 | MAXILLARY ARTERY, ligation of (Anaes.) (Assist.) | $1420.30 |
| 52141 | FACIAL, MANDIBULAR or LINGUAL ARTERY or VEIN or ARTERY and VEIN, ligation of, not being a service to which item 52138 applies (Anaes.) (Assist.) | $918.00 |
| 52144 | FOREIGN BODY, deep, removal of using interventional imaging techniques (Anaes.) (Assist.) | $855.30 |
| 52147 | DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.) | $803.00 |
| 52148 | PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.) | $1399.70 |
| 52158 | SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.) | $2291.90 |
| 52180 | MALIGNANT DISEASE AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, biopsy of (not including aftercare) (Anaes.) | $431.40 |
| 52182 | BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes.) (Assist.) | $885.00 |
| 52184 | BONE TUMOUR, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) | $1302.30 |
| 52186 | BONE TUMOUR, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) | $1557.70 |
| **GROUP O4—PLASTIC AND RECONSTRUCTIVE** | | |
| 52300 | SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, with skin or mucosa (Anaes.) (Assist.) | $588.10 |
| 52303 | SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, with buccal pad of fat (Anaes.) (Assist.) | $839.40 |
| 52306 | SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.) | $1245.70 |
| 52309 | Free grafting (mucosa or split skin) of a granulating area (Anaes.) | $415.30 |
| 52312 | FREE GRAFTING (mucosa, split skin or connective tissue) to 1 defect, including elective dissection (Anaes.) (Assist.) | $586.80 |
| 52315 | FREE GRAFTING, FULL THICKNESS, to 1 defect (mucosa or skin) (Anaes.) (Assist.) | $966.50 |
| 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.) | $402.30 |
| 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.) | $731.90 |
| 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.) | $991.10 |
| 52324 | DIRECT FLAP REPAIR, using tongue, first stage (Anaes.) (Assist.) | $1839.60 |
| 52327 | Direct flap repair, using tongue, second stage (Anaes.) | $977.90 |
| 52330 | PALATAL DEFECT (oro-nasal fistula), plastic closure of, including services to which item 52300, 52303, 52306 or 52324 applies (Anaes.) (Assist.) | $1681.70 |
| 52333 | CLEFT PALATE, primary repair (Anaes.) (Assist.) | $1586.70 |
| 52336 | CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.) (Assist.) | $1048.80 |
| 52337 | ALVEOLAR CLEFT (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes.) (Assist.) | $2321.80 |
| 52339 | CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.) | $1129.30 |
| 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.) | $1988.70 |
| 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.) | $2365.40 |
| 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.) | $2645.90 |
| 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.) | $4502.00 |
| 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.) | $2889.30 |
| 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.) | $4145.70 |
| 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.) | $3427.50 |
| 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.) | $5593.20 |
| 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.) | $3665.20 |
| 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.) | $6464.40 |
| 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.) | $3998.40 |
| 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.) | $5932.30 |
| 52378 | GENIOPLASTY including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) | $2549.00 |
| 52379 | FACE, contour reconstruction of 1 region, using autogenous bone or cartilage graft (Anaes.) (Assist.) | $2994.50 |
| 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.) | $4453.80 |
| 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.) | $6628.90 |
| 52420 | Mandible, fixation by intermaxillary wiring, excluding wiring for obesity | $624.20 |
| 52424 | DERMIS, DERMOFAT OR FASCIA GRAFT (excluding transfer of fat by injection) (Anaes.) (Assist.) | $1461.70 |
| 52430 | MICROVASCULAR REPAIR OF, using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.) | $2212.30 |
| 52440 | CLEFT LIP, unilateral—primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) | $1098.60 |
| 52442 | CLEFT LIP, unilateral—primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) | $1373.40 |
| 52444 | CLEFT LIP, bilateral—primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) | $1525.80 |
| 52446 | CLEFT LIP, bilateral—primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) | $1800.70 |
| 52450 | CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.) | $610.20 |
| 52452 | CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.) | $1010.70 |
| 52456 | CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) | $1678.60 |
| 52458 | CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) | $610.20 |
| 52460 | VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.) | $1586.70 |
| 52480 | COMPOSITE GRAFT (Chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (Anaes.) (Assist.) | $1019.10 |
| 52482 | MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.) | $980.60 |
| 52484 | MACROSTOMIA, operation for (Anaes.) (Assist.) | $1167.30 |
| **GROUP O5—PREPROSTHETIC** | | |
| 52600 | MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) | $719.60 |
| 52603 | MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.) | $668.80 |
| 52606 | Maxillary tuberosity, reduction of (Anaes.) | $510.00 |
| 52609 | PAPILLARY HYPERPLASIA OF THE PALATE, removal of—less than 5 lesions (Anaes.) (Assist.) | $668.80 |
| 52612 | PAPILLARY HYPERPLASIA OF THE PALATE, removal of—5 to 20 lesions (Anaes.) (Assist.) | $839.40 |
| 52615 | PAPILLARY HYPERPLASIA OF THE PALATE, removal of—more than 20 lesions (Anaes.) (Assist.) | $1042.10 |
| 52618 | VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed—unilateral or bilateral (Anaes.) (Assist.) | $1212.90 |
| 52621 | FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed—unilateral (Anaes.) (Assist.) | $1989.20 |
| 52624 | ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both—unilateral (Anaes.) (Assist.) | $1008.40 |
| 52626 | ALVEOLAR RIDGE AUGMENTATION—unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.) | $645.30 |
| 52627 | OSSEO-INTEGRATION PROCEDURE—in the practice of oral and maxillofacial surgery, extra oral implantation of titanium fixture (Anaes.) (Assist.) | $1083.20 |
| 52630 | OSSEO-INTEGRATION PROCEDURE—in the practice of oral and maxillofacial surgery, fixation of transcutaneous abutment (Anaes.) | $441.70 |
| 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.) | $1624.70 |
| 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.) | $783.50 |
| **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.) | $573.40 |
| 52803 | NERVE TRUNK, internal (interfascicular), NEUROLYSIS of, using microsurgical techniques (Anaes.) (Assist.) | $824.10 |
| 52806 | NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from superficial peripheral nerve (Anaes.) (Assist.) | $561.60 |
| 52809 | NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from deep peripheral nerve (Anaes.) (Assist.) | $961.20 |
| 52812 | NERVE TRUNK, PRIMARY repair of, using microsurgical techniques (Anaes.) (Assist.) | $1399.80 |
| 52815 | NERVE TRUNK, SECONDARY repair of, using microsurgical techniques (Anaes.) (Assist.) | $2935.60 |
| 52818 | NERVE, TRANSPOSITION OF (Anaes.) (Assist.) | $957.60 |
| 52821 | NERVE GRAFT TO NERVE TRUNK, (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.) | $2090.60 |
| 52824 | PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.) | $917.20 |
| 52826 | INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.) | $482.20 |
| 52828 | CUTANEOUS NERVE, primary repair of, using microsurgical techniques (Anaes.) (Assist.) | $717.10 |
| 52830 | CUTANEOUS NERVE, secondary repair of, using microsurgical techniques (Anaes.) (Assist.) | $945.80 |
| 52832 | CUTANEOUS NERVE, nerve graft to, using microsurgical techniques (Anaes.) (Assist.) | $1297.10 |
| **GROUP O7—EAR, NOSE AND THROAT** | | |
| 53000 | Maxillary antrum, proof puncture and lavage of (Anaes.) | $71.00 |
| 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.) | $189.10 |
| 53004 | MAXILLARY ANTRUM, LAVAGE OF—each attendance at which the procedure is performed, including any associated consultation (Anaes.) | $116.00 |
| 53006 | ANTROSTOMY (RADICAL) (Anaes.) (Assist.) | $1078.00 |
| 53009 | ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.) | $612.10 |
| 53012 | Antrum, drainage of, through tooth socket (Anaes.) | $243.20 |
| 53015 | ORO-ANTRAL FISTULA, plastic closure of (Anaes.) (Assist.) | $1215.30 |
| 53016 | NASAL SEPTUM, septoplasty, submucous resection or closure of septal perforation (Anaes.) (Assist.) | $1225.60 |
| 53017 | NASAL SEPTUM, reconstruction of (Anaes.) (Assist.) | $2336.00 |
| 53019 | MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.) | $1351.10 |
| 53052 | Post-nasal space, direct examination of, with or without biopsy (Anaes.) | $249.00 |
| 53054 | NASENDOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX one or more of these procedures (Anaes.) | $483.20 |
| 53056 | EXAMINATION OF NASAL CAVITY or POST-NASAL SPACE, or NASAL CAVITY AND POST-NASAL SPACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) | $148.70 |
| 53058 | NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) | $249.00 |
| 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.) | $203.90 |
| 53062 | POST SURGICAL NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) | $182.60 |
| 53064 | Cryotherapy to nose in the treatment of nasal haemorrhage (Anaes.) | $330.40 |
| 53068 | Turbinectomy or turbinectomies, partial or total, unilateral (Anaes.) | $580.20 |
| 53070 | Turbinates, submucous resection of, unilateral (Anaes.) | $516.70 |
| **GROUP O8—TEMPOROMANDIBULAR JOINT** | | |
| 53200 | Mandible, treatment of a dislocation of, not requiring open reduction (Anaes.) | $145.50 |
| 53203 | Mandible, treatment of a dislocation of, requiring open reduction (Anaes.) | $240.80 |
| 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.) | $304.50 |
| 53209 | GLENOID FOSSA, ZYGOMATIC ARCH and TEMPORAL BONE, reconstruction of (Obwegeser technique) (Anaes.) (Assist.) | $3346.10 |
| 53212 | ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.) | $1808.80 |
| 53215 | TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes.) (Assist.) | $1737.60 |
| 53218 | TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions—1 or more such procedures (Anaes.) (Assist.) | $1747.60 |
| 53220 | TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) | $668.80 |
| 53221 | TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.) | $1800.50 |
| 53224 | TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.) | $1962.20 |
| 53225 | ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.) | $599.10 |
| 53226 | TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) | $633.90 |
| 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.) | $2411.10 |
| 53230 | TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.) | $4520.80 |
| 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.) | $4789.20 |
| 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.) | $954.90 |
| 53239 | TEMPOROMANDIBULAR JOINT, arthrodesis of, not being a service to which another item in this Group applies (Anaes.) (Assist.) | $954.90 |
| 53242 | TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) | $645.90 |
| **GROUP O9—TREATMENT OF FRACTURES** | | |
| 53400 | MAXILLA, unilateral or bilateral, treatment of fracture of, not requiring splinting | $262.00 |
| 53403 | Mandible, treatment of fracture of, not requiring splinting | $326.30 |
| 53406 | MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) | $1139.70 |
| 53409 | MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) | $836.20 |
| 53410 | Zygomatic bone, treatment of fracture of, not requiring surgical reduction | $173.70 |
| 53411 | ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.) | $598.30 |
| 53412 | ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.) (Assist.) | $807.60 |
| 53413 | ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.) | $996.30 |
| 53414 | ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.) | $1539.10 |
| 53415 | MAXILLA, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) | $900.00 |
| 53416 | MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) | $901.10 |
| 53418 | MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) | $1149.50 |
| 53419 | MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) | $1165.90 |
| 53422 | MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) | $1797.50 |
| 53423 | MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) | $1475.40 |
| 53424 | MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.) | $2024.70 |
| 53425 | MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.) | $1293.60 |
| 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.) | $1732.90 |
| 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.) | $1807.70 |
| 53439 | Mandible, treatment of a closed fracture of, involving a joint surface (Anaes.) | $491.40 |
| 53453 | ORBITAL CAVITY, reconstruction of a wall or floor with or without foreign implant (Anaes.) (Assist.) | $1162.20 |
| 53455 | ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.) | $1767.20 |
| 53458 | Nasal bones, treatment of fracture of, not being a service to which item 53459 or 53460 applies | $88.80 |
| 53459 | Nasal bones, treatment of fracture of, by reduction (Anaes.) | $532.60 |
| 53460 | NASAL BONES, treatment of fractures of, by open reduction involving osteotomies (Anaes.) (Assist.) | $1682.50 |
| **GROUP O11—REGIONAL OR FIELD NERVE BLOCKS** | | |
| 53700 | (Note. Where an anaesthetic combines a regional nerve block with a general anaesthetic for an operative procedure, benefits will be paid only under the anaesthetic item relevant to the operation. The items in this Group are to be used in the practice of oral and maxillofacial surgery and are not to be used for dental procedures (eg. restorative dentistry or dental extraction.)) TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent | $253.40 |
| 53702 | TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent | $127.00 |
| 53704 | Facial nerve, injection of an anaesthetic agent | $76.20 |
| 53706 | NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies | $530.80 |
| **GROUP I1—ULTRASOUND** | | |
| **General** | | |
| 55028 | Head, ultrasound scan of (R) | $229.60 |
| 55029 | Head, ultrasound scan of (NR) | $80.70 |
| 55030 | Orbital contents, ultrasound scan of (R) | $232.70 |
| 55031 | Orbital contents, ultrasound scan of (NR) | $82.20 |
| 55032 | Neck, one or more structures of, ultrasound scan of (R) | $218.10 |
| 55033 | Neck, one or more structures of, ultrasound scan of (NR) | $80.40 |
| 55036 | Abdomen, ultrasound scan of (including scan of urinary tract when performed), for morphological assessment, if: (a) the service is not solely a transrectal ultrasonic examination of any of the following:(i) prostate gland;(ii) bladder base;(iii) urethra; and(b) within 24 hours of the service, a service mentioned in item 55038 is not performed on the same patient by the providing practitioner (R) | $224.90 |
| 55037 | Abdomen, ultrasound scan of (including scan of urinary tract when performed), for morphological assessment, if the service is not solely a transrectal ultrasonic examination of any of the following:(i) prostate gland;(ii) bladder base;(iii) urethra (NR) | $80.70 |
| 55038 | Urinary tract, ultrasound scan of, if: (a) the service is not solely a transrectal ultrasonic examination of any of the following: (i) prostate gland; (ii) bladder base; (iii) urethra; and (b) within 24 hours of the service, a service mentioned in item 55036 or 55065 is not performed on the same patient by the providing practitioner (R) | $220.30 |
| 55039 | Urinary tract, ultrasound scan of, if the service is not solely a transrectal ultrasonic examination of any of the following: (a) prostate gland; (b) bladder base; (c) urethra (NR) | $80.40 |
| 55048 | Scrotum, ultrasound scan of (R) | $221.50 |
| 55049 | Scrotum, ultrasound scan of (NR) | $75.10 |
| 55054 | Ultrasonic cross-sectional echography, in conjunction with a surgical procedure (other than a procedure to which item 55848 or 55850 applies) using interventional techniques, not being a service associated with a service to which any other item in this Group applies (R) | $218.60 |
| 55065 | Pelvis, ultrasound scan of, by any or all approaches, if:(a) the service is not solelya service to which an item (other than item 55736 or 55739) in Subgroup 5 of this Group applies ora transrectal ultrasonic examination of any of the following: prostate gland; bladder base; urethra; and (b) within 24 hours of the service, a service mentioned in item 55038 is not performed on the same patient by the providing practitioner (R) | $201.30 |
| 55066 | Breasts, both, ultrasound scan, in conjunction with a surgical procedure using interventional techniques, if:(a) the request for the scan indicates that an ultrasound guided breast intervention be performed; and(b) the service is not performed in conjunction with any other item in this Group (R) | $401.60 |
| 55068 | Pelvis, ultrasound scan of, by any or all approaches, if the service is not solely a service to which an item (other than item 55736 or 55739) in Subgroup 5 of this Group applies or a transrectal ultrasonic examination of any of the following:(i) prostate gland;(ii) bladder base;(iii) urethra (NR) | $71.80 |
| 55070 | Breast, one, ultrasound scan of (R) | $210.20 |
| 55071 | Breast, one, ultrasound scan, in conjunction with a surgical procedure using interventional techniques, if:(a) the request for the scan indicates that an ultrasound guided breast intervention be performed; and(b) the service is not performed in conjunction with any other item in this group (R) | $381.60 |
| 55073 | Breast, one, ultrasound scan of (NR) | $71.60 |
| 55076 | Breasts, both, ultrasound scan of, including an ultrasound scan for post mastectomy surveillance (R) | $229.90 |
| 55079 | Breasts, both, ultrasound scan of, including an ultrasound scan for post mastectomy surveillance (NR) | $89.00 |
| 55084 | Urinary bladder, ultrasound scan of, by any or all approaches, if within 24 hours of the service, a service mentioned in item 11917, 55036, 55038, 55065, 55600 or 55603 is not performed on the same patient by the providing practitioner (R) | $206.90 |
| 55085 | Urinary bladder, ultrasound scan of, by any or all approaches, if within 24 hours of the service, a service mentioned in item 11917, 55037, 55039, 55068, 55600 or 55603 is not performed on the same patient by the providing practitioner (NR) | $68.00 |
| **Cardiac** | | |
| 55118 | Heart, two-dimensional or three-dimensional real time transoesophageal examination of, from at least 2 levels, and in more than one plane at each level, if: (a) the service includes: (i) real time colour flow mapping and, if indicated, pulsed wave Doppler examination; and (ii) recordings on digital media; and (b) the service is not an intra-operative service; and (c) not being a service associated with a service to which an item in Subgroup 3 applies.(R) (Anaes.) | $579.20 |
| 55130 | Intraoperative two-dimensional or three-dimensional real time transoesophageal echocardiography, if the service: (a) includes Doppler techniques with colour flow mapping and recordings on digital media; and (b) is performed during cardiac surgery; and (c) incorporates sequential assessment of cardiac function before and after the surgical procedure; and (d) is not associated with a service to which item 55135, or an item in Subgroup 3, applies (R) (Anaes.) | $357.90 |
| 55135 | Intraoperative two-dimensional or three-dimensional real time transoesophageal echocardiography, if the service: (a) is provided on the same day as a service to which item 38477, 38484, 38499, 38516 or 38517 applies; and (b) includes Doppler techniques with colour flow mapping and recordings on digital media; and (c) is performed during cardiac valve surgery (replacement or repair); and (d) incorporates sequential assessment of cardiac function and valve competence before and after the surgical procedure; and (e) is not associated with a service to which item 22054, 55130, or an item in Subgroup 3, applies (R) (Anaes.) | $744.70 |
| **Vascular** | | |
| 55238 | Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb or of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with any of the following:(a) a service to which an item in Subgroup 4 applies;(b) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R) | $340.00 |
| 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 any of the following:(a) a service to which item 55246 applies;(b) a service to which an item in Subgroup 4 applies;(c) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R) | $340.80 |
| 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 any of the following:(a) a service to which item 55244 applies;(b) a service to which an item in Subgroup 4 applies;(c) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R) | $342.10 |
| 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 4 applies (R) | $340.60 |
| 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 Subgroup 4 applies (R). | $339.00 |
| 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 witha service to which an item in Subgroup 4 applies (R). | $338.90 |
| 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 witha service to which an item in Subgroup 4 applies (R) | $341.10 |
| 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 witha service to which an item in Subgroup 4 applies (R) | $355.50 |
| 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 witha service to which an item in Subgroup 4 applies (R) | $360.70 |
| 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) if 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 performed, immediately before or for a period during the performance of the service; and(d) if the 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 4 applies (R) | $356.30 |
| 55284 | Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements:(a) by spectral analysis of cavernosal tissue of the penis to confirm a diagnosis; and(b) if indicated, assess the progress and management of:(i) priapism; or(ii) fibrosis of any type; or(iii) fracture of the tunica; or(iv) arteriovenous malformations; and(c) if 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 performed, immediately before or for a period during the performance of the service; and(d) if the 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 4 applies (R) | $357.00 |
| 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 grafts in the upper or lower limbs, not being a service associated with a service to which an item in Subgroup 4 applies (R) | $358.80 |
| 55294 | Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or veins, or both, including any associated skin marking, for mapping of bypass conduit before vascular surgery, not being a service associated with any of the following:(a) a service to which an item in Subgroup 3 or 4 applies; (b) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R) | $356.40 |
| 55296 | Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow spectral analysis and marking of veins in the lower limbs below the inguinal ligament before varicose vein surgery, including any associated skin marking, not being a service associated with any of the following:(a) a service to which an item in Subgroup 3 or 4 applies;(b) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R) | $235.40 |
| **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) | $220.60 |
| 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) | $235.00 |
| **Obstetric and gynaecological** | | |
| 55700 | Pelvis or abdomen, pregnancy related or pregnancy complication, ultrasound (the current ultrasound) scan of, by any or all approaches, for determining the gestation, location, viability or number of fetuses, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is less than 12 weeks of gestation; and (b) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55704, 55705, 55707, 55708, 55740, 55741, 55742 or 55743 (R) | $121.10 |
| 55703 | Pelvis or abdomen, pregnancy related or pregnancy complication, ultrasound (the current ultrasound) scan of, by any or all approaches, for determining the gestation, location, viability or number of fetuses, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is less than 12 weeks of gestation; and (b) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55704, 55705, 55707, 55708, 55740, 55741, 55742 or 55743 (NR) | $73.80 |
| 55704 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, for determining the structure, gestation, location, viability or number of fetuses, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is 12 to 16 weeks of gestation; and (b) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (R) | $148.40 |
| 55705 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, for determining the structure, gestation, location, viability or number of fetuses, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is 12 to 16 weeks of gestation; and (b) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (NR) | $73.80 |
| 55706 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the dating for the pregnancy (as confirmed by the current ultrasound) is 17 to 22 weeks of gestation; and (b) the current ultrasound: (i) is not performed in the same pregnancy as item 55709; and (ii) is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758 (R) | $202.00 |
| 55707 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, if: (a) the pregnancy (as confirmed by the current ultrasound) is dated by a fetal crown rump length of 45 to 84 mm; and (b) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (c) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (R) | $216.70 |
| 55709 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is 17 to 22 weeks of gestation; and (b) the current ultrasound: (i) is not performed in the same pregnancy as item 55706; and (ii) is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758(NR) | $113.70 |
| 55712 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the current ultrasound is requested by a medical practitioner who: (i) is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) 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 (iv) has obstetric privileges at a non metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by the current ultrasound) is 17 to 22 weeks of gestation; and (c) further examination is clinically indicated after performance, in the same pregnancy, of a scan mentioned in item 55706 or 55709; and (d)the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758(R) | $242.30 |
| 55715 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current 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, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is 17 to 22 weeks of gestation; and (b) further examination is clinically indicated after performance, in the same pregnancy, of a scan mentioned in item 55706 or 55709; and (c)the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758(NR) | $84.20 |
| 55718 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is after 22 weeks of gestation; and (b) the current ultrasound: (i) is not performed in the same pregnancy as item 55723; and (ii) is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758(R) | $213.30 |
| 55721 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, if: (a) the current ultrasound is requested by a medical practitioner who: (i) is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) 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 (iv) has obstetric privileges at a non metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by current ultrasound) is after 22 weeks of gestation; and (c) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies; and (d)the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758(R) | $242.30 |
| 55723 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is after 22 weeks of gestation; and (b) the current ultrasound: (i) is not performed in the same pregnancy as item 55718; and (ii) is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758(NR) | $80.00 |
| 55725 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current 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, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is after 22 weeks of gestation; and (b) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies; and (c) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758(NR) | $84.20 |
| 55729 | Duplex scanning, if:(a) the service involves:(i) B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of the umbilical artery; and(ii) measured assessment of amniotic fluid volume after the 24th week of gestation; and(b) there is reason to suspect intrauterine growth retardation or a significant risk of fetal death; examination and report (R) | $57.40 |
| 55736 | Pelvis, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, if a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (R) | $305.00 |
| 55739 | Pelvis, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, if a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (NR) | $126.00 |
| 55740 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, for determining the structure, gestation, location, viability or number of fetuses, if: (a) an ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the dating of the pregnancy (as confirmed by the current ultrasound) is 12 to 16 weeks of gestation; and (c) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (R) | $191.50 |
| 55741 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, for determining the structure, gestation, location, viability or number of fetuses, if: (a) an ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the dating of the pregnancy (as confirmed by the current ultrasound) is 12 to 16 weeks of gestation; and (c) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (NR) | $95.80 |
| 55742 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, if: (a) an ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the pregnancy (as confirmed by the current ultrasound) is dated by a fetal crown rump length of 45 to 84 mm; and (c) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (d) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (R) | $191.50 |
| 55743 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, if: (a) an ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the pregnancy (as confirmed by the current ultrasound) is dated by a fetal crown rump length of 45 to 84 mm; and (c) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (d) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (NR) | $95.80 |
| 55757 | Pelvis or abdomen, ultrasound (the current ultrasound) scan of, for cervical length assessment for risk of preterm labour, by any or all approaches, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is between 14 and 30 weeks of gestation; and (b) any of the following apply: (i) the patient has a history indicating high risk of preterm labour or birth or second trimester fetal loss; (ii) the patient has symptoms suggestive of threatened preterm labour or second trimester fetal loss; (iii) the patient s cervical length is less than 25 mm on an ultrasound before 28 weeks gestation; and (c) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (R) | $91.20 |
| 55758 | Pelvis or abdomen, ultrasound (the current ultrasound) scan of, for cervical length assessment for risk of preterm labour, by any or all approaches, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is between 14 and 30 weeks of gestation; and (b) any of the following apply: (i) the patient has a history indicating high risk of preterm labour or birth or second trimester fetal loss; (ii) the patient has symptoms suggestive of threatened preterm labour or second trimester fetal loss; (iii) the patient s cervical length is less than 25 mm on an ultrasound before 28 weeks gestation; and (c) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (NR) | $34.70 |
| 55759 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) an ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the dating of the pregnancy (as confirmed by the current ultrasound) is 17 to 22 weeks gestation; and (c) the service mentioned in item 55706, 55709, 55712, 55715 or 55762 is not performed in conjunction with the current ultrasound during the same pregnancy; and (d) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758 (R) | $315.60 |
| 55762 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) an ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the dating of the pregnancy (as confirmed by the current ultrasound) is 17 to 22 weeks gestation; and (c) the service mentioned in item 55706, 55709, 55712, 55715 or 55759 is not performed in conjunction with the current ultrasound during the same pregnancy; and (d) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758 (NR) | $162.10 |
| 55764 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the service is requested by a medical practitioner who: (i) is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of Obstetrics; or (iv) has obstetric privileges at a non metropolitan hospital; and (b) an ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by the current ultrasound) is 17 to 22 weeks gestation; and (d) further examination is clinically indicated in the same pregnancy in which item 55759 or 55762 has been performed; and (e) the service mentioned in item 55706, 55709, 55712 or 55715 is not performed in conjunction with the current ultrasound during the same pregnancy; and (f)the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758(R) | $336.90 |
| 55766 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current 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, if: (a) an ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the dating of the pregnancy (as confirmed by the current ultrasound) is 17 to 22 weeks of gestation; and (c) further examination is clinically indicated in the same pregnancy in which item 55759 or 55762 has been performed; and (d) the service mentioned in item 55706, 55709, 55712 or 55715 is not performed in conjunction with the current ultrasound during the same pregnancy; and (e)the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758(NR) | $137.10 |
| 55768 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, if: (a) dating of the pregnancy (as confirmed by the current ultrasound) is after 22 weeks of gestation; and (b) an ultrasound confirms a multiple pregnancy; and (c) the service is not performed in the same pregnancy as item 55770; and (d) the service mentioned in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the current ultrasound during the same pregnancy; and (e)the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758(R) | $316.00 |
| 55770 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, if: (a) dating of the pregnancy (as confirmed by the current ultrasound) is after 22 weeks of gestation; and (b)an ultrasound confirms a multiple pregnancy; and (c)the service is not performed in the same pregnancy as item 55768; and (d) the service mentioned in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the current ultrasound during the same pregnancy; and (e)the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758(NR) | $126.30 |
| 55772 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current ultrasound) scan of, by any or all approaches, if: (a) dating of the pregnancy as confirmed by the current ultrasound is after 22 weeks of gestation; and (b)the service is requested by a medical practitioner who: (i) is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of Obstetrics; or (iv) 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 an ultrasound is a multiple pregnancy; and (e) the service mentioned in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the current ultrasound during the same pregnancy; and (f)the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758(R) | $336.90 |
| 55774 | Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound (the current 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, if: (a) dating of the pregnancy as confirmed by the current ultrasound is after 22 weeks of gestation; and (b) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed; and (c) the pregnancy as confirmed by an ultrasound is a multiple pregnancy; and (d) the service mentioned in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the current ultrasound during the same pregnancy; and (e)the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in item 55757 or 55758(NR) | $137.10 |
| **Musculoskeletal** | | |
| 55812 | Chest or abdominal wall, one or more areas, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55070, 55073, 55076 or 55079 (R) | $219.90 |
| 55814 | Chest or abdominal wall, one or more areas, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55070, 55073, 55076 or 55079 (NR) | $76.30 |
| 55844 | Assessment of a mass associated with the skin or subcutaneous structures, not being a part of the musculoskeletal system, one or more areas, ultrasound scan of (R) | $175.40 |
| 55846 | Assessment of a mass associated with the skin or subcutaneous structures, not being a part of the musculoskeletal system, one or more areas, ultrasound scan of (NR) | $79.80 |
| 55848 | Musculoskeletal ultrasound, 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 a service mentioned in item 55054 (R) | $259.50 |
| 55850 | Musculoskeletal ultrasound, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, if:(a) the medical practitioner or nurse practitioner has indicated on a request for a musculoskeletal ultrasound that an ultrasound guided intervention be performed if clinically indicated; and(b) the service is not performed in conjunction with a service mentioned in item 55054 or any other item in this Subgroup (R) | $386.70 |
| 55852 | Paediatric spine, spinal cord and overlying subcutaneous tissues, ultrasound scan of (R) | $230.10 |
| 55854 | Paediatric spine, spinal cord and overlying subcutaneous tissues, ultrasound scan of (NR) | $79.80 |
| 55856 | Hand or wrist or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55858 (R) | $231.40 |
| 55857 | Hand or wrist, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55859 (NR) | $76.30 |
| 55858 | Hand or wrist, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55856 (R) | $241.50 |
| 55859 | Hand or wrist, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55857 (NR) | $83.90 |
| 55860 | Forearm or elbow, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55862 (R) | $229.30 |
| 55861 | Forearm or elbow, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55863 (NR) | $76.00 |
| 55862 | Forearm or elbow, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55860 (R) | $262.80 |
| 55863 | Forearm or elbow, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55861 (NR) | $83.60 |
| 55864 | Shoulder or upper arm, or both, left or right, ultrasound scan of, if:(a) the service is used for the assessment of one or more of the following suspected or known conditions:(i) an injury to a muscle, tendon or muscle/tendon junction;(ii) rotator cuff tear, calcification or tendinosis (biceps, subscapular, supraspinatus or infraspinatus);(iii) biceps subluxation;(iv) capsulitis and bursitis;(v) a mass, including a ganglion;(vi) an occult fracture;(vii) acromioclavicular joint pathology; and(b) the service is not performed in conjunction with a service mentioned in item 55866 (R) | $231.50 |
| 55865 | Shoulder or upper arm, or both, left or right, ultrasound scan of, if:(a) the service is used for the assessment of one or more of the following suspected or known conditions:(i) an injury to a muscle, tendon or muscle/tendon junction;(ii) rotator cuff tear, calcification or tendinosis (biceps, subscapular, supraspinatus or infraspinatus);(iii) biceps subluxation;(iv) capsulitis and bursitis;(v) a mass, including a ganglion;(vi) an occult fracture;(vii) acromioclavicular joint pathology; and(b) the service is not performed in conjunction with a service mentioned in item 55867 (NR) | $76.20 |
| 55866 | Shoulder or upper arm, or both, left and right, ultrasound scan of, if:(a) the service is used for the assessment of one or more of the following suspected or known conditions:(i) an injury to a muscle, tendon or muscle/tendon junction;(ii) rotator cuff tear, calcification or tendinosis (biceps, subscapular, supraspinatus or infraspinatus);(iii) biceps subluxation;(iv) capsulitis and bursitis;(v) a mass, including a ganglion;(vi) an occult fracture;(vii) acromioclavicular joint pathology; and(b) the service is not performed in conjunction with a service mentioned in item 55864 (R) | $241.60 |
| 55867 | Shoulder or upper arm, or both, left and right, ultrasound scan of, if:(a) the service is used for the assessment of one or more of the following suspected or known conditions:(i) an injury to a muscle, tendon or muscle/tendon junction;(ii) rotator cuff tear, calcification or tendinosis (biceps, subscapular, supraspinatus or infraspinatus);(iii) biceps subluxation;(iv) capsulitis and bursitis;(v) a mass, including a ganglion;(vi) an occult fracture;(vii) acromioclavicular joint pathology; and(b) the service is not performed in conjunction with a service mentioned in item 55865 (NR) | $85.10 |
| 55868 | Hip or groin, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55870 (R) | $219.40 |
| 55869 | Hip or groin, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55871 (NR) | $76.30 |
| 55870 | Hip or groin, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55868 (R) | $241.30 |
| 55871 | Hip or groin, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55869 (NR) | $83.90 |
| 55876 | Buttock or thigh, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55878 (R) | $219.40 |
| 55877 | Buttock or thigh or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55879 (NR) | $78.70 |
| 55878 | Buttock or thigh, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55876 (R) | $241.30 |
| 55879 | Buttock or thigh, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55877 (NR) | $80.70 |
| 55880 | Knee, left or right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions:(i) abnormality of tendons or bursae about the knee;(ii) a meniscal cyst, popliteal fossa cyst, mass or pseudomass;(iii) a nerve entrapment or a nerve or nerve sheath tumour;(iv) an injury of collateral ligaments; and (b) the service is not performed in conjunction with item 55882 (R) | $218.80 |
| 55881 | Knee, left or right, ultrasound scan of, if:(a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) abnormality of tendons or bursae about the knee;(ii) a meniscal cyst, popliteal fossa cyst, mass or pseudomass;(iii) a nerve entrapment or a nerve or nerve sheath tumour;(iv) an injury of collateral ligaments; and(b) the service is not performed in conjunction with item 55883 (NR) | $76.30 |
| 55882 | Knee, left and right, ultrasound scan of, if:(a) the service is used for the assessment of one or more of the following suspected or known conditions:(i) abnormality of tendons or bursae about the knee;(ii) a meniscal cyst, popliteal fossa cyst, mass or pseudomass;(iii) a nerve entrapment or a nerve or nerve sheath tumour;(iv) an injury of collateral ligaments; and(b) the service is not performed in conjunction with a service mentioned in item 55880 (R) | $240.40 |
| 55883 | Knee, left and right, ultrasound scan of, if:(a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) abnormality of tendons or bursae about the knee;(ii) a meniscal cyst, popliteal fossa cyst, mass or pseudomass;(iii) a nerve entrapment or a nerve or nerve sheath tumour;(iv) an injury of collateral ligaments; and(b) the service is not performed in conjunction with item 55881 (NR) | $83.90 |
| 55884 | Lower leg, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55886 (R) | $218.20 |
| 55885 | Lower leg, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55887 (NR) | $76.50 |
| 55886 | Lower leg, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55884 (R) | $263.40 |
| 55887 | Lower leg, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55885 (NR) | $85.40 |
| 55888 | Ankle or hind foot, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55890 (R) | $220.80 |
| 55889 | Ankle or hind foot, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55891 (NR) | $76.30 |
| 55890 | Ankle or hind foot, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55888 (R) | $242.60 |
| 55891 | Ankle or hind foot, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55889 (NR) | $83.90 |
| 55892 | Mid foot or fore foot, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55894 (R) | $223.50 |
| 55893 | Mid foot or fore foot, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55895 (NR) | $80.00 |
| 55894 | Mid foot or fore foot, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55892 (R) | $229.10 |
| 55895 | Mid foot or fore foot, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55893 (NR) | $89.40 |
| **Cardiac** | | |
| 55126 | Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.1.2 Initial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows, with recordings on digital media, if the service: (a) is for the investigation of any of the following: (i) symptoms or signs of cardiac failure; (ii) suspected or known ventricular hypertrophy or dysfunction; (iii) pulmonary hypertension; (iv) valvular, aortic, pericardial, thrombotic or embolic disease; (v) heart tumour; (vi) symptoms or signs of congenital heart disease; (vii) other rare indications; and (b) is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies Applicable not more than once in a 24 month period (R) | $431.00 |
| 55127 | Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.1.2 Repeat serial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows, with recordings on digital media, if the service: (a) is for the investigation of known valvular dysfunction; and (b) is requested by a specialist or consultant physician; and (c) is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies (R) | $431.00 |
| 55128 | Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.1.2 Repeat serial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows, with recordings on digital media, if the service: (a) is for the investigation of known valvular dysfunction; and (b) is requested by a medical practitioner (other than a specialist or consultant physician) at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies (R) | $431.00 |
| 55129 | Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.1.2 Repeat serial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows, with recordings on digital media, if: (a) valvular dysfunction is not the primary issue for the patient (although it may be a secondary issue); and (b) the service is for the investigation of any of the following: (i) symptoms or signs of cardiac failure; (ii) suspected or known ventricular hypertrophy or dysfunction; (iii) pulmonary hypertension; (iv) aortic, thrombotic, embolic disease or pericardial disease (excluding isolated pericardial effusion or pericarditis); (v) heart tumour; (vi) structural heart disease; (vii) other rare indications; and (c) the service is requested by a specialist or consultant physician; and (d) the service is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies (R) | $431.00 |
| 55132 | Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.1.2 Serial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 4 acoustic windows, with recordings on digital media, if the service: (a) is for the investigation of a patient who: (i) is under 17 years of age; or (ii) has complex congenital heart disease; and (b) is performed by a specialist or consultant physician practising in the speciality of cardiology; and (c) is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies (R) | $431.00 |
| 55133 | Note: the service only applies if the patient meets one or more of the following and the requirements of Note: IR.1.2 Frequent repetition serial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows, with recordings on digital media, if the service: (a) is for the investigation of a patient who: (i) has an isolated pericardial effusion or pericarditis; or (ii) has a normal baseline study, and has commenced medication for non cardiac purposes that has cardiotoxic side effects and is a pharmaceutical benefit (within the meaning of PartVII of the National Health Act 1953) for the writing of a prescription for the supply of which under that Part an echocardiogram is required; and (b) is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies (R) | $387.90 |
| 55134 | Note: the service only applies if the patient meets one or more of the following and the requirements of Note: IR.1.2 Repeat real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows, with recordings on digital media, for the investigation of rare cardiac pathologies, if the service: (a) is requested by a specialist or consultant physician; and (b) is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies (R) | $431.00 |
| 55137 | Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.1.2 Serial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 4 acoustic windows, with recordings on digital media, if the service: (a) is for the investigation of a fetus with suspected or confirmed: (i) complex congenital heart disease; or (ii) functional heart disease; or (iii) fetal cardiac arrhythmia; or (iv) cardiac structural abnormality requiring confirmation; and (b) is performed by a specialist or consultant physician practising in the speciality of cardiology with advanced training and expertise in fetal cardiac imaging; and (c) is not associated with a service to which: (i) an item in Subgroup 2 applies (except items 55118 and 55130); or (ii) an item in Subgroup 3 applies (R) | $431.00 |
| 55141 | Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.0.1 and IR.1.2and does not apply to a service provided to a patient if, in the previous 24 months, a service associated with a service to which item 55143, 55145 or 55146 applies has been provided to the patient. Exercise stress echocardiography focused study, other than a service associated with a service to which: (a) item 11704, 11705, 11707, 11714, 11729 or 11730 applies; or (b) an item in Subgroup 3 applies Applicable not more than once in a 24 month period (R) | $768.50 |
| 55143 | Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.0.1, IR.1.1 and IR.1.2 Repeat pharmacological or exercise stress echocardiography if: (a) a service to which item 55141, 55145, 55146, or this item, applies has been performed on the patient in the previous 24 months; and (b) the patient has symptoms of ischaemia that have evolved and are not adequately controlled with optimal medical therapy; and (c) the service is requested by a specialist or a consultant physician; and (d) the service is not associated with a service to which: (i) item 11704, 11705, 11707, 11714, 11729 or 11730 applies; or (ii) an item in Subgroup 3 applies Applicable not more than once in a 12 month period (R) | $768.50 |
| 55145 | Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.0.1 and IR.1.2 Pharmacological stress echocardiography, other than a service associated with a service to which: (a) item 11704, 11705, 11707, 11714, 11729 or 11730 applies; or (b) an item in Subgroup 3 applies Applicable not more than once in a 24 month period (R) Note: this item does not apply to a service provided to a patient if, in the previous 24 months, a service associated with a service to which item 55141, 55143 or 55146 applies has been provided to the patient. | $890.70 |
| 55146 | Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.0.1 and IR.1.2 Pharmacological stress echocardiography if: (a) a service to which item 55141 applies has been performed on the patient in the previous 4 weeks, and the test has failed due to an inadequate heart rate response; and (b) the service is not associated with a service to which: (i) item 11704, 11705, 11707, 11714, 11729 or 11730 applies; or (ii) an item in Subgroup 3 applies Applicable not more than once in a 24 month period (R) Note: this item does not apply to a service provided to a patient if, in the previous 24 months, a service associated with a service to which item 55143 or 55145 applies has been provided to the patient. | $890.70 |
| **GROUP I2—COMPUTED TOMOGRAPHY** | | |
| 56001 | Computed tomography scan of brain without intravenous contrast medium, not being a service to which item 57001 applies (R) (Anaes.) | $397.90 |
| 56007 | Computed tomography scan of brain with intravenous contrast medium and with any scans of the brain before intravenous contrast injection, when performed, not being a service to which item 57007 applies (R) (Anaes.) | $504.40 |
| 56010 | Computed tomography scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when performed (R) (Anaes.) | $535.50 |
| 56013 | COMPUTED TOMOGRAPHY—scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (Anaes.) | $499.60 |
| 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) (Anaes.) | $589.70 |
| 56022 | Computed tomography scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (Anaes.) | $449.60 |
| 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 before intravenous contrast injection, when performed (R) (Anaes.) | $710.60 |
| 56030 | Computed tomography scan of facial bones, para nasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (Anaes.) | $453.90 |
| 56036 | Computed tomography scan of facial bones, para nasal sinuses or both, with scan of brain, with intravenous contrast medium, if:(a) a scan without intravenous contrast medium has been performed; and(b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (Anaes.) | $714.50 |
| 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) (Anaes.) | $484.90 |
| 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) before intravenous contrast injection, when undertaken, not being a service associated with a service to which item 56807 applies (R) (Anaes.) | $678.80 |
| 56219 | Computed tomography scan of spine, one 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) (Anaes.) | $695.50 |
| 56220 | Computed tomography scan of spine, cervical region, without intravenous contrast medium (R) (Anaes.) | $480.80 |
| 56221 | Computed tomography scan of spine, thoracic region, without intravenous contrast medium (R) (Anaes.) | $488.30 |
| 56223 | Computed tomography scan of spine, lumbosacral region, without intravenous contrast medium (R) (Anaes.) | $485.10 |
| 56224 | Computed tomography scan of spine, cervical region, with intravenous contrast medium and with any scans of the cervical region of the spine before intravenous contrast injection when undertaken (R) (Anaes.) | $704.10 |
| 56225 | Computed tomography scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine before intravenous contrast injection when undertaken (R) (Anaes.) | $716.00 |
| 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 (R) (Anaes.) | $690.40 |
| 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, 2 examinations of the kind referred to in items 56220, 56221 and 56223, without intravenous contrast medium (R) (Anaes.) | $480.30 |
| 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, 2 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 before intravenous contrast injection when undertaken (R) (Anaes.) | $741.80 |
| 56237 | Computed tomography scan of spine, 3 regions cervical, thoracic and lumbosacral, without intravenous contrast medium (R) (Anaes.) | $480.80 |
| 56238 | Computed tomography scan of spine, 3 regions, cervical, thoracic and lumbosacral, with intravenous contrast medium and with any scans of these regions of the spine before intravenous contrast injection when undertaken (R) (Anaes.) | $746.50 |
| 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) (Anaes.) | $592.70 |
| 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 before 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) (Anaes.) | $794.40 |
| 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) (Anaes.) | $513.30 |
| 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) before intravenous contrast injection, when undertaken, not being a service to which item 56307, 56507, 56807 or 57007 applies (R) (Anaes.) | $758.00 |
| 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) (Anaes.) | $495.90 |
| 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) before intravenous contrast injection, when undertaken, not being a service to which item 56407 applies (R) (Anaes.) | $726.30 |
| 56501 | Computed tomography scan of upper abdomen and pelvis without intravenous contrast medium, not for the purposes of virtual colonoscopy and not being a service to which item 56801 or 57001 applies(R) (Anaes.) | $741.90 |
| 56507 | Computed tomography scan of upper abdomen and pelvis with intravenous contrast medium and with any scans of upper abdomen and pelvis before intravenous contrast injection, when performed, not for the purposes of virtual colonoscopy and not being a service to which item 56807 or 57007 applies (R) (Anaes.) | $963.90 |
| 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 service is requested by a specialist or consultant physician who performs colonoscopies in the practice of the specialist s or consultant physician s 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(R) (Anaes.) | $1041.40 |
| 56620 | Computed tomography scan of knee, without intravenous contrast medium, not being a service to which item 56622 or 56629 applies (R) (Anaes.) | $415.40 |
| 56622 | Computed tomography scan of lower limb, left or right or both, one region (other than knee), or more than one region (which may include knee), without intravenous contrast medium, not being a service to which item 56620 applies (R) (Anaes.) (Anaes.) | $441.20 |
| 56623 | Computed tomography scan of lower limb, left or right or both, one region (other than knee), or more than one region (which may include knee), with intravenous contrast medium and with any scans of the lower limb before intravenous contrast injection, when performed, not being a service to which item 56626 applies (R) (Anaes.) (Anaes.) | $673.70 |
| 56626 | Computed tomography scan of knee, with intravenous contrast medium and with any scans of the knee before intravenous contrast injection, when performed, not being a service to which items 56623 or 56630 apply (R) (Anaes.) | $631.90 |
| 56627 | Computed tomography scan of upper limb, left or right or both, any one region, or more than one region, without intravenous contrast medium (R) (Anaes.) (Anaes.) | $441.20 |
| 56628 | Computed tomography scan of upper limb, left or right or both, any one region, or more than one region, with intravenous contrast medium and with any scans of the upper limb before intravenous contrast injection, when performed (R) (Anaes.) (Anaes.) | $673.70 |
| 56629 | Computed tomography scan of upper limb and lower limb, left or right or both, any one region (other than knee), or more than one region (which may include knee) without intravenous contrast medium not being a service to which item 56620 applies (R) (Anaes.) (Anaes.) | $441.20 |
| 56630 | Computed tomography scan of upper limb and lower limb, left or right or both, any one region (other than knee), or more than one region (which may include knee) with intravenous contrast medium with any scans of the limbs before intravenous contrast injection, when performed, not being a service to which item 56626 applies (R) (Anaes.) | $673.70 |
| 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) (Anaes.) | $916.20 |
| 56807 | Computed tomography scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck before intravenous contrast injection, when performed, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (Anaes.) | $1109.40 |
| 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) (Anaes.) | $925.20 |
| 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 before intravenous contrast injection, when performed, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (Anaes.) | $1140.10 |
| 57201 | Computed tomography pelvimetry (R) (Anaes.) | $316.10 |
| 57341 | Computed tomography, in conjunction with a surgical procedure using interventional techniques (R) (Anaes.) | $882.60 |
| 57352 | Computed tomography angiography with intravenous contrast medium of any or all, or any part, of: (a) the arch of the aorta; or (b) the carotid arteries; or (c) the vertebral arteries and their branches (head and neck); including any scans performed before intravenous contrast injection one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if: (d) either: (i) the service is requested by a specialist or consultant physician; or (ii) the service is requested by a medical practitioner (other than a specialist or consultant physician) and the request indicates that the patient s case has been discussed with a specialist or consultant physician; and (e) the service is not a service to which another item in this group applies; and (f) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (g) the service is not a study performed to image the coronary arteries (R) (Anaes.) | $1040.40 |
| 57353 | Computed tomography angiography with intravenous contrast medium of any or all, or any part, of: (a) the ascending and descending aorta; or (b) the common iliac and abdominal branches including upper limbs (chest, abdomen and upper limbs); including any scans performed before intravenous contrast injection one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if: (c) either: (i) the service is requested by a specialist or consultant physician; or (ii) the service is requested by a medical practitioner (other than a specialist or consultant physician) and the request indicates that the patient s case has been discussed with a specialist or consultant physician; and (d) the service is not a service to which another item in this group applies; and (e) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (f) the service is not a study performed to image the coronary arteries (R) (Anaes.) | $1040.40 |
| 57354 | Computed tomography angiography with intravenous contrast medium of any or all, or any part, of: (a) the descending aorta; or (b) the pelvic vessels (aorto iliac segment) and lower limbs; including any scans performed before intravenous contrast injection one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if: (c) either: (i) the service is requested by a specialist or consultant physician; or (ii) the service is requested by a medical practitioner (other than a specialist or consultant physician) and the request indicates that the patient s case has been discussed with a specialist or consultant physician; and (d) the service is not a service to which another item in this group applies; and (e) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (f) the service is not a study performed to image the coronary arteries (R) (Anaes.) | $1040.40 |
| 57357 | Computed tomography angiography with intravenous contrast medium of any or all, or any part, of the pulmonary arteries and their branches, including any scans performed before intravenous contrast injection one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if: the service is not a service to which another item in this group applies; and the service is not a study performed to image the coronary arteries; and the service is:(i) performed for the exclusion of pulmonary arterial stenosis, occlusion, aneurysm or embolism and is requested by a specialist or consultant physician; or(ii) performed for the exclusion of pulmonary arterial stenosis, occlusion or aneurysm and is requested by a medical practitioner (other than a specialist or consultant physician) and the request indicates that the patient s case has been discussed with a specialist or consultant physician; or (iii) for the exclusion of pulmonary embolism and is requested be a medical practitioner (other than a specialist or consultant physician) (R) (Anaes.) | $952.70 |
| 57360 | Computed tomography of the coronary arteries performed on a minimum of a 64 slice (or equivalent) scanner if: (a) the request is made by a specialist or consultant physician; and (b) the patient has stable or acute symptoms consistent with coronary ischaemia; and (c) the patient is at low to intermediate risk of an acute coronary event, including having no significant cardiac biomarker elevation and no electrocardiogram changes indicating acute ischaemia (R) Note: See explanatory note IN.2.2 for claiming restrictions for this item. (Anaes.) | $1485.50 |
| 57362 | Cone beam computed tomography dental and temporo mandibular joint imaging (without contrast medium) for diagnosis and management of any of the following:(a) mandibular and dento alveolar fractures;(b) dental implant planning;(c) orthodontics;(d) endodontic conditions;(e) periodontal conditions;(f) temporo mandibular joint conditions Applicable once per patient per day, not being for a service to which any of items 57960 to 57969 apply, and not being a service associated with another service in Group I2 (R) (Anaes.) | $231.60 |
| 57364 | Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: TR.8.3 (item 38247), TR.8.2 (item 38249) or item 38252if subclause (iv) applies. Computed tomography of the coronary arteries performed on a minimum of a 64 slice (or equivalent) scanner, if: (a) the service is requested by a specialist or consultant physician; and (b) at least one of the following apply to the patient: (i) the patient has stable symptoms and newly recognised left ventricular systolic dysfunction of unknown aetiology; (ii) the patient requires exclusion of coronary artery anomaly or fistula; (iii) the patient will be undergoing non-coronary cardiac surgery; (iv) the patient meets the criteria to be eligible for a service to which item 38247, 38249 or 38252 applies, but as an alternative to selective coronary angiography will require an assessment of the patency of one or more bypass grafts (R) (Anaes.) | $1319.70 |
| **GROUP I3—DIAGNOSTIC RADIOLOGY** | | |
| **Radiographic examination of extremities** | | |
| 57506 | Hand, wrist, forearm, elbow or humerus (NR) | $60.60 |
| 57509 | Hand, wrist, forearm, elbow or humerus (R) | $83.80 |
| 57512 | Hand and wrist, or hand, wrist and forearm, or forearm and elbow, or elbow and humerus (NR) | $85.20 |
| 57515 | Hand and wrist, or hand, wrist and forearm, or forearm and elbow, or elbow and humerus (R) | $110.30 |
| 57518 | Foot, ankle, leg or femur (NR) | $64.90 |
| 57521 | Foot, ankle, leg or femur (R) | $91.50 |
| 57522 | Knee (NR) | $61.50 |
| 57523 | Knee (R) | $81.90 |
| 57524 | FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (NR) | $99.70 |
| 57527 | Foot and ankle, or ankle and leg, or leg and knee, or knee and femur (R) | $131.90 |
| **Radiographic examination of shoulder or pelvis** | | |
| 57700 | Shoulder or scapula (NR) | $83.00 |
| 57703 | Shoulder or scapula (R) | $114.80 |
| 57706 | Clavicle (NR) | $64.70 |
| 57709 | Clavicle (R) | $86.70 |
| 57712 | Hip joint (R) | $95.00 |
| 57715 | Pelvic girdle (R) | $121.20 |
| 57721 | FEMUR, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R) | $208.70 |
| **Radiographic examination of head** | | |
| 57901 | Skull, not in association with item 57902 (R) | $130.30 |
| 57902 | Cephalometry, not in association with item 57901 (R) | $129.30 |
| 57905 | Mastoids or petrous temporal bones (R) | $118.80 |
| 57907 | Sinuses or facial bones orbit, maxilla or malar, any or all (R) | $87.10 |
| 57915 | Mandible, not by orthopantomography technique (R) | $95.40 |
| 57918 | Salivary calculus (R) | $100.90 |
| 57921 | Nose (R) | $95.40 |
| 57924 | Eye (R) | $93.50 |
| 57927 | Temporo mandibular joints (R) | $99.70 |
| 57930 | Teeth single area (R) | $68.60 |
| 57933 | Teeth—full mouth(R) | $158.40 |
| 57939 | Palato pharyngeal studies with fluoroscopic screening (R) | $136.70 |
| 57942 | Palato pharyngeal studies without fluoroscopic screening (R) | $104.60 |
| 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) | $86.90 |
| 57960 | Orthopantomography for diagnosis or management (or both) of trauma, infection, tumour or a congenital or surgical condition of the teeth or maxillofacial region (R) | $94.00 |
| 57963 | Orthopantomography for diagnosis or management (or both) of any of the following conditions, if the signs and symptoms of the condition is present:(a) impacted teeth;(b) caries;(c) periodontal pathology;(d) periapical pathology (R) | $93.90 |
| 57966 | Orthopantomography for diagnosis or management (or both) of missing or crowded teeth, or developmental anomalies of the teeth or jaws (R) | $96.20 |
| 57969 | Orthopantomography for diagnosis or management (or both) of temporo mandibular joint arthroses or dysfunction (R) | $100.90 |
| **Radiographic examination of spine** | | |
| 58100 | Spine cervical (R) | $134.80 |
| 58103 | Spine thoracic (R) | $110.90 |
| 58106 | Spine lumbosacral (R) | $154.50 |
| 58108 | Spine 4 regions, cervical, thoracic, lumbosacral and sacrococcygeal (R) | $220.40 |
| 58109 | Spine sacrococcygeal (R) | $94.20 |
| 58112 | NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item Spine 2 examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R) | $197.50 |
| 58115 | NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item Spine 3 examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R) | $220.40 |
| 58120 | Spine 4 regions, cervical, thoracic, lumbosacral and sacrococcygeal, if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year (R) | $220.40 |
| 58121 | NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item Spine 3 examinations of the kind mentioned in items 58100, 58103, 58106 and 58109, if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year (R) | $232.10 |
| **Bone age study and skeletal surveys** | | |
| 58300 | Bone age study (R) | $81.80 |
| 58306 | Skeletal survey (R) | $190.20 |
| **Radiographic examination of thoracic region** | | |
| 58500 | Chest (lung fields) by direct radiography (NR) | $74.00 |
| 58503 | Chest (lung fields) by direct radiography (R) | $94.20 |
| 58506 | Chest (lung fields) by direct radiography with fluoroscopic screening (R) | $122.60 |
| 58509 | Thoracic inlet or trachea (R) | $89.30 |
| 58521 | Left ribs, right ribs or sternum (R) | $87.20 |
| 58524 | Left and right ribs, left ribs and sternum, or right ribs and sternum (R) | $113.10 |
| 58527 | Left ribs, right ribs and sternum (R) | $136.70 |
| **Radiographic examination of urinary tract** | | |
| 58700 | Plain renal only (R) | $92.70 |
| 58706 | Intravenous pyelography, with or without preliminary plain films and with or without tomography (R) | $334.20 |
| 58715 | Antegrade or retrograde pyelography with or without preliminary plain films and with preparation and contrast injection, one side (R) | $324.10 |
| 58718 | Retrograde cystography or retrograde urethrography with or without preliminary plain films and with preparation and contrast injection (R) (Anaes.) | $267.50 |
| 58721 | Retrograde micturating cysto urethrography, with preparation and contrast injection (R) (Anaes.) | $274.20 |
| **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) | $69.50 |
| 58903 | Plain abdominal only, not being a service associated with a service to which item 58909, 58912 or 58915 applies (R) | $95.30 |
| 58909 | Barium or other opaque meal of one 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 or 57945 applies (R) | $189.30 |
| 58912 | Barium or other opaque meal of oesophagus, stomach, duodenum and follow through to colon, with or without screening of chest and with or without preliminary plain film (R) | $225.00 |
| 58915 | BARIUM or other opaque meal, SMALL BOWEL SERIES ONLY, with or without preliminary plain film (R) | $174.20 |
| 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.) | $295.20 |
| 58921 | Opaque enema, with or without air contrast study and with or without preliminary plain films (R) | $284.90 |
| 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) | $163.00 |
| 58933 | Cholegraphy, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection (R) | $441.50 |
| 58936 | Cholegraphy, drip infusion, with or without preliminary plain films, with preparation and contrast injection and with or without tomography (R) | $410.40 |
| 58939 | Defaecogram (R) | $278.20 |
| **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) | $42.70 |
| **Radiographic examination of breasts** | | |
| 59300 | Mammography of both breasts if there is reason to suspect the presence of malignancy because of:(a) the past occurrence of breast malignancy in the patient; or(b) significant history of breast or ovarian malignancy in the patient s family; or(c) symptoms or indications of breast disease found on examination of the patient by a medical practitioner (R) (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) | $179.00 |
| 59302 | Three dimensional tomosynthesis of both breasts, if there is reason to suspect the presence of malignancy because of: a) the past occurrence of breast malignancy in the patient; or b) significant history of breast or ovarian malignancy in the patient s family; or c) symptoms or indications of breast disease found on examination of the patient by a medical practitioner Not being a service to which item 59300 applies (R) | $381.30 |
| 59303 | Mammography of one breast if: (a) the service is specifically requested 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(ii) significant history of breast or ovarian malignancy in the patient s family; or(iii) symptoms or indications of breast disease found on examination of the patient by a medical practitioner (R) | $113.70 |
| 59305 | Three dimensional tomosynthesis of one breast, if there is reason to suspect the presence of malignancy because of: a) the past occurrence of breast malignancy in the patient; or b) significant history of breast or ovarian malignancy in the patient s family; or c) symptoms or indications of breast disease found on examination of the patient by a medical practitioner Not being a service to which item 59303 applies (R) | $215.30 |
| 59312 | Radiographic examination of both breasts, in conjunction with a surgical procedure on each breast, using interventional techniques (R) | $187.90 |
| 59314 | Radiographic examination of one breast, in conjunction with a surgical procedure using interventional techniques (R) | $123.90 |
| 59318 | Radiographic examination of excised breast tissue to confirm satisfactory excision of one or more lesions in one breast or both following pre-operative localisation in conjunction with a service under item 31536 (R) | $101.60 |
| **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.) (Anaes.) | $196.20 |
| 59703 | Dacryocystography, one side, with or without preliminary plain film and with preparation and contrast injection (R) | $162.90 |
| 59712 | Hysterosalpingography, with or without preliminary plain films and with preparation and contrast injection (R)(Anaes.) (Anaes.) | $241.50 |
| 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) (Anaes.) (Anaes.) | $301.00 |
| 59718 | Phlebography, one side, with or without preliminary plain films and with preparation and contrast injection (R) (Anaes.) (Anaes.) | $272.00 |
| 59724 | Myelography, one 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.) (Anaes.) | $446.70 |
| 59733 | Sialography, one side, with preparation and contrast injection, not being a service associated with a service to which item 57918 applies (R) | $216.00 |
| 59739 | Sinogram or fistulogram, one or more regions, with or without preliminary plain films and with preparation and contrast injection (R) | $157.70 |
| 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) | $275.60 |
| 59754 | Lymphangiography, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection (R) | $462.80 |
| 59763 | Air insufflation during video fluoroscopic imaging including associated consultation (R) | $280.90 |
| **Angiography** | | |
| 59970 | Angiography or digital subtraction angiography, or both, with fluoroscopy and image acquisition, using a mobile image intensifier, including any preliminary plain films, preparation and contrast injection one or more regions (R) (Anaes.) | $355.00 |
| 60000 | Digital subtraction angiography, examination of head and neck with or without arch aortography 1 to 3 data acquisition runs (R) (Anaes.) | $1186.70 |
| 60003 | Digital subtraction angiography, examination of head and neck with or without arch aortography 4 to 6 data acquisition runs (R) (Anaes.) | $1678.20 |
| 60006 | Digital subtraction angiography, examination of head and neck with or without arch aortography 7 to 9 data acquisition runs (R) (Anaes.) | $2464.90 |
| 60009 | Digital subtraction angiography, examination of head and neck with or without arch aortography 10 or more data acquisition runs (R) (Anaes.) | $2932.40 |
| 60012 | Digital subtraction angiography, examination of thorax 1 to 3 data acquisition runs (R) (Anaes.) | $1151.00 |
| 60015 | Digital subtraction angiography, examination of thorax 4 to 6 data acquisition runs (R) (Anaes.) | $1745.50 |
| 60018 | Digital subtraction angiography, examination of thorax 7 to 9 data acquisition runs (R) (Anaes.) | $2526.40 |
| 60021 | Digital subtraction angiography, examination of thorax 10 or more data acquisition runs (R) (Anaes.) | $2812.70 |
| 60024 | Digital subtraction angiography, examination of abdomen 1 to 3 data acquisition runs (R) (Anaes.) | $1128.70 |
| 60027 | Digital subtraction angiography, examination of abdomen 4 to 6 data acquisition runs (R) (Anaes.) | $1761.40 |
| 60030 | Digital subtraction angiography, examination of abdomen 7 to 9 data acquisition runs (R) (Anaes.) | $2503.50 |
| 60033 | Digital subtraction angiography, examination of abdomen 10 or more data acquisition runs (R) (Anaes.) | $2894.10 |
| 60036 | Digital subtraction angiography, examination of upper limb or limbs 1 to 3 data acquisition runs (R) (Anaes.) | $1185.40 |
| 60039 | Digital subtraction angiography, examination of upper limb or limbs 4 to 6 data acquisition runs (R) (Anaes.) | $1745.50 |
| 60042 | Digital subtraction angiography, examination of upper limb or limbs 7 to 9 data acquisition runs (R) (Anaes.) | $2489.00 |
| 60045 | Digital subtraction angiography, examination of upper limb or limbs 10 or more data acquisition runs (R) (Anaes.) | $2919.80 |
| 60048 | Digital subtraction angiography, examination of lower limb or limbs 1 to 3 data acquisition runs (R) (Anaes.) | $1186.20 |
| 60051 | Digital subtraction angiography, examination of lower limb or limbs 4 to 6 data acquisition runs (R) (Anaes.) | $1767.70 |
| 60054 | Digital subtraction angiography, examination of lower limb or limbs 7 to 9 data acquisition runs (R) (Anaes.) | $2503.50 |
| 60057 | Digital subtraction angiography, examination of lower limb or limbs 10 or more data acquisition runs (R) (Anaes.) | $2956.60 |
| 60060 | Digital subtraction angiography, examination of aorta and lower limb or limbs 1 to 3 data acquisition runs (R) (Anaes.) | $1196.70 |
| 60063 | Digital subtraction angiography, examination of aorta and lower limb or limbs 4 to 6 data acquisition runs (R) (Anaes.) | $1747.80 |
| 60066 | Digital subtraction angiography, examination of aorta and lower limb or limbs 7 to 9 data acquisition runs (R) (Anaes.) | $2506.10 |
| 60069 | Digital subtraction angiography, examination of aorta and lower limb or limbs 10 or more data acquisition runs (R) (Anaes.) | $2900.70 |
| 60072 | Selective arteriography or selective venography by digital subtraction angiography technique one vessel (NR) (Anaes.) | $101.60 |
| 60075 | Selective arteriography or selective venography by digital subtraction angiography technique 2 vessels (NR) (Anaes.) | $202.20 |
| 60078 | Selective arteriography or selective venography by digital subtraction angiography technique 3 or more vessels (NR) (Anaes.) | $307.40 |
| **Fluoroscopic examination** | | |
| 60500 | FLUOROSCOPY, with general anaesthesia (not being a service associated with a radiographic examination) (R) (Anaes.) | $93.70 |
| 60503 | FLUOROSCOPY, without general anaesthesia (not being a service associated with a radiographic examination) (R) | $73.10 |
| 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 Group applies (R) | $135.40 |
| 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 Group applies (R) | $201.70 |
| **Preparation for radiological procedure** | | |
| 60918 | Arteriography (peripheral) or phlebography one vessel, when used in association with a service to which item 59970 applies, not being a service associated with a service to which any of items 60000 to 60078 apply (NR) (Anaes.) | $99.50 |
| 60927 | Selective arteriogram or phlebogram, when used in association with a service to which item 59970 applies, not being a service associated with a service to which any of items 60000 to 60078 apply (NR) (Anaes.) | $81.20 |
| **Interventional techniques** | | |
| 61109 | Fluoroscopy in an angiography suite with image intensification, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this Group applies (R) | $526.70 |
| **GROUP I4—NUCLEAR MEDICINE IMAGING** | | |
| 61310 | Myocardial infarct avid study (R) | $736.20 |
| 61313 | Gated cardiac blood pool study, (equilibrium) (R) | $609.90 |
| 61314 | Gated cardiac blood pool study, with or without intervention, and first pass blood flow or cardiac shunt study (R) | $774.20 |
| 61321 | Single rest myocardial perfusion study for the assessment of the extent and severity of viable and non viable myocardium, with single photon emission tomography, with or without planar imaging, if: (a) the patient has left ventricular systolic dysfunction and probable or confirmed coronary artery disease; and (b) the service uses a single rest technetium 99m (Tc 99m) protocol; and (c) the service is requested by a specialist or a consultant physician; and (d) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61325, 61329, 61345, 61398 or 61406 applies; and (e) if the patient is 17 years or older a service to which this item, or item 61325, 61329, 61345, 61398 or 61406 applies has not been provided to the patient in the previous 24 months (R) | $605.60 |
| 61324 | Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting ECG, continuous ECG monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a specialist or consultant physician; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61325, 61329, 61345, 61357, 61394, 61398, 61406 or 61414 applies; and (f) if the patient is 17 years or older a service to which this item, or item 61329, 61345, 61357, 61394, 61398, 61406, 61410 or 61414, applies has not been provided to the patient in the previous 24 months (R) | $1202.20 |
| 61325 | Single rest myocardial perfusion study for the assessment of the extent and severity of viable and non viable myocardium, with single photon emission tomography, with or without planar imaging, if: (a) the patient has left ventricular systolic dysfunction and probable or confirmed coronary artery disease; and (b) the service uses: (i) an initial rest study followed by a redistribution study on the same day; and (ii) a thallous chloride 201 (Tl 201) protocol; and (c) the service is requested by a specialist or a consultant physician; and (d) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61329, 61345, 61398 or 61406 applies; and (e) if the patient is 17 years or older: (i) a service to which item 61321, 61329, 61345, 61398 or 61406 applies has not been provided to the patient in the previous 24 months; and (ii) the service is applicable only twice each 24 months (R) | $605.60 |
| 61328 | Lung perfusion study (R) | $445.80 |
| 61329 | 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, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61345, 61357, 61394, 61398, 61406 or 61414 applies; and (f) if the patient is 17 years or older a service to which this item, or item 61321, 61324, 61325, 61345, 61357, 61394, 61398, 61406 or 61414, applies has not been provided to the patient in the previous 24 months (R) | $1807.60 |
| 61333 | Lung ventilation study using Galligas and lung perfusion study using gallium-68 macro aggregated albumin (68Ga-MAA), with PET, if the service is performed because the service to which item 61348 applies cannot be performed due to unavailability of technetium-99m (R) | $804.10 |
| 61336 | Cerebral study, with PET, if the service is performed because the service to which item 61402 applies cannot be performed due to unavailability of technetium-99m (R) | $1097.40 |
| 61340 | Lung ventilation study using aerosol, technegas or xenon gas (R) | $432.30 |
| 61341 | Bone study whole body with PET, with delayed imaging when undertaken, if the service is performed because the services to which item 61421 or 61425 apply cannot be performed due to unavailability of technetium-99m (R) | $1089.60 |
| 61345 | 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, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a specialist or consultant physician; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61357, 61394, 61398, 61406 or 61414 applies (R); and (f) if the patient is 17 years or older a service to which this item, or item 61321, 61324, 61325, 61329, 61357, 61394, 61398, 61406 or 61414, applies has not been provided to the patient in the previous 24 months (R) | $1807.60 |
| 61348 | Lung perfusion study and lung ventilation study using aerosol, technegas or xenon gas (R) | $870.60 |
| 61349 | Repeat 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, with or without planar imaging, if: (a) both: (i) a service has been provided to the patient in the previous 24 months to which this item, or item 61324, 61329, 61345, 61357, 61394, 61398, 61406, 61410 or 61414 applies; and (ii) the patient has subsequently undergone a revascularisation procedure; and (b) the patient has one or more symptoms of cardiac ischaemia that have evolved and are not adequately controlled with optimal medical therapy; and (c) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (d) the service is requested by a specialist or a consultant physician; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730 or 61410 applies; and (f) if the patient is 17 years or older a service to which this item, or item 61410, applies has not been provided to the patient in the previous 12 months (R) | $1807.60 |
| 61353 | Liver and spleen study (colloid) (R) | $733.50 |
| 61356 | Red blood cell spleen or liver study (R) | $784.10 |
| 61357 | Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which items 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61394, 61398, 61406 or 61414 applies; and (f) if the patient is 17 years or older a service to which this item, or item 61324, 61329, 61345, 61394, 61398, 61406, or 61414, applies has not been provided to the patient in the previous 24 months (R) | $1202.20 |
| 61360 | Hepatobiliary study, including morphine administration or pre-treatment with a cholagogue when performed (R) | $779.70 |
| 61361 | Hepatobiliary study with formal quantification following baseline imaging, using a cholagogue (R) | $900.60 |
| 61364 | Bowel haemorrhage study (R) | $973.00 |
| 61368 | Meckel s diverticulum study (R) | $418.50 |
| 61369 | Indium-labelled octreotide study (including single photon emission tomography when undertaken), if:(a) a gastro-entero-pancreatic endocrine 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 endocrine tumour has been identified on the basis of conventional techniques; and(ii) the study is to exclude additional disease sites (R) | $3873.40 |
| 61372 | Salivary study (R) | $430.10 |
| 61373 | Gastro-oesophageal reflux study, including delayed imaging on a separate occasion when performed (R) | $940.70 |
| 61376 | Oesophageal clearance study (R) | $276.70 |
| 61381 | Gastric emptying study, using single tracer (R) | $1104.90 |
| 61383 | COMBINED SOLID AND LIQUID GASTRIC EMPTYING STUDY using dual isotope technique or the same isotope on separate days (R) | $1200.50 |
| 61384 | Radionuclide colonic transit study (R) | $1321.30 |
| 61386 | RENAL STUDY, including perfusion and renogram images and computer analysis OR cortical study with planar imaging (R) | $640.50 |
| 61387 | RENAL CORTICAL STUDY, with single photon emission tomography and planar quantification (R) | $830.20 |
| 61389 | SINGLE RENAL STUDY with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R) | $742.40 |
| 61390 | Renal study with diuretic administration after a baseline study (R) | $790.30 |
| 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) | $1131.40 |
| 61394 | Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a specialist or consultant physician; and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61398, 61406 or 61414 applies; and (g) if the patient is 17 years or older a service to which this item, or item 61324, 61329, 61345, 61357, 61398, 61406 or 61414, applies has not been provided to the patient in the previous 24 months (R) | $1202.20 |
| 61397 | Cystoureterogram (R) | $481.20 |
| 61398 | 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, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the services is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61406 or 61414 applies; and (g) if the patient is 17 years or older a service to which this item, or item 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61406 or 61414, applies has not been provided to the patient in the previous 24 months (R) | $1807.60 |
| 61402 | Cerebral perfusion study, with single photon emission tomography and with planar imaging when performed (R) | $1144.00 |
| 61406 | 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, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a specialist or consultant physician; and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61398 or 61414 applies; and (g) if the patient is 17 years or older a service to which this item, or item 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61398 or 61414, applies has not been provided to the patient in the previous 24 months (R) | $1807.60 |
| 61409 | Cerebro-spinal fluid transport study using technetium 99m, with imaging on 2 or more separate occasions (R) | $1628.90 |
| 61410 | Repeat 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, with or without planar imaging, if: (a) both: (i) a service has been provided to the patient in the previous 24 months to which this item, or item 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406 or 61414 applies; and (ii) the patient has subsequently undergone a revascularisation procedure; and (b) the patient has one or more symptoms of cardiac ischaemia that have evolved and are not adequately controlled with optimal medical therapy; and (c) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (d) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729 or 11730 applies; and (f) if the patient is 17 years or older a service to which item 61349 applies has not been provided to the patient in the previous 12 months | $1807.60 |
| 61413 | Cerebro spinal fluid shunt patency study (R) | $428.10 |
| 61414 | Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61398 or 61406 applies; and (g) if the patient is 17 years or older a service to which this item, or item 61324, 61329, 61345, 61357, 61398 or 61406, applies has not been provided to the patient in the previous 24 months (R) | $1202.20 |
| 61421 | Bone study whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) | $885.50 |
| 61425 | Bone study whole body and single photon emission tomography, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) | $1114.60 |
| 61426 | Whole body study using iodine (R) | $1070.40 |
| 61429 | Whole body study using gallium (R) | $1033.70 |
| 61430 | Whole body study using gallium, with single photon emission tomography (R) | $1214.80 |
| 61433 | Whole body study using cells labelled with technetium (R) | $959.90 |
| 61434 | WHOLE BODY STUDY using cells labelled with technetium, with single photon emission tomography (R) | $1133.40 |
| 61438 | Whole body study using thallium (R) | $1283.20 |
| 61441 | Bone marrow study whole body using technetium labelled bone marrow agents (R) | $950.10 |
| 61442 | Whole body study, using gallium with single photon emission tomography of 2 or more body regions acquired separately (R) | $1428.10 |
| 61445 | Bone marrow study localised using technetium labelled agent (R) | $538.70 |
| 61446 | Regional scintigraphic study, using an approved bone scanning agent, including when undertaken, blood flow imaging, blood pool imaging and repeat imaging on a separate occasion (R) | $659.60 |
| 61449 | Regional scintigraphic study, using an approved bone scanning agent and single photon emission tomography, including when undertaken, blood flow imaging, blood pool imaging and repeat imaging on a separate occasion (R) | $903.80 |
| 61450 | Localised study using gallium (R) | $740.70 |
| 61453 | Localised study using gallium, with single photon emission tomography (R) | $1028.20 |
| 61454 | Localised study using cells labelled with technetium (R) | $679.80 |
| 61457 | LOCALISED STUDY using cells labelled with technetium, with single photon emission tomography (R) | $904.20 |
| 61461 | Localised study using thallium (R) | $1014.40 |
| 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 item 61364, 61426, 61429, 61430, 61442, 61450, 61453, 61469 or 61485, if there is no additional administration of radiopharmaceutical and if the previous radionuclide scan was abnormal or equivocal (R) | $258.40 |
| 61466 | Cerebro-spinal fluid transport study using indium-111, with imaging on 2 or more separate occasions (R) | $7727.80 |
| 61469 | Lymphoscintigraphy (R) | $668.50 |
| 61473 | Thyroid study (R) | $338.90 |
| 61480 | Parathyroid study (R) | $750.10 |
| 61485 | Adrenal study, with single photon emission tomography (R) | $1893.80 |
| 61495 | Tear duct study (R) | $418.50 |
| 61499 | Particle perfusion study (infra arterial) or Le Veen shunt study (R) | $509.50 |
| 61505 | CT scan performed at the same time and covering the same body area as single photon emission tomography or positron emission tomography for the purpose of anatomic localisation or attenuation correction if no separate diagnostic CT report is issued and performed in association with a service to which an item in Subgroup 1 or 2 of Group I4 applies (R) | $200.50 |
| 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) | $1831.30 |
| 61527 | Whole body study using PET, if the service is performed because the services to which items 61429, 61430, 61442, 61450 or 61453 apply cannot be performed due to unavailability of gallium-67 (R) | $1330.20 |
| 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) | $1831.30 |
| 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) | $1731.40 |
| 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) | $1831.30 |
| 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) | $1919.80 |
| 61559 | FDG PET study of the brain, performed for the evaluation of refractory epilepsy which is being evaluated for surgery (R) | $1764.10 |
| 61563 | Whole body prostate-specific membrane antigen PET study performed for the initial staging of intermediate to high-risk prostate adenocarcinoma, for a previously untreated patient who is considered suitable for locoregional therapy with curative intent Applicable once per lifetime (R) | $2298.60 |
| 61564 | Whole body prostate-specific membrane antigen PET study performed for the restaging of recurrent prostate adenocarcinoma, for a patient who:(a) has undergone prior locoregional therapy; and(b) is considered suitable for further locoregional therapy to determine appropriate therapeutic pathways and timing of treatment initiation Applicable twice per lifetime (R) | $2298.60 |
| 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) | $1831.30 |
| 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) | $1831.30 |
| 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) | $1768.90 |
| 61577 | Whole body FDG PET study, performed for the staging of proven oesophageal or GEJ carcinoma, in patients considered suitable for active therapy (R). | $1831.30 |
| 61598 | Whole body FDG PET study performed for the staging of biopsy-proven newly diagnosed or recurrent head and neck cancer (R). | $1831.30 |
| 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). | $1831.30 |
| 61610 | Whole body FDG PET study performed for the evaluation of metastatic squamous cell carcinoma of unknown primary site involving cervical nodes (R). | $1831.30 |
| 61612 | Whole body FDG PET study for the initial staging of eligible cancer types, for a patient who is considered suitable for active therapy, if: (a) the eligible cancer type is: (i) a rare or uncommon cancer (less than 12 cases per 100,000 persons per year); and (ii) a typically FDG avid cancer; and (b) there is at least a 10% likelihood that the PET study result will inform a significant change in management for the patient Applicable once per cancer diagnosis (R) | $1685.10 |
| 61620 | Whole body FDG PET study for the initial staging of newly diagnosed or previously untreated Hodgkin or non-Hodgkin lymphoma (R) | $1768.90 |
| 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) | $1831.30 |
| 61628 | Whole body FDG PET study for restaging following confirmation of recurrence of Hodgkin or non-Hodgkin lymphoma (R) | $1831.30 |
| 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) | $1768.90 |
| 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) | $1919.80 |
| 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) | $1919.80 |
| 61647 | Whole body 68Ga DOTA peptide PET study, 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) | $1851.00 |
| 61650 | LeukoScan study of the long bones and feet for suspected osteomyelitis, if:(a) the patient does not have access to ex vivo white blood cell scanning; and(b) the patient is not being investigated for other sites of infection (R) | $1664.70 |
| **Nuclear medicine—non PET** | | |
| 61310 | Myocardial infarct avid study (R) | $736.20 |
| 61313 | Gated cardiac blood pool study, (equilibrium) (R) | $609.90 |
| 61314 | Gated cardiac blood pool study, with or without intervention, and first pass blood flow or cardiac shunt study (R) | $774.20 |
| 61321 | Single rest myocardial perfusion study for the assessment of the extent and severity of viable and non viable myocardium, with single photon emission tomography, with or without planar imaging, if: (a) the patient has left ventricular systolic dysfunction and probable or confirmed coronary artery disease; and (b) the service uses a single rest technetium 99m (Tc 99m) protocol; and (c) the service is requested by a specialist or a consultant physician; and (d) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61325, 61329, 61345, 61398 or 61406 applies; and (e) if the patient is 17 years or older a service to which this item, or item 61325, 61329, 61345, 61398 or 61406 applies has not been provided to the patient in the previous 24 months (R) | $605.60 |
| 61324 | Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting ECG, continuous ECG monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a specialist or consultant physician; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61325, 61329, 61345, 61357, 61394, 61398, 61406 or 61414 applies; and (f) if the patient is 17 years or older a service to which this item, or item 61329, 61345, 61357, 61394, 61398, 61406, 61410 or 61414, applies has not been provided to the patient in the previous 24 months (R) | $1202.20 |
| 61325 | Single rest myocardial perfusion study for the assessment of the extent and severity of viable and non viable myocardium, with single photon emission tomography, with or without planar imaging, if: (a) the patient has left ventricular systolic dysfunction and probable or confirmed coronary artery disease; and (b) the service uses: (i) an initial rest study followed by a redistribution study on the same day; and (ii) a thallous chloride 201 (Tl 201) protocol; and (c) the service is requested by a specialist or a consultant physician; and (d) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61329, 61345, 61398 or 61406 applies; and (e) if the patient is 17 years or older: (i) a service to which item 61321, 61329, 61345, 61398 or 61406 applies has not been provided to the patient in the previous 24 months; and (ii) the service is applicable only twice each 24 months (R) | $605.60 |
| 61328 | Lung perfusion study (R) | $445.80 |
| 61329 | 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, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61345, 61357, 61394, 61398, 61406 or 61414 applies; and (f) if the patient is 17 years or older a service to which this item, or item 61321, 61324, 61325, 61345, 61357, 61394, 61398, 61406 or 61414, applies has not been provided to the patient in the previous 24 months (R) | $1807.60 |
| 61340 | Lung ventilation study using aerosol, technegas or xenon gas (R) | $432.30 |
| 61345 | 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, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a specialist or consultant physician; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61357, 61394, 61398, 61406 or 61414 applies (R); and (f) if the patient is 17 years or older a service to which this item, or item 61321, 61324, 61325, 61329, 61357, 61394, 61398, 61406 or 61414, applies has not been provided to the patient in the previous 24 months (R) | $1807.60 |
| 61348 | Lung perfusion study and lung ventilation study using aerosol, technegas or xenon gas (R) | $870.60 |
| 61349 | Repeat 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, with or without planar imaging, if: (a) both: (i) a service has been provided to the patient in the previous 24 months to which this item, or item 61324, 61329, 61345, 61357, 61394, 61398, 61406, 61410 or 61414 applies; and (ii) the patient has subsequently undergone a revascularisation procedure; and (b) the patient has one or more symptoms of cardiac ischaemia that have evolved and are not adequately controlled with optimal medical therapy; and (c) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (d) the service is requested by a specialist or a consultant physician; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730 or 61410 applies; and (f) if the patient is 17 years or older a service to which this item, or item 61410, applies has not been provided to the patient in the previous 12 months (R) | $1807.60 |
| 61353 | Liver and spleen study (colloid) (R) | $733.50 |
| 61356 | Red blood cell spleen or liver study (R) | $784.10 |
| 61357 | Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which items 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61394, 61398, 61406 or 61414 applies; and (f) if the patient is 17 years or older a service to which this item, or item 61324, 61329, 61345, 61394, 61398, 61406, or 61414, applies has not been provided to the patient in the previous 24 months (R) | $1202.20 |
| 61360 | Hepatobiliary study, including morphine administration or pre-treatment with a cholagogue when performed (R) | $779.70 |
| 61361 | Hepatobiliary study with formal quantification following baseline imaging, using a cholagogue (R) | $900.60 |
| 61364 | Bowel haemorrhage study (R) | $973.00 |
| 61368 | Meckel s diverticulum study (R) | $418.50 |
| 61369 | Indium-labelled octreotide study (including single photon emission tomography when undertaken), if:(a) a gastro-entero-pancreatic endocrine 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 endocrine tumour has been identified on the basis of conventional techniques; and(ii) the study is to exclude additional disease sites (R) | $3873.40 |
| 61372 | Salivary study (R) | $430.10 |
| 61373 | Gastro-oesophageal reflux study, including delayed imaging on a separate occasion when performed (R) | $940.70 |
| 61376 | Oesophageal clearance study (R) | $276.70 |
| 61381 | Gastric emptying study, using single tracer (R) | $1104.90 |
| 61383 | COMBINED SOLID AND LIQUID GASTRIC EMPTYING STUDY using dual isotope technique or the same isotope on separate days (R) | $1200.50 |
| 61384 | Radionuclide colonic transit study (R) | $1321.30 |
| 61386 | RENAL STUDY, including perfusion and renogram images and computer analysis OR cortical study with planar imaging (R) | $640.50 |
| 61387 | RENAL CORTICAL STUDY, with single photon emission tomography and planar quantification (R) | $830.20 |
| 61389 | SINGLE RENAL STUDY with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R) | $742.40 |
| 61390 | Renal study with diuretic administration after a baseline study (R) | $790.30 |
| 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) | $1131.40 |
| 61394 | Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a specialist or consultant physician; and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61398, 61406 or 61414 applies; and (g) if the patient is 17 years or older a service to which this item, or item 61324, 61329, 61345, 61357, 61398, 61406 or 61414, applies has not been provided to the patient in the previous 24 months (R) | $1202.20 |
| 61397 | Cystoureterogram (R) | $481.20 |
| 61398 | 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, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the services is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61406 or 61414 applies; and (g) if the patient is 17 years or older a service to which this item, or item 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61406 or 61414, applies has not been provided to the patient in the previous 24 months (R) | $1807.60 |
| 61402 | Cerebral perfusion study, with single photon emission tomography and with planar imaging when performed (R) | $1144.00 |
| 61406 | 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, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a specialist or consultant physician; and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61398 or 61414 applies; and (g) if the patient is 17 years or older a service to which this item, or item 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61398 or 61414, applies has not been provided to the patient in the previous 24 months (R) | $1807.60 |
| 61409 | Cerebro-spinal fluid transport study using technetium 99m, with imaging on 2 or more separate occasions (R) | $1628.90 |
| 61410 | Repeat 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, with or without planar imaging, if: (a) both: (i) a service has been provided to the patient in the previous 24 months to which this item, or item 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406 or 61414 applies; and (ii) the patient has subsequently undergone a revascularisation procedure; and (b) the patient has one or more symptoms of cardiac ischaemia that have evolved and are not adequately controlled with optimal medical therapy; and (c) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (d) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729 or 11730 applies; and (f) if the patient is 17 years or older a service to which item 61349 applies has not been provided to the patient in the previous 12 months | $1807.60 |
| 61413 | Cerebro spinal fluid shunt patency study (R) | $428.10 |
| 61414 | Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61398 or 61406 applies; and (g) if the patient is 17 years or older a service to which this item, or item 61324, 61329, 61345, 61357, 61398 or 61406, applies has not been provided to the patient in the previous 24 months (R) | $1202.20 |
| 61421 | Bone study whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) | $885.50 |
| 61425 | Bone study whole body and single photon emission tomography, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) | $1114.60 |
| 61426 | Whole body study using iodine (R) | $1070.40 |
| 61429 | Whole body study using gallium (R) | $1033.70 |
| 61430 | Whole body study using gallium, with single photon emission tomography (R) | $1214.80 |
| 61433 | Whole body study using cells labelled with technetium (R) | $959.90 |
| 61434 | WHOLE BODY STUDY using cells labelled with technetium, with single photon emission tomography (R) | $1133.40 |
| 61438 | Whole body study using thallium (R) | $1283.20 |
| 61441 | Bone marrow study whole body using technetium labelled bone marrow agents (R) | $950.10 |
| 61442 | Whole body study, using gallium with single photon emission tomography of 2 or more body regions acquired separately (R) | $1428.10 |
| 61445 | Bone marrow study localised using technetium labelled agent (R) | $538.70 |
| 61446 | Regional scintigraphic study, using an approved bone scanning agent, including when undertaken, blood flow imaging, blood pool imaging and repeat imaging on a separate occasion (R) | $659.60 |
| 61449 | Regional scintigraphic study, using an approved bone scanning agent and single photon emission tomography, including when undertaken, blood flow imaging, blood pool imaging and repeat imaging on a separate occasion (R) | $903.80 |
| 61450 | Localised study using gallium (R) | $740.70 |
| 61453 | Localised study using gallium, with single photon emission tomography (R) | $1028.20 |
| 61454 | Localised study using cells labelled with technetium (R) | $679.80 |
| 61457 | LOCALISED STUDY using cells labelled with technetium, with single photon emission tomography (R) | $904.20 |
| 61461 | Localised study using thallium (R) | $1014.40 |
| 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 item 61364, 61426, 61429, 61430, 61442, 61450, 61453, 61469 or 61485, if there is no additional administration of radiopharmaceutical and if the previous radionuclide scan was abnormal or equivocal (R) | $258.40 |
| 61466 | Cerebro-spinal fluid transport study using indium-111, with imaging on 2 or more separate occasions (R) | $7727.80 |
| 61469 | Lymphoscintigraphy (R) | $668.50 |
| 61473 | Thyroid study (R) | $338.90 |
| 61480 | Parathyroid study (R) | $750.10 |
| 61485 | Adrenal study, with single photon emission tomography (R) | $1893.80 |
| 61495 | Tear duct study (R) | $418.50 |
| 61499 | Particle perfusion study (infra arterial) or Le Veen shunt study (R) | $509.50 |
| 61505 | CT scan performed at the same time and covering the same body area as single photon emission tomography or positron emission tomography for the purpose of anatomic localisation or attenuation correction if no separate diagnostic CT report is issued and performed in association with a service to which an item in Subgroup 1 or 2 of Group I4 applies (R) | $200.50 |
| 61650 | LeukoScan study of the long bones and feet for suspected osteomyelitis, if:(a) the patient does not have access to ex vivo white blood cell scanning; and(b) the patient is not being investigated for other sites of infection (R) | $1664.70 |
| **GROUP I5—MAGNETIC RESONANCE IMAGING** | | |
| **Scan of head—for specified conditions** | | |
| 63001 | MRI scan of head (including MRA, if performed) for tumour of the brain or meninges (R) (Anaes.) (Contrast) (Anaes.) | $787.40 |
| 63004 | MRI scan of head (including MRA, if performed) for inflammation of brain or meninges (R) (Anaes.) (Contrast) (Anaes.) | $787.40 |
| 63007 | MRI scan of head (including MRA, if performed) for skull base or orbital tumour (R) (Anaes.) (Contrast) (Anaes.) | $787.40 |
| 63010 | MRI scan of head (including MRA, if performed) for stereotactic scan of brain, with fiducials in place, for the sole purpose of allowing planning for stereotactic neurosurgery (R) (Anaes.) (Contrast) (Anaes.) | $662.50 |
| 63040 | MRI scan of head (including MRA, if performed) for acoustic neuroma (R) (Anaes.) (Contrast) (Anaes.) | $643.80 |
| 63043 | MRI scan of head (including MRA, if performed) for pituitary tumour (R) (Anaes.) (Contrast) (Anaes.) | $674.20 |
| 63046 | MRI scan of head (including MRA, if performed) for toxic or metabolic or ischaemic encephalopathy (R) (Anaes.) (Contrast) (Anaes.) | $787.40 |
| 63049 | MRI scan of head (including MRA, if performed) for demyelinating disease of the brain (R) (Anaes.) (Contrast) (Anaes.) | $787.40 |
| 63052 | MRI scan of head (including MRA, if performed) for congenital malformation of the brain or meninges (R) (Anaes.) (Contrast) (Anaes.) | $787.40 |
| 63055 | MRI scan of head (including MRA, if performed) for venous sinus thrombosis (R) (Anaes.) (Contrast) (Anaes.) | $787.40 |
| 63058 | MRI scan of head (including MRA, if performed) for head trauma (R) (Anaes.) (Contrast) (Anaes.) | $787.40 |
| 63061 | MRI scan of head (including MRA, if performed) for epilepsy (R) (Anaes.) (Contrast) (Anaes.) | $787.40 |
| 63064 | MRI scan of head (including MRA, if performed) for stroke (R) (Anaes.) (Contrast) (Anaes.) | $787.40 |
| 63067 | MRI scan of head (including MRA, if performed) for carotid or vertebral artery dissection (R) (Anaes.) (Contrast) (Anaes.) | $787.40 |
| 63070 | MRI scan of head (including MRA, if performed) for intracranial aneurysm (R) (Anaes.) (Contrast) (Anaes.) | $787.40 |
| 63073 | MRI scan of head (including MRA, if performed) for intracranial arteriovenous malformation (R) (Anaes.) (Contrast) (Anaes.) | $787.40 |
| **Scan of head and neck vessels—for specified conditions** | | |
| 63101 | MRI and MRA of extracranial or intracranial circulation (or both) scan of head and neck vessels for stroke (R) (Anaes.) (Contrast) (Anaes.) | $1032.30 |
| **Scan of head and cervical spine—for specified conditions** | | |
| 63111 | MRI scan of head and cervical spine (including MRA, if performed) for tumour of the central nervous system or meninges (R) (Anaes.) (Contrast) (Anaes.) | $1032.30 |
| 63114 | MRI scan of head and cervical spine (including MRA, if performed) for inflammation of the central nervous system or meninges (R) (Anaes.) (Contrast) (Anaes.) | $1032.30 |
| 63125 | MRI scan of head and cervical spine (including MRA, if performed) for demyelinating disease of the central nervous system (R) (Anaes.) (Contrast) (Anaes.) | $1032.30 |
| 63128 | MRI scan of head and cervical spine (including MRA, if performed) for congenital malformation of the central nervous system or meninges (R) (Anaes.) (Contrast) (Anaes.) | $1032.30 |
| 63131 | MRI scan of head and cervical spine (including MRA, if performed) for syrinx (congenital or acquired) (R) (Anaes.) (Contrast) (Anaes.) | $1032.30 |
| **Scan of spine—one region or two contiguous regions—for infection or tumour** | | |
| 63151 | MRI scan of one region or 2 contiguous regions of the spine for infection (R) (Anaes.) (Contrast) (Anaes.) | $674.20 |
| 63154 | MRI scan of one region or 2 contiguous regions of the spine for tumour (R) (Anaes.) (Contrast) (Anaes.) | $674.20 |
| **Scan of spine—one region or two contiguous regions—for other conditions** | | |
| 63161 | MRI scan of one region or 2 contiguous regions of the spine for demyelinating disease (R) (Anaes.) (Contrast) (Anaes.) | $674.20 |
| 63164 | MRI scan of one region or 2 contiguous regions of the spine for congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Anaes.) (Contrast) (Anaes.) | $674.20 |
| 63167 | MRI scan of one region or 2 contiguous regions of the spine for myelopathy (R) (Anaes.) (Contrast) (Anaes.) | $674.20 |
| 63170 | MRI scan of one region or 2 contiguous regions of the spine for syrinx (congenital or acquired) (R) (Anaes.) (Contrast) (Anaes.) | $674.20 |
| 63173 | MRI scan of one region or 2 contiguous regions of the spine for cervical radiculopathy (R) (Anaes.) (Contrast) (Anaes.) | $674.20 |
| 63176 | MRI scan of one region or 2 contiguous regions of the spine for sciatica (R) (Anaes.) (Contrast) (Anaes.) | $674.20 |
| 63179 | MRI scan of one region or 2 contiguous regions of the spine for spinal canal stenosis (R) (Anaes.) (Contrast) (Anaes.) | $674.20 |
| 63182 | MRI scan of one region or 2 contiguous regions of the spine for previous spinal surgery (R) (Anaes.) (Contrast) (Anaes.) | $674.20 |
| 63185 | MRI scan of one region or 2 contiguous regions of the spine for trauma (R) (Anaes.) (Anaes.) | $674.20 |
| **Scan of spine—three contiguous regions or two non-contiguous regions—for infection or tumour** | | |
| 63201 | MRI scan of 3 contiguous or 2 non contiguous regions of the spine for infection (R) (Anaes.) (Contrast) (Anaes.) | $948.70 |
| 63204 | MRI scan of 3 contiguous or 2 non contiguous regions of the spine for tumour (R) (Anaes.) (Contrast) (Anaes.) | $948.70 |
| **Scan of spine—three contiguous regions or two non-contiguous regions—for other conditions** | | |
| 63219 | MRI scan of 3 contiguous or 2 non contiguous regions of the spine for demyelinating disease (R) (Anaes.) (Contrast) (Anaes.) | $948.70 |
| 63222 | MRI scan of 3 contiguous or 2 non contiguous regions of the spine for congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Anaes.) (Contrast) (Anaes.) | $948.70 |
| 63225 | MRI scan of 3 contiguous or 2 non contiguous regions of the spine for myelopathy (R) (Anaes.) (Contrast) (Anaes.) | $948.70 |
| 63228 | MRI scan of 3 contiguous or 2 non contiguous regions of the spine for syrinx (congenital or acquired) (R) (Anaes.) (Contrast) (Anaes.) | $948.70 |
| 63231 | MRI scan of 3 contiguous or 2 non contiguous regions of the spine for cervical radiculopathy (R) (Anaes.) (Contrast) (Anaes.) | $948.70 |
| 63234 | MRI scan of 3 contiguous or 2 non contiguous regions of the spine for sciatica (R) (Anaes.) (Contrast) (Anaes.) | $948.70 |
| 63237 | MRI scan of 3 contiguous or 2 non contiguous regions of the spine for spinal canal stenosis (R) (Anaes.) (Contrast) (Anaes.) | $948.70 |
| 63240 | MRI scan of 3 contiguous or 2 non contiguous regions of the spine for previous spinal surgery (R) (Anaes.) (Contrast) (Anaes.) | $948.70 |
| 63243 | MRI scan of 3 contiguous or 2 non contiguous regions of the spine for trauma (R) (Anaes.) (Anaes.) | $948.70 |
| **Scan of cervical spine and brachial plexus—for specified conditions** | | |
| 63271 | MRI scan of cervical spine and brachial plexus for tumour (R) (Anaes.) (Contrast) (Anaes.) | $1032.30 |
| 63274 | MRI scan of cervical spine and brachial plexus for trauma (R) (Anaes.) (Contrast) (Anaes.) | $1032.30 |
| 63277 | MRI scan of cervical spine and brachial plexus for cervical radiculopathy (R) (Anaes.) (Contrast) (Anaes.) | $1032.30 |
| 63280 | MRI scan of cervical spine and brachial plexus for previous surgery (R) (Anaes.) (Contrast) (Anaes.) | $1032.30 |
| **Scan of musculoskeletal system—for tumour, infection or osteonecrosis** | | |
| 63301 | MRI scan of musculoskeletal system for tumour arising in bone or musculoskeletal system, excluding tumours arising in breast, prostate or rectum (R) (Anaes.) (Contrast) (Anaes.) | $754.40 |
| 63304 | MRI scan of musculoskeletal system for infection arising in bone or musculoskeletal system, excluding infection arising in breast, prostate or rectum (R) (Anaes.) (Contrast) (Anaes.) | $754.40 |
| 63307 | MRI scan of musculoskeletal system for osteonecrosis (R) (Anaes.) (Contrast) (Anaes.) | $754.40 |
| **Scan of musculoskeletal system—for joint derangement** | | |
| 63322 | MRI scan of musculoskeletal system for derangement of hip or its supporting structures (R) (Anaes.) (Contrast) (Anaes.) | $787.60 |
| 63325 | MRI scan of musculoskeletal system for derangement of shoulder or its supporting structures (R) (Anaes.) (Contrast) (Anaes.) | $787.60 |
| 63328 | MRI scan of musculoskeletal system for derangement of knee or its supporting structures (R) (Anaes.) (Contrast) (Anaes.) | $787.60 |
| 63331 | MRI scan of musculoskeletal system for derangement of ankle or foot (or both) or its supporting structures (R) (Anaes.) (Contrast) (Anaes.) | $787.60 |
| 63334 | MRI scan of musculoskeletal system for derangement of one or both temporomandibular joints or their supporting structures (R) (Anaes.) (Contrast) (Anaes.) | $662.50 |
| 63337 | MRI scan of musculoskeletal system for derangement of wrist or hand (or both) or its supporting structures (R) (Anaes.) (Contrast) (Anaes.) | $948.70 |
| 63340 | MRI scan of musculoskeletal system for derangement of elbow or its supporting structures (R) (Anaes.) (Contrast) (Anaes.) | $787.60 |
| **Scan of musculoskeletal system—for Gaucher disease** | | |
| 63361 | MRI scan of musculoskeletal system for Gaucher disease (R) (Anaes.) (Anaes.) | $787.60 |
| **Scan of cardiovascular system—for specified conditions** | | |
| 63385 | MRI scan of cardiovascular system for congenital disease of the heart or a great vessel (R) (Anaes.) (Contrast) (Anaes.) | $948.70 |
| 63388 | MRI scan of cardiovascular system for tumour of the heart or a great vessel (R) (Anaes.) (Contrast) (Anaes.) | $948.70 |
| 63391 | MRI scan of cardiovascular system for abnormality of thoracic aorta (R) (Anaes.) (Contrast) (Anaes.) | $787.60 |
| 63395 | MRI scan of cardiovascular system for 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(R) (Contrast) (Anaes.) | $1651.10 |
| 63397 | MRI scan of cardiovascular system for 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)(R) (Contrast) (Anaes.) | $1651.10 |
| 63399 | MRI scan of cardiovascular system for the assessment of myocardial structure and function, if the service is requested by a consultant physician who has assessed the patient, and the request for the scan indicates: the patient has suspected myocarditis after receiving a mRNA COVID-19 vaccine; and the patient had symptom onset within 21 days of a mRNA COVID-19 vaccine administration; and the results from the following examinations are inconclusive to form a diagnosis of myocarditis:(i)echocardiogram; and(ii) troponin; and(iii)chest X-ray. Applicable not more than once in a patient s lifetime (R) (Contrast) (Anaes.) | $1512.10 |
| **Magnetic resonance angiography—scan of cardiovascular system—for specified conditions** | | |
| 63401 | MRA if the request for the scan specifically identifies the clinical indication for the scan of cardiovascular system for vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (R) (Contrast) (Anaes.) | $787.60 |
| 63404 | MRA if the request for the scan specifically identifies the clinical indication for the scan of cardiovascular system for obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (R) (Contrast) (Anaes.) | $787.60 |
| **Magnetic resonance angiography—for specified conditions—person under the age of 16 years** | | |
| 63416 | MRA 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.) | $787.60 |
| **Magnetic resonance imaging—person under the age of 16 years ?for physeal fusion or Gaucher disease** | | |
| 63425 | MRI scan of person under the age of 16 for post inflammatory or post traumatic physeal fusion (R) (Anaes.) | $787.60 |
| 63428 | MRI scan of person under the age of 16 for Gaucher disease (R) (Anaes.) | $787.60 |
| **Magnetic resonance imaging—person under the age of 16 years ?for other conditions** | | |
| 63440 | MRI scan of person under the age of 16 for pelvic or abdominal mass (R) (Contrast) (Anaes.) | $787.60 |
| 63443 | MRI scan of person under the age of 16 for mediastinal mass (R) (Contrast) (Anaes.) | $787.60 |
| 63446 | MRI scan of person under the age of 16 for congenital uterine or anorectal abnormality (R) (Contrast) (Anaes.) | $787.60 |
| **Scan of body—for specified conditions** | | |
| 63461 | MRI scan of the body for adrenal mass in a patient with a malignancy that is otherwise resectable (R) (Anaes.) | $739.10 |
| 63464 | MRI scan of both breasts for the detection of cancer in a patient, if: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient is asymptomatic and is younger than 60 years of age; and (c) the request for the scan identifies that the patient is at high risk of developing breast cancer due to one or more of the following: (i) genetic testing has identified the presence of a high risk breast cancer gene mutation in the patient or in a first degree relative of the patient; (ii) both: (A) one of the patient s first or second degree relatives was diagnosed with breast cancer at age 45 years or younger; and (B) another first or second degree relative on the same side of the patient s family was diagnosed with bone or soft tissue sarcoma at age 45 years or younger; (iii) the patient has a personal history of breast cancer before the age of 50 years; (iv) the patient has a personal history of mantle radiation therapy; (v) the patient has a lifetime risk estimation greater than 30% or a 10 year absolute risk estimation greater than 5% using a clinically relevant risk evaluation algorithm; and (d) the service is not performed in conjunction with item 55076 or 55079 Applicable not more than once in a 12 month period (R) (Contrast) (Anaes.) | $1442.70 |
| 63467 | MRI scan of both breasts for the detection of cancer, if:(a) a dedicated breast coil is used; and(b) the person has had an abnormality detected as a result of a service mentioned in item 63464 performed in the previous 12 months (R) (Anaes.) | $1437.10 |
| 63487 | MRI scan of both breasts, if:(a) a dedicated breast coil is used; and(b) 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) (Anaes.) | $1353.50 |
| 63489 | MRI scan of one breast, performed in conjunction with a biopsy procedure on that breast and an ultrasound scan of that breast, if: (a) the request for the MRI scan identifies that the patient has a suspicious lesion seen on MRI but not on conventional imaging; and (b) the ultrasound scan is performed immediately before the MRI scan and confirms that the lesion is not amenable to biopsy guided by conventional imaging; and (c) a dedicated breast coil is used (R) (Anaes.) | $2301.90 |
| 63541 | Multiparametric MRI scan of the prostate for the detection of cancer, requested by a specialist in the speciality of urology, radiation oncology or medical oncology: (a) if the request for the scan identifies that the patient is suspected of developing prostate cancer: (i) on the basis of a digital rectal examination; or (ii) in the circumstances mentioned in clause2.5.9A; and (b) using a standardised image acquisition protocol involving: (i) T2 weighted imaging; and (ii) diffusion weighted imaging; and (iii) (unless contraindicated) dynamic contrast enhancement (R) Note: See explanatory note IN.5.1 for the meaning of Clause 2.5.9 in the descriptor for this item and the claiming limitations. (Anaes.) | $868.70 |
| 63543 | Multiparametric MRI scan of the prostate for the assessment of cancer, requested by a specialist in the speciality of urology, radiation oncology or medical oncology: (a) if the request for the scan identifies that the patient: (i) is under active surveillance following a confirmed diagnosis of prostate cancer by biopsy histopathology; and (ii) is not undergoing, or planning to undergo, treatment for prostate cancer; and (b) using a standardised image acquisition protocol involving: (i) T2 weighted imaging; and (ii) diffusion weighted imaging; and (iii) (unless contraindicated) dynamic contrast enhancement (R) Note: See explanatory note IN.5.2 for claiming restrictions for this item. (Anaes.) | $868.70 |
| 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(R) (Contrast) (Anaes.) | $1332.10 |
| 63564 | Note: the requirements for services provided under item 63564 are detailed under note IN.5.4 MRI whole body scan for the early detection of cancer: a)requested by a specialist or consultant physician in consultation with a clinical geneticist in a familial cancer or genetic clinic; and b)the request identifies that the patient has a high risk of developing cancer malignancy due to heritableTP53- related cancer (hTP53rc) syndrome (R) (Anaes.) | $2471.10 |
| **Scan of pelvis and upper abdomen—for specified conditions** | | |
| 63454 | MRI scan of the pelvis or abdomen, for a patient who is pregnant, if: (a) the pregnancy is at, or after, 18 weeks gestation; and (b) fetal abnormality is suspected; and (c) an ultrasound has been performed and is provided by, or on behalf of, or at the request of, a specialist who is practising in the specialty of obstetrics; and (d) the diagnosis of fetal abnormality as a result of the ultrasound is indeterminate or requires further examination; and (e) the MRI service is requested by a specialist practising in the specialty of obstetrics(R) (Contrast) (Anaes.) | $2265.70 |
| 63470 | MRI scan of the pelvis for the staging of histologically diagnosed cervical cancer at FIGO stage 1B or greater, if the request for scan identifies that: (a) a histological diagnosis of carcinoma of the cervix has been made; and(b) the patient has been diagnosed with cervical cancer at FIGO stage 1B or greater (R) (Contrast) (Anaes.) | $787.60 |
| 63473 | MRI scan of the pelvis and upper abdomen, in a single examination, for the staging of histologically diagnosed cervical cancer at FIGO stage 1B or greater, if the request for the scan identifies that: (a) a histological diagnosis of carcinoma of the cervix has been made; and(b) the patient has been diagnosed with cervical cancer at FIGO stage 1B or greater (R) (Contrast) (Anaes.) | $1283.30 |
| 63476 | MRI scan of the pelvis for the initial staging of rectal cancer, if: (a) a phased array body coil is used; and(b) the request for the scan identifies that the indication is for the initial staging of rectal cancer (including cancer of the rectosigmoid and anorectum) (R) (Contrast) (Anaes.) | $850.60 |
| 63549 | MRI scan of the pelvis or abdomen, for a patient with a multiple pregnancy, if: (a) the multiple pregnancy is at, or after, 18 weeks gestation; and (b) fetal abnormality is suspected; and (c) an ultrasound has been performed and is provided by, or on behalf of, or at the request of, a specialist who is practising in the specialty of obstetrics; and (d) the diagnosis of fetal abnormality as a result of the ultrasound is indeterminate or requires further examination; and (e) the MRI service is requested by a specialist practising in the specialty of obstetrics (R) (Contrast) (Anaes.) | $3233.60 |
| 63563 | MRI scan of the pelvis or abdomen, if the request for the scan identifies that the investigation is for: (a) sub fertility that requires one or more of the following: (i) an investigation of suspected Mullerian duct anomaly seen in pelvic ultrasound or hysterosalpingogram; (ii) an assessment of uterine mass identified on pelvic ultrasound before consideration of surgery; (iii) an investigation of recurrent implantation failure in IVF (2 or more embryo transfer cycles without viable pregnancy); or (b) surgical planning of a patient with known or suspected deep endometriosis involving the bowel, bladder or ureter (or any combination of the bowel, bladder or ureter), where the results of pelvic ultrasound are inconclusive Applicable not more than once in a 2 year period (R) (Contrast) (Anaes.) | $724.30 |
| 63740 | MRI scan to evaluate small bowel Crohn s disease if the service is provided to a patient for: (a) evaluation of disease extent at time of initial diagnosis of Crohn s disease; or(b) evaluation of exacerbation, or suspected complications, of known Crohn s disease; or(c) evaluation of known or suspected Crohn s disease in pregnancy; or(d) assessment of change to therapy in a patient with small bowel Crohn s disease (R) (Contrast) | $936.80 |
| 63741 | MRI scan with enteroclysis for Crohn s disease if the service is related to item 63740 (R) | $543.40 |
| 63743 | MRI scan for fistulising perianal Crohn s disease if the service is provided to a patient for:(a) evaluation of pelvic sepsis and fistulas associated with established or suspected Crohn s disease; or(b) assessment of change to therapy of pelvis sepsis and fistulas from Crohn s disease (R) (Contrast) | $826.00 |
| **Scan of body—for suspected hepato-biliary or pancreatic pathology** | | |
| 63482 | MRI scan of pancreas and biliary tree for suspected biliary or pancreatic pathology (R) (Anaes.) | $807.80 |
| 63545 | MRI—multiphase scans of liver (including delayed imaging, if performed) with a contrast agent, for characterisation, or staging where surgical resection or interventional techniques are under consideration, if: (a) the patient has a confirmed extra hepatic primary malignancy (other than hepatocellular carcinoma); and (b) computed tomography is negative or inconclusive for hepatic metastatic disease; and (c) the identification of liver metastases would change the patient s treatment planning Applicable not more than once in a 12 month period (R) (Contrast) (Anaes.) | $1038.50 |
| 63546 | MRI multiphase scans of the liver (including delayed imaging, if performed) with a contrast agent, for diagnosis or staging, if: (a) the patient has:(i) known or suspected hepatocellular carcinoma; and(ii) chronic liver disease that has been confirmed by a specialist or consultant physician; and(b) the patient s liver function has been identified as Child Pugh or B; and(c) the patient has an identified hepatic lesion over 10 mm in diameter. For any particular patient applicable not more than once in a 12 month period (R) (Contrast) (Anaes.) | $1038.50 |
| **Modifying items** | | |
| 63491 | 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. MRI or MRA service to which an item in this Group (other than an item in this Subgroup) applies if: (a) the service is performed on a person in accordance with clause 2.5.1; and(b) the item for the service includes in its description (Contrast) ; and(c) the service is performed using a contrast agent | $89.90 |
| 63494 | MRI or MRA service to which an item in this Group (other than an item in this Subgroup) applies if: (a) the service is performed on a person in accordance with clause 2.5.1; and(b) the service is performed using intravenous or intra muscular sedation | $94.70 |
| 63496 | 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. MRI service to which item 63545 or 63546 applies if: (a) the service is performed on a person under the supervision of an eligible provider; and(b) the service is performed using an hepatobiliary specific contrast agent | $472.10 |
| 63497 | MRI or MRA service to which an item in this Group (other than an item in this Subgroup) applies if: (a) the service is performed on a person in accordance with clause 2.5.1; and(b) the service is performed under anaesthetic in the presence of a medical practitioner who is qualified to perform an anaesthetic | $314.10 |
| 63498 | MRI service to which item 63501, 63502, 63504 or 63505 applies, if the service is performed on a person using intravenous or intra muscular sedation | $89.10 |
| 63499 | MRI service to which item 63501, 63502, 63504 or 63505 applies, if the service is performed on a person under anaesthetic in the presence of a medical practitioner who is qualified to perform an anaesthetic | $312.30 |
| **Magnetic resonance imaging—PIP breast implant** | | |
| 63501 | MRI scan of one or both breasts for the evaluation of implant integrity, if: (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) | $996.00 |
| 63502 | MRI scan of one or both breasts for the evaluation of implant integrity, if: (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) | $996.00 |
| 63504 | MRI scan of one or both breasts for the evaluation of implant integrity, if: (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) | $996.00 |
| 63505 | MRI scan of one or both breasts for the evaluation of implant integrity, if: (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) | $996.00 |
| **Scan of body—person under the age of 16 years ?general practice requests** | | |
| 63507 | MRI scan of head for a patient under 16 years if the service is for:(a) an unexplained seizure; or(b) an unexplained headache if significant pathology is suspected; or(c) paranasal sinus pathology that has not responded to conservative therapy (R) (Contrast) (Anaes.) | $787.40 |
| 63510 | MRI scan of spine following radiographic examination for a patient under 16 years if the service is for: (a) significant trauma; or(b) unexplained neck or back pain with associated neurological signs; or(c) unexplained back pain if significant pathology is suspected (R) (Contrast) (Anaes.) | $948.70 |
| 63513 | MRI scan of knee for internal joint derangement for a patient under 16 years (R) (Contrast) (Anaes.) | $787.60 |
| 63516 | MRI scan of hip following radiographic examination for a patient under 16 years if any of the following is suspected: (a) septic arthritis;(b) slipped capital femoral epiphysis;(c) Perthes disease (R) (Contrast) (Anaes.) | $787.60 |
| 63519 | MRI scan of elbow following radiographic examination for a patient under 16 years if a significant fracture or avulsion injury, which would change the way in which the patient is managed, is suspected (R) (Contrast) (Anaes.) | $787.60 |
| 63522 | MRI scan of wrist following radiographic examination for a patient under 16 years if a scaphoid fracture is suspected (R) (Contrast) (Anaes.) | $948.70 |
| **Scan of body—person over the age of 16 years ?general practice requests** | | |
| 63551 | MRI—scan of head for a patient 16 years or older, after a request by a medical practitioner (other than a specialist or consultant physician), for any of the following: (a) unexplained seizure(s);(b) unexplained chronic headache with suspected intracranial pathology (R) (Contrast) (Anaes.) | $851.70 |
| 63554 | MRI—scan of spine for a patient 16 years or older, after referral by a medical practitioner (other than a specialist or consultant physician), for suspected cervical radiculopathy (R) (Contrast) (Anaes.) | $757.00 |
| 63557 | MRI—scan of spine for a patient 16 years or older, after referral by a medical practitioner (other than a specialist or consultant physician), for suspected cervical spinal trauma (R) (Contrast) (Anaes.) | $1040.80 |
| 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 16 to 49 years with: (a) inability to extend the knee suggesting the possibility of acute meniscal tear; or(b) clinical findings suggesting acute anterior cruciate ligament tear (R) (Contrast) (Anaes.) | $851.70 |
| **GROUP P1—HAEMATOLOGY** | | |
| 65060 | Haemoglobin, erythrocyte sedimentation rate, blood viscosity—1 or more tests | $15.30 |
| 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 | $17.90 |
| 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 sets 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 | $32.70 |
| 65072 | Examination for reticulocytes including a reticulocyte count by any method—1 or more tests | $19.60 |
| 65075 | Haemolysis or metabolic enzymes—assessment by: (a)erythrocyte autohaemolysis test; or (b)erythrocyte osmotic fragility test; or (c)sugar water test; or (d)G-6-P D (qualitative or quantitative) test; or (e)pyruvate kinase (qualitative or quantitative) test; or (f)acid haemolysis test; or (g) quantitation of muramidase in serum or urine; or (h) Donath Landsteiner antibody test; or (i) other erythrocyte metabolic enzyme tests 1 or more tests | $100.70 |
| 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 | $169.90 |
| 65079 | Tests described in item 65078 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18) | $169.90 |
| 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 | $182.40 |
| 65082 | Tests described in item 65081 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18) | $182.40 |
| 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 | $314.60 |
| 65087 | Bone marrow—examination of aspirated material (including clot sections where necessary), including (if performed): any test described in item 65060, 65066 or 65070 | $156.50 |
| 65090 | Blood grouping (including back-grouping if performed)—ABO and Rh (D antigen) | $21.40 |
| 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) | $41.50 |
| 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 | $77.30 |
| 65099 | Compatibility tests by crossmatch—all tests performed on any1 day for up to 6 units, including: (a)direct testing of donor red cells from each unit against the serum of the patient by one or more accepted crossmatching techniques; and (b) all grouping checks of the patient and donor; and (c)examination for antibodies, and if necessary identification of any antibodies detected; and (d)(if performed) any tests described in item 65060, 65070, 65090 or 65096 (Item is subject to rule 5) | $208.50 |
| 65102 | Compatibility tests by crossmatch—all tests performed on any1 day in excess of 6 units, including: (a) direct testing of donor red cells from each unit against serum of the patient by one or more accepted crossmatching techniques; and (b) all grouping checks of the patient and donor; and (c)examination for antibodies, and if necessary identification of any antibodies detected; and (d)(if performed) any tests described in item 65060, 65070, 65090, 65096, 65099 or 65105 (Item is subject to rule 5) | $310.90 |
| 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) | $210.60 |
| 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 (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) | $310.10 |
| 65109 | Release of fresh frozen plasma or cryoprecipitate for the use in a patient for the correction of a coagulopathy—1 release. | $24.90 |
| 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. | $24.90 |
| 65111 | Examination of serum for blood group antibodies (including identification and, if necessary, quantitation of any antibodies detected) | $45.10 |
| 65114 | 1 or more of the following tests: (a)direct Coombs (antiglobulin) test; (b)qualitative or quantitative test for cold agglutinins or heterophil antibodies | $15.70 |
| 65117 | 1 or more of the following tests: (a)Spectroscopic examination of blood for chemically altered haemoglobins; (b)detection of methaemalbumin (Schumm’s test) | $38.20 |
| 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 | $25.90 |
| 65123 | 2 tests described in item 65120 | $39.30 |
| 65126 | 3 tests described in item 65120 | $53.50 |
| 65129 | 4 or more tests described in item 65120 | $67.90 |
| 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 | $48.80 |
| 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 | $48.80 |
| 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 | $106.70 |
| 65147 | Quantitation of anti-Xa activity when monitoring is required for a patient receiving a low molecular weight heparin or heparinoid—1 test | $72.90 |
| 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 ) | $133.70 |
| 65153 | 2 tests described in item 65150 (Item is subject to rule 6 ) | $267.50 |
| 65156 | 3 or more tests described in item 65150 (Item is subject to rule 6 ) | $401.20 |
| 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) | $133.70 |
| 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) | $133.70 |
| 65159 | Quantitation of circulating coagulation factor inhibitors by Bethesda assay—1 test | $133.70 |
| 65162 | Examination of a maternal blood film for the presence of fetal red blood cells (Kleihauer test) | $20.10 |
| 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 | $66.10 |
| 65166 | A test described in item 65165 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18) | $65.00 |
| 65171 | Test for the presence of antithrombin III deficiency, protein C deficiency, protein S deficiency or activated protein C resistance in a first degree relative of a person who has a proven defect of any of the above—1 or more tests | $48.80 |
| 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) | $48.80 |
| 65176 | 2 tests described in item 65175 (Item is subject to rule 6) | $91.60 |
| 65177 | 3 tests described in item 65175 (Item is subject to rule 6) | $135.80 |
| 65178 | 4 tests described in item 65175 (Item is subject to rule 6) | $179.70 |
| 65179 | 5 tests described in item 65175 (Item is subject to rule 6) | $223.40 |
| 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 rule6 and 18) | $48.80 |
| 65181 | A test described in item 65175, if rendered by a receiving APP, if one or more tests described in the item have been rendered by the referring APP—one test (Item is subject to rule 6 and 18) | $44.00 |
| **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 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 | $16.70 |
| 66503 | 2 tests described in item 66500 | $19.80 |
| 66506 | 3 tests described in item 66500 | $23.50 |
| 66509 | 4 tests described in item 66500 | $27.00 |
| 66512 | 5 or more tests described in item 66500 | $30.50 |
| 66517 | Quantitation of bile acids in blood in pregnancy. Applicable not more than 3 times in a pregnancy. | $38.00 |
| 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 | $38.20 |
| 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 | $76.90 |
| 66522 | Faecal calprotectin test for the diagnosis of inflammatory bowel disease, if all the following apply: the patient is under 50 years of age; the patient has gastrointestinal symptoms suggestive of inflammatory or functional bowel disease of more than 6 weeks duration; infectious causes have been excluded; the likelihood of malignancy has been assessed as low; no relevant clinical alarms are present | $138.10 |
| 66523 | Faecal calprotectin test for the diagnosis of inflammatory bowel disease, if all the following apply: the results of a service to which item 66522 applies were inconclusive for the patient (that is, the results showed a faecal calprotectin level of more than 50 g/g but not more than 100 g/g); the patient has ongoing gastrointestinal symptoms suggestive of inflammatory or functional bowel disease; the service is requested by a specialist or consultant physician practising as a specialist gastroenterologist; the request indicates that an endoscopic examination is not initially required; no relevant clinical alarms are present | $138.10 |
| 66536 | Quantitation of hdl cholesterol | $18.90 |
| 66539 | Electrophoresis of serum for demonstration of lipoprotein subclasses, if the cholesterol is &gt;6.5 mmol/L and triglyceride &gt;4.0 mmol/L or in the diagnosis of types III and IV hyperlipidaemia—(Item is subject to rule 25) | $54.80 |
| 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 | $36.00 |
| 66545 | Oral glucose challenge test in pregnancy for the detection of gestational diabetes that includes: (a)administration of glucose; and (b)1 or 2 measurements of blood glucose; and (c)(if performed) any test in item 66695 | $30.50 |
| 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) | $38.50 |
| 66551 | Quantitation of glycated haemoglobin performed in the management of established diabetes (See para PR.2.2 of explanatory notes to this Category) | $32.40 |
| 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) | $32.40 |
| 66557 | Quantitation of fructosamine performed in the management of established diabetes—each test to a maximum of 4 tests in a 12 month period | $18.80 |
| 66560 | Microalbumin—quantitation in urine | $38.10 |
| 66563 | Osmolality, estimation by osmometer, in serum or in urine—1 or more tests | $42.40 |
| 66566 | Quantitation of: (a)blood gases (including pO2, oxygen saturation and pCO2) ; 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 | $67.20 |
| 66569 | Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 2 specimens performed within any 1 day | $80.30 |
| 66572 | Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 3 specimens performed within any 1 day | $98.80 |
| 66575 | Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 4 specimens performed within any 1 day | $113.90 |
| 66578 | Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 5 specimens performed within any 1 day | $133.30 |
| 66581 | Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 6 or more specimens performed within any 1 day | $149.60 |
| 66584 | Quantitation of ionised calcium (except if performed as part of item 66566)—1 test | $18.80 |
| 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 | $89.60 |
| 66590 | Calculus, analysis of 1 or more | $58.60 |
| 66593 | Ferritin—quantitation, except if requested as part of iron studies | $34.70 |
| 66596 | Iron studies, consisting of quantitation of: (a)serum iron; and (b)transferrin or iron binding capacity; and (c)ferritin | $62.80 |
| 66605 | Vitamins—quantitation of vitamins B1, B2, B3, B6 or Cin blood, urine or other body fluid—1 or more tests | $57.80 |
| 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) | $57.80 |
| 66607 | Vitamins—quantitation of vitamins a or e in blood, urine or other body fluid—1 or more tests within a 6 month period | $142.80 |
| 66610 | A test described in item 66607 if rendered by a receiving app—1 or more tests | $141.50 |
| 66623 | All qualitative and quantitative tests on blood, urine or other body fluid for: (a)a drug or drugs of abuse (including illegal drugs and legally available drugs taken other than in appropriate dosage); or (b)ingested or absorbed toxic chemicals; including a service described in item 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 | $71.30 |
| 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) | $45.50 |
| 66629 | Beta-2-microglobulin—quantitation in serum, urine or other body fluids—1 or more tests | $38.10 |
| 66632 | Caeruloplasmin, haptoglobins, or prealbumin—quantitation in serum, urine or other body fluids—1 or more tests | $38.10 |
| 66635 | Alpha-1-antitrypsin—quantitation in serum, urine or other body fluid—1 or more tests | $38.10 |
| 66638 | Isoelectric focussing or similar methods for determination of alpha-1-antitrypsin phenotype in serum—1 or more tests | $84.10 |
| 66639 | A test described in item 66638 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18) | $55.10 |
| 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 | $55.10 |
| 66642 | A test described in item 66641 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18) | $55.10 |
| 66644 | C-1 esterase inhibitor—quantitation | $34.70 |
| 66647 | C-1 esterase inhibitor—functional assay | $77.40 |
| 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) | $45.90 |
| 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) | $45.90 |
| 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) | $38.40 |
| 66653 | 2 or more tests described in item 66650 (Item is subject to rule 6) | $84.20 |
| 66655 | Prostate specific antigen quantitation For any particular patient, applicable not more than once in 23 months | $38.10 |
| 66656 | Prostate specific antigen (PSA) quantitation in the monitoring of previously diagnosed prostatic disease (includingprostate cancer, prostatitis or a premalignant condition such as atypical small acinar proliferation) | $38.10 |
| 66659 | Prostate specific antigen (PSA), 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 under item 66654 or 66655 that lies at: (a) more than 2.0 ug/L but less than or equal to 5.5 ug/L for patients with a family history of prostate cancer; or (b) more than 3.0 ug/L but less than or equal to 5.5 ug/L for patients who are at least 50 years of age but under 70 years of age; or (c) more than 5.5 ug/L but less than or equal to 10.0 ug/L for patients who are at least 70 years of age For any particular patient, applicable not more than once in 11 months | $71.80 |
| 66660 | Prostate specific antigen (PSA), quantitation of 2 or more fractions of PSA and any derived index, in the monitoring of previously diagnosed prostatic disease, including, if performed, a test described in item 66656, if the current PSA level lies at: (a) more than 2.0 ug/L but less than or equal to 5.5 ug/L for patients with a family history of prostate cancer; or (b) more than 3.0 ug/L but less than or equal to 5.5 ug/L for patients who are at least 50 years of age but under 70 years of age; or (c) more than 5.5 ug/L but less than or equal to 10.0 ug/L for patients who are at least 70 years of age For any particular patient, applicable not more than 4 times in 11 months | $70.90 |
| 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 | $150.80 |
| 66663 | A test described in item 66662 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18) | $150.80 |
| 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 | $52.70 |
| 66666 | A test described in item 66665 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18) | $57.80 |
| 66667 | Quantitation of serum zinc in a patient receiving intravenous alimentation—each test | $57.80 |
| 66671 | Quantitation of serum aluminium in a patient in a renal dialysis program—each test | $69.60 |
| 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 | $75.90 |
| 66677 | Test for tryptic activity in faeces in the investigation of diarrhoea of longer than 4 weeks duration in children under 6 years old | $21.40 |
| 66680 | Quantitation of disaccharidases and other enzymes in intestinal tissue—1 or more tests | $142.90 |
| 66683 | Enzymes—quantitation in solid tissue or tissues other than blood elements or intestinal tissue—1 or more tests | $140.50 |
| 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 | $95.50 |
| 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) | $52.50 |
| 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) | $57.60 |
| 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) | $25.40 |
| 66698 | 2 tests described in item 66695 (Item is subject to rule 6) | $82.40 |
| 66701 | 3 tests described in item 66695 (Item is subject to rule 6) | $107.50 |
| 66704 | 4 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 tests specified on the request form or performs 4 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) | $132.20 |
| 66707 | 5 or more tests described in item 66695 (Item is subject to rule 6) | $157.30 |
| 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) | $58.20 |
| 66712 | Two tests described in item 66711 (Item is subject to rule 6) | $83.50 |
| 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) | $57.80 |
| 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) | $30.00 |
| 66716 | TSH quantitation | $43.10 |
| 66719 | Thyroid function tests (comprising the service described in item 66716 and either or both of a test for free thyroxine and a test for free T3) for a patient, if: (a)the patient has a level of TSH that is outside the normal reference range for the particular method of assay used to determine the level; or (b)the request from the requesting medical practitioner indicates that the tests are performed: (i)for the purpose of monitoring thyroid disease in the patient; or (ii)to investigate the sick euthyroid syndrome if the patient is an admitted patient; or (iii)to investigate dementia or psychiatric illness of the patient; or (iv)to investigate amenorrhoea or infertility of the patient; or (c)the request from the requesting medical practitioner indicates that the medical practitionersuspects the patient has a pituitary dysfunction; or (d)the request from the requesting medical practitioner indicates that the patient is on drugs that interfere with thyroid hormone metabolism or function | $59.60 |
| 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) | $71.50 |
| 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) | $71.50 |
| 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) | $24.80 |
| 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) | $96.20 |
| 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 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) | $121.10 |
| 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) | $145.70 |
| 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) | $170.60 |
| 66743 | Quantitation of alpha-fetoprotein in serum or other body fluids during pregnancy except if requested as part of items 66750 or 66751 | $38.90 |
| 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 | $63.20 |
| 66750 | Quantitation, in pregnancy, of any2 of the following to detect foetal abnormality- 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 (uE3), alpha-fetoprotein (AFP)—including (if performed) a service described in item 73527or 73529—Applicable not more than once in a pregnancy | $76.40 |
| 66751 | Quantitation, in pregnancy, of any three or more tests described in 66750 (Item is subject to rule 25) | $106.00 |
| 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 | $47.70 |
| 66755 | 2 or more tests described in item 66752 | $73.40 |
| 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. | $185.40 |
| 66757 | Quantitation of 10 or more amino acids for monitoring of previously diagnosed inborn errors of metabolism in 1 tissue type. | $185.40 |
| 66758 | Quantitation of angiotensin converting enzyme, or cholinesterase—1 or more tests | $47.70 |
| 66761 | Test for reducing substances in faeces by any method (except reagent strip or dipstick) | $24.80 |
| 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 | $16.90 |
| 66767 | 2 examinations described in item 66764 performed on separately collected and identified specimens | $34.40 |
| 66770 | 3 examinations described in item 66764 performed on separately collected and identified specimens | $50.50 |
| 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) | $42.30 |
| 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 | $42.30 |
| 66779 | Adrenaline, noradrenaline, dopamine, histamine, hydroxyindoleacetic acid (5HIAA), hydroxymethoxymandelic acid (HMMA), homovanillic acid (HVA), metanephrines, methoxyhydroxyphenylethylene glycol (MHPG), phenylacetic acid (PAA) or serotoninquantitation—1 or more tests | $75.50 |
| 66780 | A test described in item 66779 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18) | $75.50 |
| 66782 | Porphyrins or porphyrins precursors—detection in plasma, red cells, urine or faeces—1 or more tests | $25.30 |
| 66783 | A test described in item 66782 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18) | $24.80 |
| 66785 | Porphyrins or porphyrins precursors—quantitation in plasma, red cells, urine or faeces—1 test (Item is subject to rule 6) | $75.50 |
| 66788 | Porphyrins or porphyrins precursors—quantitation in plasma, red cells, urine or faeces—2 or more tests (Item is subject to rule 6) | $124.20 |
| 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) | $75.50 |
| 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) | $49.00 |
| 66791 | Porphyrin biosynthetic enzymes—measurement of activity in blood cells or other tissues—1 or more tests | $140.50 |
| 66792 | A test described in item 66791 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18) | $140.50 |
| 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, salicylate, theophylline, tobramycin, valproate or vancomycin—1 test (Item to be subject to rule 6) | $35.50 |
| 66803 | 2 tests described in item 66800 (Item is subject to rule 6) | $59.70 |
| 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) | $34.90 |
| 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) | $23.30 |
| 66806 | 3 tests described in item 66800 (Item is subject to rule 6) | $81.30 |
| 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) | $67.20 |
| 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) | $112.30 |
| 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) | $67.20 |
| 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) | $47.80 |
| 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) | $57.80 |
| 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) | $57.80 |
| 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) | $42.10 |
| 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) | $98.80 |
| 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) | $57.80 |
| 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 ) | $57.80 |
| 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) | $42.10 |
| 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 maximum of 3 of this item in a 6 month period (Item is subject to rule 6, 22 and 25) | $98.80 |
| 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) | $113.60 |
| 66831 | Quantitation of copper or iron in liver tissue biopsy | $59.30 |
| 66832 | A test described in item 66831 if rendered by a receiving app (item is subject to rule 18a and 22) | $58.40 |
| 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 | $56.20 |
| 66834 | A test described in item 66833 if rendered by a receiving APP (Item is subject to Rule 18) | $56.20 |
| 66835 | 1, 25-dihydroxyvitamin D—quantification in serum, if the request for the test is made by, or on advice of, the specialist or consultant physician managing the treatment of the patient | $72.90 |
| 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 | $72.90 |
| 66837 | A test described in item 66835 or 66836 if rendered by a receiving APP (Item is subject to Rule 18) | $72.90 |
| 66838 | Serum vitamin B12 test (Item is subject to Rule 25) | $44.00 |
| 66839 | Quantification of vitamin B12 markers such as holoTranscobalamin or methylmalonic acid, where initial serum vitamin B12 result is low or equivocal | $80.10 |
| 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 | $44.00 |
| 66841 | Quantitation of HbA1c (glycated haemoglobin) performed for the diagnosis of diabetes in asymptomatic patients at high risk.(Item is subject to rule 25) | $31.20 |
| 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. | $146.40 |
| **GROUP P3—MICROBIOLOGY** | | |
| 69300 | Microscopy of wet film material other than blood, from 1 or more sites, obtained directly from a patient (not cultures) including: (a)differential cell count (if performed); or (b)examination for dermatophytes; or (c)dark ground illumination; or (d)stained preparation or preparations using any relevant stain or stains; 1 or more tests | $23.70 |
| 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 | $41.50 |
| 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 | $63.50 |
| 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 Schedule; or (b)a service described in items 69300, 69303, 69306, 69312, 69318; 1 or more tests on 1 or more specimens | $92.20 |
| 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 | $63.50 |
| 69316 | Detection of Chlamydia trachomatis by any method—1 test (Item is subject to rule 26) | $54.00 |
| 69317 | 1 test described in item 69494 and a test described in 69316.(Item is subject to rule 26) | $67.60 |
| 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): (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 | $63.50 |
| 69319 | 2 tests described in item 69494 and a test described in 69316. (Item is subject to rule 26) | $82.90 |
| 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 | $92.60 |
| 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 described in item 69300 | $82.40 |
| 69325 | A test described in item 69324 if rendered by a receiving APP (Item is subject to rule 18) | $81.00 |
| 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 | $161.40 |
| 69328 | A test described in item 69327 if rendered by a receiving APP (Item is subject to rule 18) | $160.20 |
| 69330 | Microscopy (with appropriate stains) and culture for mycobacteria—3 specimens of sputum, urine, or other body fluid or 3 operative or biopsy specimens, including (if performed): (a)microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b)pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300 | $244.70 |
| 69331 | A test described in item 69330 if rendered by a receiving APP (Item is subject to rule 18) | $241.40 |
| 69333 | Urine examination (including serial examinations) 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 | $38.90 |
| 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 described in item 69300—1 of this item in any 7 day period | $64.50 |
| 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 | $32.80 |
| 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 | $99.80 |
| 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 | $61.60 |
| 69357 | 2 sets of cultures described in item 69354 | $122.60 |
| 69360 | 3 sets of cultures described in item 69354 | $183.50 |
| 69363 | Detection of clostridium difficile or clostridium difficile toxin (except if a service described in item 69345 has been performed)—one or more tests | $54.00 |
| 69378 | Quantitation of HIV viral RNA load in plasma or serum in the monitoring of a HIV sero-positive patient not on antiretroviral therapy—1 or more tests | $339.70 |
| 69379 | A test described in item 69378 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18) | $339.70 |
| 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 | $1439.40 |
| 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 | $339.70 |
| 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 | $339.70 |
| 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) | $339.70 |
| 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) | $29.60 |
| 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) | $54.80 |
| 69390 | 3 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 estimations specified on the request form or performs 3 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) | $81.40 |
| 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) | $102.70 |
| 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) | $129.10 |
| 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) | $29.60 |
| 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) | $25.20 |
| 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 | $29.60 |
| 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 | $54.80 |
| 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 | $80.00 |
| 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 | $105.00 |
| 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 | $129.10 |
| 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) | $173.80 |
| 69451 | A test described in item 69445 if rendered by a receiving APP—1 test. (Item is subject to rule 18 and 25) | $173.80 |
| 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) | $67.30 |
| 69472 | Detection of antibodies to Epstein Barr Virus using specific serology—1 test | $29.60 |
| 69474 | Detection of antibodies to Epstein Barr Virus using specific serology—2 or more tests | $54.00 |
| 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) | $29.60 |
| 69478 | 2 tests described in 69475 (item subject to rule 11) | $55.10 |
| 69481 | Investigation of infectious causes of acute or chronic hepatitis—3 tests for hepatitis antibodies or antigens, (item subject to rule 11) | $76.40 |
| 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) | $286.80 |
| 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) | $286.80 |
| 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) | $32.90 |
| 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) | $339.70 |
| 69489 | A test described in item 69488 if rendered by a receiving APP (Item is subject to rule 18 and 25) | $339.70 |
| 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 | $386.20 |
| 69492 | A test described in item 69491 if rendered by a receiving APP—1 test(Item is subject to rule 18 and 25) | $386.20 |
| 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) | $54.00 |
| 69495 | 2 tests described in 69494 (Item is subject to rule 6 and 26) | $67.60 |
| 69496 | 3 or more tests described in 69494 (Item is subject to rule 6 and 26) | $83.10 |
| 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) | $54.00 |
| 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) | $13.70 |
| 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 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) | $173.80 |
| 69500 | A test described in item 69499 if rendered by a receiving APP—1 test (Item is subject to rule 18,19 and 25) | $173.80 |
| 69505 | Sequencing and analysis of the genome of mycobacterium tuberculosis complex from an isolate or nucleic acid extract: (a) to speciate the organism: (i) at the time of a patient s initial diagnosis and commencement of initial empiric therapy; or (ii) following recurrence of a patient s symptoms or a patient s failure to respond to treatment within the expected timeframe; and (b) for the purpose of: (i) genome wide determination of the antimicrobial resistance markers (resistome) of the isolate; and (ii) individualising the patient s treatment Applicable once at initial diagnosis and once per episode of disease recurrence | $247.10 |
| 69511 | Detection of a SARS-CoV-2 nucleic acid if the person receives a bulk billed service | $121.80 |
| 69512 | Detection of a viral, fungal, atypical pneumonia pathogen or Bordetella species nucleic acid from a nasal swab, throat swab, nasopharyngeal aspirate and/or lower respiratory tract sample, including a service described in 69511, if the person receives a bulk billed service 2 to 4 tests | $132.10 |
| 69513 | 5 to 8 tests described in 69512 | $142.70 |
| 69514 | 9 to 12 tests described in 69512 | $153.00 |
| 69515 | 13 or more tests described in item 69512 | $163.50 |
| **GROUP P4—IMMUNOLOGY** | | |
| 71057 | Electrophoresis, quantitative and qualitative, of serum, urine or other body fluid all collected within a 28 day period, to demonstrate: (a)protein classes; or (b)presence and amount of paraprotein; including the preliminary quantitation of total protein, albumin and globulin—1 specimen type | $63.10 |
| 71058 | Examination as described in item 71057 of 2 or more specimen types | $97.20 |
| 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) | $69.20 |
| 71060 | Examination as described in item 71059 of 2 or more specimen types | $84.50 |
| 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 | $84.50 |
| 71064 | Detection and quantitation of cryoglobulins or cryofibrinogen—1 or more tests | $39.30 |
| 71066 | Quantitation of total immunoglobulin A by any method in serum, urine or other body fluid—1 test | $27.50 |
| 71068 | Quantitation of total immunoglobulin G by any method in serum, urine or other body fluid—1 test | $27.50 |
| 71069 | 2 tests described in items 71066, 71068, 71072 or 71074 | $39.10 |
| 71071 | 3 or more tests described in items 71066, 71068, 71072 or 71074 | $53.40 |
| 71072 | Quantitation of total immunoglobulin M by any method in serum, urine or other body fluid—1 test | $27.50 |
| 71073 | Quantitation of all 4 immunoglobulin G subclasses | $182.30 |
| 71074 | Quantitation of total immunoglobulin D by any method in serum, urine or other body fluid—1 test | $27.50 |
| 71075 | Quantitation of immunoglobulin e (total), 1 test. (Item is subject to rule 25) | $39.50 |
| 71076 | A test described in item 71073 if rendered by a receiving APP—1 test (Item is subject to rule 18) | $200.10 |
| 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) | $51.00 |
| 71079 | Detection of specific immunoglobulin E antibodies to single or multiple potential allergens, 1 test (Item is subject to rule 25) | $50.60 |
| 71081 | Quantitation of total haemolytic complement | $78.30 |
| 71083 | Quantitation of complement components C3 and C4 or properdin factor B—1 test | $34.70 |
| 71085 | 2 tests described in item 71083 | $49.90 |
| 71087 | 3 or more tests described in item 71083 | $66.90 |
| 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) | $50.10 |
| 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) | $54.90 |
| 71091 | 2 tests described in item 71089 (Item is subject to rule 6) | $90.90 |
| 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) | $45.80 |
| 71093 | 3 or more tests described in item 71089 (Item is subject to rule 6) | $131.50 |
| 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 | $76.40 |
| 71096 | A test described in item 71095 if rendered by a receiving APP. (Item is subject to rule 18) | $76.40 |
| 71097 | Antinuclear antibodies—detection in serum or other body fluids, including quantitation if required | $42.00 |
| 71099 | Double-stranded DNA antibodies—quantitation by 1 or more methods other than the Crithidia method | $45.50 |
| 71101 | Antibodies to 1 or more extractable nuclear antigens—detection in serum or other body fluids | $30.00 |
| 71103 | Characterisation of an antibody detected in a service described in item 71101 (including that service) | $89.50 |
| 71106 | Rheumatoid factor—detection by any technique in serum or other body fluids, including quantitation if required | $21.40 |
| 71119 | Antibodies to tissue antigens not elsewhere specified in this Table—detection, including quantitation if required, of 1 antibody | $30.00 |
| 71121 | Detection of 2 antibodies specified in item 71119 | $35.70 |
| 71123 | Detection of 3 antibodies specified in item 71119 | $41.70 |
| 71125 | Detection of 4 or more antibodies specified in item 71119 | $47.60 |
| 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 | $303.20 |
| 71129 | 2 tests described in item 71127 | $374.40 |
| 71131 | 3 or more tests described in item 71127 | $445.80 |
| 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 | $20.00 |
| 71134 | Investigation of recurrent infection by quantitative assessment of oxidative pathways by flow cytometric techniques, including a test described in 71133 (if performed) | $196.20 |
| 71135 | Quantitation of neutrophil function, comprising at least 2 of the following: (a)chemotaxis; (b)phagocytosis; (c)oxidative metabolism; (d)bactericidal activity; including any test described in items 65066, 65070, 71133 or 71134 (if performed), 1 of this item to a maximum of 2 in a 12 month period | $357.30 |
| 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 | $67.00 |
| 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 | $178.90 |
| 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 | $339.30 |
| 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 | $446.80 |
| 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 | $765.70 |
| 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 | $196.20 |
| 71147 | HLA-B27 typing (Item is subject to rule 27) | $76.40 |
| 71148 | A test described in item 71147 if rendered by a receiving APP. (Item is subject to rule 18 and 27) | $76.40 |
| 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 | $186.00 |
| 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 | $204.30 |
| 71153 | Investigations in the assessment or diagnosis of systemic inflammatory disease or vasculitis—antineutrophil cytoplasmic antibody immunofluorescence (ANCA test), antineutrophil proteinase 3 antibody (PR-3 ANCA test), antimyeloperoxidase antibody (MPO ANCA test) or antiglomerular basement membrane antibody (GBM test)—detection of 1 antibody (Item is subject to rule 6 and 23) | $59.30 |
| 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) | $65.20 |
| 71155 | Detection of 2 antibodies described in item 71153 (Item is subject to rule 6 and 23) | $81.60 |
| 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) | $24.40 |
| 71157 | Detection of 3 antibodies described in item 71153 (Item is subject to rule 6 and 23) | $103.80 |
| 71159 | Detection of 4 or more antibodies described in item 71153 (Item is subject to rule 6 and 23) | $125.80 |
| 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;—1 test | $47.80 |
| 71164 | Two or more tests described in 71163 and including a service described in 71066 (if performed) | $75.40 |
| 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) | $65.20 |
| 71166 | Detection of 2 antibodies described in item 71165 (Item is subject to rule 6) | $89.50 |
| 71167 | Detection of 3 antibodies described in item 71165 (Item is subject to rule 6) | $113.90 |
| 71168 | Detection of 4 or more antibodies described in item 71165 (Item is subject to rule 6) | $137.90 |
| 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) | $65.20 |
| 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) | $24.40 |
| 71175 | A test, requested by a specialist or consultant physician, to diagnose neuromyelitis optica spectrum disorder (NMOSD) or myelin oligodendrocyte glycoprotein antibody related demyelination (MARD), by the detection of one or more antibodies, for a patient: suspected of having NMOSD or MARD; and with any of the following: recurrent, bilateral or severe optic neuritis; recurrent longitudinal extensive transverse myelitis (LETM); area postrema syndrome (unexplained hiccups, nausea or vomiting); acute brainstem syndrome; symptomatic narcolepsy or acute diencephalic clinical syndrome with typical NMOSD magnetic resonance imaging lesions; symptomatic cerebral syndrome with typical NMOSD magnetic resonance imaging lesions; monophasic neuromyelitis optica (no recurrence, and simultaneous or closely related optic neuritis and LETM within 30 days of each other); acute disseminated encephalomyelitis; aseptic meningitis and encephalomyelitis; poor recovery from multiple sclerosis relapses Applicable not more than 4 times in 12 months | $92.00 |
| 71180 | Antibody to cardiolipin or beta-2 glycoprotein I—detection, including quantitation if required; one antibody specificity (IgG or IgM) | $65.20 |
| 71183 | Detection of two antibodies described in item 71180 | $89.50 |
| 71186 | Detection of three or more antibodies described in item 71180 | $113.90 |
| 71189 | Detection of specific IgG antibodies to 1 or more respiratory disease allergens not elsewhere specified. | $29.90 |
| 71192 | 2 items described in item 71189. | $53.60 |
| 71195 | 3 or more items described in item 71189. | $75.60 |
| 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. | $76.40 |
| 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. | $86.70 |
| 71203 | Determination of HLAB5701 status by flow cytometry or cytotoxity assay prior to the initiation of Abacavir therapy including item 73323 if performed. | $76.40 |
| **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) | $138.30 |
| 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: (a) non small cell lung cancer; or (b) recurrent or metastatic squamous cell carcinoma of the oral cavity, pharynx or larynx; or (c) locally recurrent unresectable or metastatic triple-negative breast cancer. | $140.80 |
| 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) | $162.90 |
| 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) | $182.70 |
| 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) | $207.50 |
| 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) | $187.40 |
| 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) | $283.70 |
| 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) | $350.00 |
| 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) | $375.40 |
| 72827 | 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—12 to 17 separately identified specimens (Item is subject to Rule 13) | $402.80 |
| 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) | $430.10 |
| 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) | $534.10 |
| 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) | $793.30 |
| 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) | $886.90 |
| 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 | $59.20 |
| 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) | $112.90 |
| 72847 | Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen—4-6 antibodies (Item is subject to rule 13) | $172.00 |
| 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) | $140.90 |
| 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) | $196.40 |
| 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) | $223.70 |
| 72851 | Electron microscopic examination of biopsy material—1 separately identified specimen (Item is subject to rule 13) | $384.80 |
| 72852 | Electron microscopic examination of biopsy material—2 or more separately identified specimens (Item is subject to rule 13) | $528.80 |
| 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) | $371.80 |
| 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) | $467.50 |
| 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) | $553.20 |
| 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. | $360.50 |
| 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. | $741.20 |
| 72860 | Retrieval and review of one or more archived formalin fixed paraffin embedded blocks to determine the appropriate samples for the purpose of conducting genetic testing, other than: (a) a service associated with a service to which item 72858 or 72859 applies; or (b) a service associated with, and rendered in the same patient episode as, a service to which an item in Group P5, P6, P10 or P11 applies Applicable not more than once in a patient episode | $160.60 |
| **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 changes1 or more tests | $43.20 |
| 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 | $94.50 |
| 73047 | Cytology of a series of 3 sputum or urine specimens for malignant cells | $176.30 |
| 73049 | Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues—1 identified site | $133.00 |
| 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 | $328.00 |
| 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) | $83.00 |
| 73060 | Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen—4 to 6antibodies (Item is subject to rule 13) | $108.60 |
| 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) | $98.40 |
| 73062 | Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues—2 or more separately identified sites. | $167.90 |
| 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 | $187.40 |
| 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 (Item is subject to rule 13) | $135.30 |
| 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) | $162.20 |
| 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 | $413.90 |
| 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 | $241.30 |
| 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 | $67.70 |
| 73071 | A test, including partial genotyping, for oncogenic human papillomavirus that may be associated with cervical pre cancer or cancer, if performed: (a) on a self collected vaginal specimen; and (b) for an asymptomatic patient who is at least 24 years and 9 months of age For any particular patient, applicable once in 57 months | $67.70 |
| 73072 | A test, including partial genotyping, for oncogenic human papillomavirus: (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; or (g) for a patient previously treated for a genital tract malignancy when performed as a co-test for both human papillomavirus (HPV) and liquid-based cytology (LBC). | $67.70 |
| 73074 | A test, including partial genotyping, for oncogenic human papillomavirus, for the investigation of a patient following a total hysterectomy. | $67.70 |
| 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, 73074 or this item applies; and (b) the specimen collected for the previous test is unsatisfactory | $67.70 |
| 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: (i) a test to which item 73070, 73071, 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 | $88.80 |
| **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 | $761.30 |
| 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 | $676.90 |
| 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. | $744.00 |
| 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. | $435.50 |
| 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. | $1112.20 |
| 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. | $435.50 |
| 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. | $435.50 |
| 73295 | Detection of germline BRCA1 or BRCA2 pathogenic or likely pathogenic gene variants, in a patient with advanced (FIGO III-IV) high-grade serous or high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer for whom testing of tumour tissue is not feasible, requested by a specialist or consultant physician, to determine eligibility for treatment witha poly (adenosine diphosphate [ADP]-ribose) polymerase (PARP) inhibitor under the Pharmaceutical Benefits Scheme (PBS) Maximum of one test per patient s lifetime | $2353.70 |
| 73296 | Characterisation of germline gene variants, including copy number variation where appropriate, requested by a specialist or consultant physician: (a) in genes associated with breast, ovarian, fallopian tube or primary peritoneal cancer, which must include at least: (i) BRCA1 and BRCA 2 genes; and (ii) one or more STK11, PTEN, CDH1, PALB2 and TP53 genes; and (b) in a patient: (i) with breast, ovarian, fallopian tube or primary peritoneal cancer; and (ii) for whom clinical and family history criteria place the patient at greater than 10% risk of having a pathogenic or likely pathogenic gene associated with breast, ovarian, fallopian tube or primary peritoneal cancer Once per cancer diagnosis | $2316.80 |
| 73297 | Characterisation of germline gene variants, including copy number variation where appropriate, requested by a specialist or consultant physician: (a) in genes associated with breast, ovarian, fallopian tube or primary peritoneal cancer, which may include the following genes: (i) BRCA1 or BRCA2; (ii) STK11, PTEN, CDH1, PALB2 and TP53; and (b) in a patient: (i) who has a biological relative who has had a pathogenic or likely pathogenic gene variant identified in one or more of the genes mentioned in paragraph(a); or (ii) who has not previously received a service to which item 73295, 73296 or 73302 applies Once per variant | $772.20 |
| 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. | $2265.70 |
| 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 insubparagraphs(a)(i), (ii) and (iii); and (ii) has not previously received a service which item 73298 applies; requested by a specialist or consultant physician. | $755.30 |
| 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 | $190.80 |
| 73305 | Detection of mutation of the FMR1 gene by Southern Blot analysis where the results in item 73300 are inconclusive | $382.20 |
| 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 | $68.90 |
| 73309 | A test described in item 73308, if rendered by a receiving APP—1 or more tests (Item is subject to rule 18) | $68.90 |
| 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 | $68.90 |
| 73312 | A test described in item 73311, if rendered by a receiving APP—1 or more tests (Item is subject to rule 18) | $68.90 |
| 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; | $435.60 |
| 73315 | A test described in item 73314, if rendered by a receiving APP—1 or more tests (Item is subject to rule 18) | $435.60 |
| 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) | $68.90 |
| 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) | $68.90 |
| 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) | $76.40 |
| 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) | $76.40 |
| 73323 | Determination of HLAB5701 status by molecular techniques prior to the initiation of Abacavir therapy including item 71203 if performed. | $76.40 |
| 73324 | A test described in item 73323 if rendered by a receiving APP 1 or more tests (Item is subject to Rule 18) | $77.30 |
| 73325 | Determination of JAK2 V617F variant allele frequency in the diagnostic work up by, or on behalf of, a specialist or consultant physician, for a patient with clinical and laboratory evidence of a myeloproliferative neoplasm | $164.20 |
| 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 | $431.70 |
| 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 | $97.10 |
| 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. | $589.20 |
| 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 (ii) 2 or more haemangioblastomas; or (iii) 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 (b) in a patient presenting with one or more of the following clinical features suggestive of VHL syndrome: (i) haemangiblastomas of the brain, spinal cord, or retina; (ii) phaeochromocytoma; (iii) functional extra adrenal paraganglioma | $1208.00 |
| 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 | $684.70 |
| 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 | $946.30 |
| 73336 | A test of tumour tissue from a patient withstage 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,vemurafenib or encorafenibunder the Pharmaceutical Benefits Scheme are fulfilled. | $444.10 |
| 73337 | A test of tumour tissue from a patient with a new diagnosis of 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, if the test is: (a) to determine if requirements relating to epidermal growth factor receptor (EGFR) gene status for access to an immunotherapy listed under the Pharmaceutical Benefits Scheme (PBS) are fulfilled; and (b) not associated with a service to which item 73437 or 73438 applies | $764.20 |
| 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: (a) requirements relating to rat sarcoma oncogene (RAS) gene variant status for access to cetuximab or panitumumab under the Pharmaceutical Benefits Scheme are fulfilled, if: the test is conducted for all clinically relevant mutations on KRAS exons 2, 3 and 4 and NRAS exons 2, 3, and 4; or a clinically-relevant RAS variant is detected; and, in cases where no RAS variant is detected (b) the requirements relating to BRAF V600 gene variant status for access to encorafenib under the Pharmaceutical Benefits Scheme are fulfilled. | $487.70 |
| 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) | $746.20 |
| 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. One test.(Item is subject to rule 25) | $373.10 |
| 73341 | Fluorescence in situ hybridisation (FISH) test of tumour tissue from a patient with a new diagnosis of 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 &gt; 0, and with documented absence of activating mutations of the epidermal growth factor receptor (EGFR) gene, requested by a specialist or consultant physician, if the test is: (a) to determine if requirements relating to ALK gene rearrangement status for access to an immunotherapy listed under the Pharmaceutical Benefits Scheme (PBS) are fulfilled; and (b) not associated with a service to which item 73437 or 73439 applies | $801.10 |
| 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. | $631.50 |
| 73343 | Detection of 17p chromosomal deletions by fluorescence in situ hybridisation or genome wide micro array, in a patient with chronic lymphocytic leukaemia or small lymphocytic lymphoma, on a peripheral blood, bone marrow or lymph node sample, requested by a specialist or consultant physician For any particular patient: (a) at initial diagnosis; or (b) at disease relapse; or (c) on disease progression; but only where initiation of, or change in, therapy is anticipated | $445.80 |
| 73344 | Fluorescence in situ hybridization (FISH) test of tumour tissue from a patient with a new diagnosis of locally advanced or metastatic non-small cell lung cancer, 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, if the test is: (a) to determine if requirements relating to ROS1 gene arrangement status for access to an immunotherapy listed under the Pharmaceutical Benefits Scheme (PBS) are fulfilled: and (b) not associated with a service to which item 73437 or 73439 applies | $755.30 |
| 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. | $965.40 |
| 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. | $965.40 |
| 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. | $965.40 |
| 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, 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). | $482.60 |
| 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. | $965.40 |
| 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 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. | $482.60 |
| 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. | $750.30 |
| 73422 | Characterisation of a gene variant or gene variants using a gene panel, in a patient presenting with clinical signs and symptoms suggestive of a genetic neuromuscular disorder (other than signs and symptoms associated with variants that are not detected by massively parallel sequencing), if the service is requested: (a) by a specialist or consultant physician; and (b) after exclusion of non genetic causes Applicable once per lifetime | $2121.70 |
| 73423 | Detection of a single identified gene variant, in a biological relative of a person with a germline gene variant for a neuromuscular disorder identified by a service described in item 73422, 73425 or 73426, if the service is requested by a specialist or consultant physician Applicable once per variant | $884.10 |
| 73424 | Prenatal detection of an actionable pathogenic familial gene variant or gene variants (including maternal cell contamination assessment), requested by a specialist or consultant physician, for a genetic neuromuscular disorder previously identified in an index person in the patient s family as a result of a service described in item 73422 Applicable once per pregnancy | $2829.00 |
| 73425 | Prenatal detection of unknown gene variants (including maternal cell contamination assessment) using a gene panel, if: (a) the service is requested: (i) by a specialist or consultant physician, for a suspected genetic neuromuscular disorder; and (ii) after exclusion of non genetic causes; and (b) the service is performed using a sample from the fetus; and (c) the service is not performed in conjunction with a service to which item 73426 applies Applicable once per pregnancy | $3182.70 |
| 73426 | Prenatal detection of unknown gene variants (including maternal cell contamination assessment) using a gene panel, if: (a) the service is requested: (i) by a specialist or consultant physician; and (ii) for a suspected genetic neuromuscular disorder; and (iii) after exclusion of non genetic causes; and (b) the request states that singleton testing is inappropriate; and (c) the service is performed using a sample from the fetus and a sample from each of the fetus s biological parents; and (d) the service is not performed in conjunction with a service to which item 73425 applies Applicable once per pregnancy | $4243.60 |
| 73427 | Single gene testing for the characterisation of a germline gene variant or germline gene variants: (a) if requested by a specialist or consultant physician; and (b) within the same gene in which the patient s reproductive partner has a documented pathogenic germline recessive gene variant for a neuromuscular disorder identified by a service described in: (i) item 73422, 73425 or 73426; or (ii) item 73434, if the patient has been provided a service described in item 73434 and that service has not identified a relevant variant Applicable once per gene | $2121.70 |
| 73429 | Genetic testing (including characterisation of single nucleotide variants, structural variants, fusions and copy number alterations) in a single gene panel, requested by a specialist or consultant physician, for a patient with clinical or laboratory evidence of a glioma, glioneuronal tumour or glioblastoma, to aid diagnosis and classification of the relevant tumour, including assessments of at least the following kinds: (a) IDH1, IDH2 variant testing; (b) 1p/19q co deletion assessment; (c) H3F3A variant status; (d) TERT promoter variant status; (e) EGFR amplification; (f) CDKN2A/B deletion; (g) BRAF variants Applicable to one test per diagnostic episode | $1462.80 |
| 73434 | Detection of pathogenic or likely pathogenic gene variants, requested by a specialist or consultant physician, for any of the following: (a) a patient with a suspected neuromuscular disorder; (b) a relative of a patient with a pathogenic or likely pathogenic germline gene variant associated with a neuromuscular disorder (confirmed by laboratory findings); (c) the reproductive partner of a patient with a recessive pathogenic or likely pathogenic germline gene variant associated with a neuromuscular disorder (confirmed by laboratory findings) Applicable once per gene per lifetime | $645.80 |
| 73435 | Detection of pathogenic or likely pathogenic DUX4 gene variants, requested by a specialist or consultant physician, for: (a) a patient with a suspected neuromuscular disorder; or (b) a relative of a patient with a pathogenic or likely pathogenic germline gene variant associated with a neuromuscular disorder (confirmed by laboratory findings) Applicable once per gene per lifetime | $1647.40 |
| 73436 | A test of tumour tissue from a patient with a new diagnosis of locally advanced or metastatic non-small cell lung cancer requested by, or on behalf of, a specialist or consultant physician, if the test is: (a) to determine if the requirements relating to MET proto-oncogene, receptor tyrosine kinase (MET) exon 14 skipping alterations (METex14sk) status for access to an immunotherapy listed under the Pharmaceutical Benefits Scheme (PBS) are fulfilled: and (b) not associated with a service to which item 73437 or 73438 applies | $702.60 |
| **GROUP P8—INFERTILITY AND PREGNANCY TESTS** | | |
| 73521 | Semen examination for presence of spermatozoa or examination of cervical mucus for spermatozoa (Huhner’s test) | $18.70 |
| 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) | $87.00 |
| 73525 | Sperm antibodies—sperm-penetrating ability—1 or more tests | $54.70 |
| 73527 | Human chorionic gonadotrophin (hcg)—detection in serum or urine by 1 or more methods for diagnosis of pregnancy—1 or more tests | $18.90 |
| 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 | $54.00 |
| **GROUP P9—SIMPLE BASIC PATHOLOGY TESTS** | | |
| 73801 | Semen examination for presence of spermatozoa | $13.30 |
| 73802 | Leucocyte count, erythrocyte sedimentation rate, examination of blood film (including differential leucocyte count), haemoglobin, haematocrit or erythrocyte count—1 test | $8.80 |
| 73803 | 2 tests described in item 73802 | $12.00 |
| 73804 | 3 or more tests described in item 73802 | $15.70 |
| 73805 | Microscopy of urine, excluding dipstick testing. | $8.80 |
| 73806 | Pregnancy test by 1 or more immunochemical methods | $19.60 |
| 73807 | Microscopy for wet film other than urine, including any relevant stain | $13.30 |
| 73808 | Microscopy of Gram-stained film, including (if performed) a service described in item 73805 or 73807 | $19.00 |
| 73809 | Chemical tests for occult blood in faeces by reagent stick, strip, tablet or similar method | $4.50 |
| 73810 | Microscopy for fungi in skin, hair or nails—1 or more sites | $15.20 |
| 73811 | Mantoux test | $21.70 |
| 73812 | Quantitation of glycated haemoglobin (HbA1c) performed in the management of established diabetes, if performed: (a) as a point of care test; and (b) by or on behalf of a medical practitioner who works in a general practice that is accredited to the Royal Australian College of General Practitioners Standards for point of-care testing under the National General Practice Accreditation Scheme; and (c) using a method certified by the National Glycohemoglobin Standardization Program (NGSP), if the instrumentation used has a total coefficient variation less than 3.0% at 48 mmol/mol (6.5%) Applicable not more than 3 times per 12 months per patient | $21.60 |
| **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 | $11.80 |
| 73900 | Initiation of a patient episode that consists of a service described in item 72858 or 72859 if the service is rendered in a prescribed laboratory. | $4.50 |
| 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 | $4.60 |
| 73922 | Initiation of a patient episode that consists of a service described in item 73070, 73071, 73072, 73074, 73075 or 73076(in circumstances other than those described in item 73923) | $15.70 |
| 73923 | Initiation of a patient episode that consists of a service described in items 73070, 73071, 73072, 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 | $4.60 |
| 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. | $28.10 |
| 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. | $4.70 |
| 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. | $15.70 |
| 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. | $4.60 |
| 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 | $11.40 |
| 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 | $4.60 |
| 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 | $15.20 |
| 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 | $4.70 |
| 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 | $19.80 |
| 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 | $4.60 |
| 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 | $33.30 |
| 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 | $4.60 |
| 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. | $11.50 |
| 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: ()the service is performed in a prescribed laboratory or ()the person is a private patient in a recognised hospital | $4.60 |
| 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 | $15.40 |
| 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 | $4.60 |
| **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 another approved pathology authority | $19.80 |
| **GROUP A35—SERVICES FOR PATIENTS IN RESIDENTIAL AGED CARE FACILITIES** | | |
| 90001 | For the first patient attended during one attendance by a general practitioner at one residential aged care facility on one occasion, the fee for the medical service described in whichever of items 90020, 90035, 90043, 90051 or 90054 applies is the amount listed in the item plus $60.55. | $103.90 |
| 90002 | For the first patient attended during one attendance by a medical practitioner at one residential aged care facility on one occasion, the fee for the medical service described in whichever of items 90092, 90093, 90095, 90096, 90098, 90183, 90188, 90202, 90212 or 90215 applies is the amount listed in the item plus $43.95. | $75.50 |
| 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. | $32.50 |
| 90035 | Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item applies, lasting at least 6 minutes and 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 (subject to clause 2.30.1) | $71.10 |
| 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 | $137.40 |
| 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 | $202.30 |
| 90054 | Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item applies, lasting at least 60 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 (subject to clause 2.30.1) | $286.80 |
| 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. | $16.00 |
| 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. | $30.20 |
| 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. | $67.10 |
| 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, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 45 minutes, but less than 60 minutes an attendance on one or more patients at one residential aged care facility on one occasion each patient (subject to clause 2.30.1), by a medical practitioner who is not a general practitioner | $108.60 |
| 90183 | 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 within such a complex, if the patient is a care recipient in the facility who is not a resident of a self contained unit, lasting not more than 5 minutes an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area each patient (subject to subclause 2.30.1(2)) | $25.90 |
| 90188 | 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 within such a complex, if the patient is a care recipient in the facility who is not a resident of a self contained unit, lasting more than 5 minutes but not more than 25 minutes an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area each patient (subject to subclause 2.30.1(2)) | $56.90 |
| 90202 | 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 within such a complex, if the patient is a care recipient in the facility who is not a resident of a self contained unit, lasting more than 25 minutes but not more than 45 minutes an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area each patient (subject to subclause 2.30.1(2)) | $110.00 |
| 90212 | 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 a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 45 minutes but not more than 60 minutes an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area each patient (subject to subclause 2.30.1(2)) | $161.90 |
| 90215 | 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 a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 60 minutes an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area each patient (subject to subclause 2.30.1(2)) | $229.40 |
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Schedule 1b

*Scale of Charges─Other Medical Services*

This Schedule must be read in conjunction with the Medical 1B—Other Medical Services Fee Schedule and Policy.

The following guidelines apply to all medical reports described in this schedule:

• printed on A4 size paper

• addressed specifically to the report requestor

• all margins to be no more than 2.5cms

• line spacing of no more than 1.5 lines

• font size no more than 12 pt

• signed by the provider of the report.

| **Item No.** | **Description** | **Max Fee (excl. GST)** |
| --- | --- | --- |
|  |  |  |
| **RECOVERY AND RETURN TO WORK PLANS** | | |
| RRTWG | General practitioners: reviewing and signing of a Recovery and return to work plan, expected to be provided within 10 business days of receipt of the initial request. | $74.50  flat fee |
| RRTWR | Consultant physicians, specialists in a surgical discipline: reviewing and signing of a recovery and return to work plan, expected to be provided within 10 business days of receipt of the initial request. | $146.20  flat fee |
|  | Note 1: A Recovery and return to work plan must be requested by:—a claims manager or self-insured employer—a worker’s employer (including the employer’s return to work coordinator)—an approved return to work service provider.  Note 2: The date of request is taken to be two business days after the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.  Note 3: Payment will only be made following submission of the signed plan. | |
| **SHORT MEDICAL REPORT—TREATING DOCTOR** | | |
| WMG37 | General practitioners: Short medical report, expected to be provided within 72 hours of receipt of the initial request or examination (where applicable), whichever is the later. | $114.60  flat fee |
| WMP37 | Consultant physicians: Short medical report, expected to be provided within 72 hours of receipt of the initial request or examination (where applicable), whichever is the later. | $146.20  flat fee |
| WMS37 | Specialists in a surgical discipline: Short medical report expected to be provided within 72 hours of receipt of the initial request or examination (where applicable), whichever is the later. | $146.20  flat fee |
|  | Note 1: A short medical report must be requested in writing and may be requested by a:—claims manager or self-insured employer—worker, worker’s representative or advocate.  Note 2: The date of request is taken to be two business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.  Note 3: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified.  Note 4: A short report should be based on the medical practitioner’s notes and would not usually require a consultation with the patient. Where a consultation is appropriate (for example, if the practitioner has not seen the patient for some time), a consultation fee is to be billed in accordance with item numbers WMG70; WMP70; WMS70; WMY73. Consultation items in Schedule 1A must not be used for this purpose.  Note 5: A short report should be concise and focused. The expected length of a short report is approximately half an A4 page.  Note 6: A short report may be faxed to the requestor with the relevant account for services.  Note 7: Payment will only be made following submission of the report. | |
| **STANDARD MEDICAL REPORT—TREATING DOCTOR (EXCLUDING PSYCHIATRISTS)** | | |
| WMG16 | General practitioners: Treating doctor standard medical report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the later. | $298.10  flat fee |
| WMP16 | Consultant physicians: Treating doctor standard medical report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the later. | $558.60  flat fee |
| WMS16 | Specialists in a surgical discipline: Treating doctor standard medical report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the later. | $558.60  flat fee |
|  | Note 1: A standard medical report must be requested in writing and may be requested by a:—claims manager or self-insured employer—worker, worker’s representative or advocate.  Note 2: The date of request is taken to be two business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.  Note 3: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified.  Note 4: A standard medical report should be based on the medical practitioner’s notes and would not usually require a consultation with the patient. Where a consultation is appropriate (for example, if the practitioner has not seen the patient for some time), a consultation fee is to be billed in accordance with item numbers WMG70; WMP70 or WMS70. Consultation items in Schedule 1A must not be used for this purpose.  Note 5: Payment will only be made following submission of the report. | |
| **COMPLEX MEDICAL REPORT—TREATING DOCTOR (EXCLUDING PSYCHIATRISTS)** | | |
| WMG40 | General practitioners: Treating doctor complex medical report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the later. | $372.60  flat fee |
| WMP40 | Consultant physicians: Treating doctor complex medical report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the later. | $700.40  flat fee |
| WMS40 | Specialists in a surgical discipline: Treating doctor complex medical report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the later. | $700.40  flat fee |
|  | Note 1: A complex medical report must be requested in writing and may be requested by a:—claims manager or self-insured employer—worker, worker’s representative or advocate.  Note 2: The date of request is taken to be two business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.  Note 3: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified.  Note 4: A complex medical report should be based on the medical practitioner’s notes and would not usually require a consultation with the patient. Where a consultation is appropriate (for example, if the practitioner has not seen the patient for some time), a consultation fee is to be billed in accordance with item numbers WMG70; WMP70 or WMS70. Consultation items in Schedule 1A must not be used for this purpose.  Note 5: A complex medical report requires additional information above that required in a standard report, and may be deemed complex compared to a standard report when the worker has:—three or more ongoing compensable injuries arising from the same claim—pre-existing conditions that have a significant impact on the compensable disability—co-morbidities that have a significant impact on the compensable disability.  Note 6: Payment will only be made following submission of the report. | |
| **STANDARD MEDICAL REPORT—TREATING PSYCHIATRIST** | | |
| WMY43 | Psychiatrists: Treating doctor standard medical report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the later. | $700.40  flat fee |
|  | Note 1: A standard medical report must be requested in writing and may be requested by a:—claims manager or self-insured employer,—worker, worker’s representative or advocate.  Note 2: The date of request is taken to be two business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.  Note 3: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified.  Note 4: A standard medical report should be based on the medical practitioner’s notes and would not usually require a consultation with the patient. Where a consultation is appropriate (for example, if the practitioner has not seen the patient for some time), a consultation fee is to be billed in accordance with item number WMY73. Consultation items in Schedule 1A must not be used for this purpose.  Note 5: Payment will only be made following submission of the report. | |
| **COMPLEX MEDICAL REPORT—TREATING PSYCHIATRIST** | | |
| WMY46 | Psychiatrists: Treating doctor complex medical report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the later. | $871.70  flat fee |
|  | Note 1: A complex medical report must be requested in writing and may be requested by a:—claims manager or self-insured employer,—worker, worker’s representative or advocate.  Note 2: The date of request is taken to be two business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.  Note 3: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified.  Note 4: A complex medical report should be based on the medical practitioner’s notes and would not usually require a consultation with the patient. Where a consultation is appropriate (for example, if the practitioner has not seen the patient for some time), a consultation fee is to be billed in accordance with item number WMY73. Consultation items in Schedule 1A must not be used for this purpose.  Note 5: Payment will only be made following submission of the report. | |
| **CONSULTATION, MEDICAL REVIEW FOR PREPARATION OF A REPORT—TREATING DOCTOR** | | |
| WMG70 | General Practitioner: Consultation: medical review for the preparation of a treating doctor report. | $68.20  flat fee |
| WMP70 | Consultant Physicians: Consultation: medical review for the preparation of a treating doctor report. | $136.60  flat fee |
| WMS70 | Specialist in a surgical discipline: Consultation: medical review for the preparation of a treating doctor report. | $136.60  flat fee |
| WMY73 | Psychiatrists: Consultation: medical review for the preparation of a treating doctor report. | $379.30  flat fee |
| **READING TIME TO PREPARE A REPORT—TREATING DOCTOR** | | |
| WMG55 | DERIVED FEE, General practitioners: Reading time payable to a treating doctor for reading prior reports or other information forwarded or approved by the requestor in order to prepare a report. Derived fee: The fee for item WMG55 is $68.20 for reading time up to and including 12 pages, plus $5.90 per page thereafter. | DF |
| WMP55 | DERIVED FEE, Consultant physicians: Reading time payable to a treating doctor for reading prior reports or other information forwarded or approved by the requestor in order to prepare a report. Derived fee: The fee for item WMP55 is $136.60 for reading time up to and including 12 pages, plus $10.80 per page thereafter. | DF |
| WMS55 | DERIVED FEE, Specialists in a surgical discipline: Reading time payable to a treating doctor for reading prior reports or other information forwarded or approved by the requestor in order to prepare a report. Derived fee: The fee for item WMS55 is $136.60 for reading time up to and including 12 pages, plus $10.80 per page thereafter. | DF |
| WMY55 | DERIVED FEE, Psychiatrists: Reading time payable to a treating doctor for reading prior reports or other information forwarded or approved by the requestor in order to prepare a report. Derived fee: The fee for item WMY55 is $177.50 for reading time up to and including 12 pages, plus $10.80 per page thereafter. | DF |
|  | Note 1: Payment for reading of written material will only be made where the reading is required in order for the doctor to prepare a report, and where the reading is at the request or approval of a:—claims manager or self-insured employer—worker, worker’s representative or advocate.  Note 2: A fee is not payable for the reading of case notes, clinical material or any other material that is not directly supplied or approved by the parties listed in note 1.  Note 3: A full page for reading time consists of a whole A4 size page of standard print (12 point font or smaller) of information, full page letters and detailed reports. Examples include: hospital treatment notes, medical reports, investigation reports. A half page of reading time consists of half an A4 page or a full A5 size page of standard print (12 point font or smaller) of information, brief file notes, scattered file notes on a page, letters consisting of one or two paragraphs, results and certificates. Examples include: pathology results, notice of disability, full page of handwritten notes.  Note 4: The reading of material supplied by the requestor can only be charged once. No additional charge can be submitted for re-reading of material. | |
| **MEDICAL REPORT CLARIFICATION—TREATING DOCTOR** | | |
| WMG25 | General practitioners: Clarification of a medical report, re-examination not required. | $67.00  flat fee |
| WMP25 | Consultant physicians: Clarification of a medical report, re-examination not required. | $122.00  flat fee |
| WMS25 | Specialists in a surgical discipline: Clarification of a medical report, re-examination not required. | $122.00  flat fee |
|  | Note 1: Clarification of a medical report must be requested in writing and may be requested by a:—claims manager or self-insured employer—worker, worker’s representative or advocate.  Note 2: The requestor must specify that he or she is seeking a clarification of a previous medical report.  Note 3: A medical report clarification fee is not payable if the clarification is sought as a result of failure by the doctor to address the original questions in the letter of request.  Note 4: Payment will only be made following submission of the report. | |
| **TELEPHONE CALL (EXCLUDING CALLS MADE TO OR RECEIVED FROM INJURED WORKERS)** | | |
| WMG24 | General practitioners: Telephone call up to and including 60 minutes duration. | $298.10  per hour |
| WMP24 | Consultant physicians: Telephone call up to and including 60 minutes duration. | $584.20  per hour |
| WMS24 | Specialists in a surgical discipline: Telephone call up to and including 60 minutes duration. | $584.20  per hour |
|  | Note 1: Telephone calls are chargeable if related to the management of the worker’s claim, or to progress their recovery and return to work, made to or received from:—a claims manager or self-insured employer—a worker’s employer (including the employer’s return to work co-ordinator)—a worker’s representative or advocate—a ReturnToWorkSA medical advisor—an approved return to work service provider—a worker’s referring/treating practitioner.  Note 2: There is no charge for a telephone call to or from a worker.  Note 3: A fee is payable if the telephone contact occurs during a consultation with the worker provided that the consultation duration excludes the duration of the telephone call. For example, if the consultation and telephone call duration is 20 minutes and the call duration alone is 10 minutes, the consultation should be charged as a 10 minute consultation.  Note 4: Invoices for telephone calls in accordance with this item must record the name of the other party and the duration of the phone call in minutes.  Note 5: Any part of an hour should be billed proportionately and rounded to the nearest six minutes. | |
| **CASE CONFERENCE** | | |
| WMG09 | General practitioners: Case conference to determine details of limitations to work, recommendations facilitating a return to work and options for management of the injured worker’s recovery, including medical treatment strategies. | $298.10  per hour |
| WMP09 | Consultant physicians: Case conference to determine details of limitations to work, recommendations facilitating a return to work and options for management of the injured worker’s recovery, including medical treatment strategies. | $584.20  per hour |
| WMS09 | Specialists in a surgical discipline: Case conference to determine details of limitations to work, recommendations facilitating a return to work and options for management of the injured worker’s recovery, including medical treatment strategies. | $584.20  per hour |
|  | Note 1: A case conference may be requested by:—a claims manager or self-insured employer—a worker’s employer (including the employer’s rehabilitation and return to work co-ordinator)—a worker or worker’s representative—an approved return to work service provider—a treating medical expert.  Note 2: The claims manager or self-insured employer should attend the case conference if at all possible. If the claims manager or self-insured employer is unable to attend, they should delegate a representative. No fee is payable for records made by any medical practitioner during the case conference unless delegated as the representative by the claims manager or self-insured employer. It is the responsibility of the claims manager, self-insured employer or delegated representative to make a written and signed record of the case conference that is to be distributed to all attendees. Differences of opinion should be noted in the record. The worker or worker’s representative must always be invited to attend the case conference.  Note 3: Case conferences conducted by telephone (teleconferencing) are chargeable under this item.  Note 4: Any part of an hour should be billed proportionately and rounded to the nearest six minutes. | |
| **WORKSITE ASSESSMENT** | | |
| WMG08 | General practitioners: Worksite assessment, for the purpose of assessing and reporting the duties that are or can be made available, and the capacity of the worker to undertake these duties. | $298.10  per hour |
| WMP08 | Consultant physicians: Worksite assessment, for the purpose of assessing and reporting the duties that are or can be made available, and the capacity of the worker to undertake these duties. | $584.20  per hour |
| WMS08 | Specialist in a surgical discipline: Worksite assessment, for the purpose of assessing and reporting the duties that are or can be made available, and the capacity of the worker to undertake these duties. | $584.20  per hour |
|  | Note 1: A worksite assessment may be requested by a:—claims manager or self-insured employer—worker, worker’s representative or advocate.  Note 2: At worksite visits it is expected that the employer, worker or worker’s representative, claims manager or self-insured employer representative should be present.  Note 3: The claims manager or self-insured employer should contact the employer to ensure appropriate access to the worksite and to arrange for an employer representative to be available to help maximise the value of time spent in the workplace.  Note 4: The worksite assessment must include an assessment of the physical environment, mental work demands, human behaviour, working conditions, educational requirements and other conditions.  Note 5: The report of a worksite assessment is to be completed and distributed by the medical practitioner undertaking the assessment to relevant parties in attendance during the worksite assessment. A copy must also be provided to the claims manager, treating doctor and worker (if not present) within one week of the assessment. No additional fee is payable for completion of the form.  Note 6: Any part of an hour should be billed proportionately and rounded to the nearest six minutes. | |
| **THIRD PARTY CONSULTATION** | | |
| WMG14 | General practitioners: Third party consultation at the doctor’s rooms where the worker is usually not present. | $298.10  per hour |
| WMP14 | Consultant physicians: Third party consultation at the doctor’s rooms where the worker is usually not present. | $584.20  per hour |
| WMS14 | Specialists in a surgical discipline: Third party consultation at the doctor’s rooms where the worker is usually not present. | $584.20  per hour |
|  | Note 1: A third party consultation must involve at least one of the following:—claims manager or self-insured employer—worker, worker’s representative or advocate—worker’s employer (including the employer’s rehabilitation and return to work co-ordinator)—investigator—approved return to work service provider.  Note 2: A third party consultation may include a video viewing of a worker’s normal duties, alternative duties or other activities.  Note 3: It is the responsibility of the claims manager or self-insured employer to ensure a written and signed record is made of the third party consultation that is to be distributed to all attendees. No fee is payable for records made by any medical practitioner during the third party consultation.  Note 4: If as a result of the third party consultation the medical practitioner has amended details regarding the worker’s limitations to work, capacity, recommendations for facilitating a return to work and/or options for management of the worker, the medical practitioner must consider the worker’s input into this decision.  Note 5: Any part of an hour should be billed proportionately and rounded to the nearest six minutes. | |
| **ATTENDANCE AT A DISPUTE RESOLUTION** | | |
| WMG15 | General practitioners: Attendance at a dispute resolution. | $298.10  per hour |
| WMP15 | Consultant physicians: Attendance at a dispute resolution. | $584.20  per hour |
| WMS15 | Specialists in a surgical discipline: Attendance at a dispute resolution. | $584.20  per hour |
|  | Note 1: Attendance at a dispute resolution must be at the request of a:—claims manager or self-insured employer—worker, worker’s representative or advocate—worker’s employer or employer’s representative.  Note 2: Court attendances can be charged under this item.  Note 3: A witness at a dispute resolution proceeding is entitled to reimbursement of any expense that the dispute resolution authority certifies has been, or is likely to be, reasonably incurred by the witness as a consequence of appearing before the authority.  Note 4: Any part of an hour should be billed proportionately and rounded to the nearest six minutes. | |
| **TRAVEL TIME: WORKSITE ASSESSMENT, CASE CONFERENCE, DISPUTE RESOLUTION OR THIRD PARTY CONSULTATION** | | |
| WMG10 | General practitioners: Travel time for the purpose of a worksite assessment, case conference, dispute resolution or third party consultation. | $298.10  per hour |
| WMP10 | Consultant physicians: Travel time for the purpose of a worksite assessment, case conference, dispute resolution or third party consultation. | $584.20  per hour |
| WMS10 | Specialists in a surgical discipline: Travel time for the purpose of a worksite assessment, case conference, dispute resolution or third party consultation. | $584.20  per hour |
|  | Note 1: All accounts must include the total time spent travelling plus the distance travelled.  Note 2: Where more than one worksite assessment, case conference or dispute resolution is conducted, the travel fee is to be apportioned accordingly.  Note 3: Any part of an hour should be billed proportionately and rounded to the nearest six minutes. | |
| **CANCELLATION: CASE CONFERENCE, WORKSITE ASSESSMENT, DISPUTE RESOLUTION OR THIRD PARTY CONSULTATION** | | |
| WMG36 | General practitioners: Cancellation of case conference, worksite assessment, dispute resolution or third party consultation. | $298.10  per hour |
| WMP36 | Consultant physicians: Cancellation of case conference, worksite assessment, dispute resolution or third party consultation. | $584.20  per hour |
| WMS36 | Specialists in a surgical discipline: Cancellation of case conference, worksite assessment, dispute resolution or third party consultation. | $584.20  per hour |
|  | Note 1: Payment for cancellation will only be made when the attendance was at the request of a:—claims manager or self-insured employer—worker, worker’s representative or advocate—employer or employer’s representative.  Note 2: A cancellation fee is payable only if the cancellation occurs less than 48 hours (excluding weekends and public holidays in South Australia) before the time of the proposed attendance.  Note 3: A cancellation fee is not payable if the doctor is responsible for the cancellation.  Note 4: If the cancelled appointment is subsequently filled with any other earning activity, no cancellation fee will be payable.  Note 5: Any part of an hour should be billed proportionately and rounded to the nearest six minutes. | |
| **JOB ANALYSIS AND/OR RECOMMENDED JOB DESCRIPTION STATEMENT** | | |
| WMG56 | General practitioners: Formal job analysis and/or recommended job descriptions. Reading of and written recommendations on the suitability of proposals for return to work, expected to be provided within 10 business days of receipt of the initial request. | $114.60  flat fee |
| WMP56 | Consultant physicians: Formal job analysis and/or recommended job descriptions. Reading of and written recommendations on the suitability of proposals for return to work, expected to be provided within 10 business days of receipt of the initial request. | $146.20  flat fee |
| WMS56 | Specialists in a surgical discipline: Formal job analysis and/or recommended job descriptions. Reading of and written recommendations on the suitability of proposals for return to work, expected to be provided within 10 business days of receipt of the initial request. | $146.20  flat fee |
|  | ||Note 1: A job analysis and/or job description statement must be requested in writing and may be requested by:—a claims manager or self-insured employer—a worker, worker’s representative or advocate—an approved return to work service provider.  Note 2: The date of request is taken to be two business days after the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia. | |
| **SPECIFIED DUTIES FORM** | | |
| WMG23 | General practitioners: Completion of a specified duties form. | $26.20  flat fee |
| WMP23 | Consultant physicians: Completion of a specified duties form. | $26.20  flat fee |
| WMS23 | Specialist in a surgical discipline: Completion of a specified duties form. | $26.20  flat fee |
|  | Note 1: This form is to be completed at the request of a:—claims manager or self-insured employer—worker, worker’s representative or advocate.  Note 2: A fee is not payable if the form is completed during a consultation with the worker. | |
| **PHOTOCOPYING** | | |
| WMADM | General practitioners, consultant physicians, specialists in a surgical discipline: Administration fee for the time to prepare and provide requested documents, and radiology, including postage. This may include where applicable, scanning and saving documents to a device (e.g. USB, disc), including the cost of the device. | $79.50  flat fee |
| WMGSP | General practitioners, consultant physicians, specialists in a surgical discipline: Photocopying of medical notes, reports and results of relevant tests e.g. pathology, diagnostic imaging reports. This service includes photocopying/printing costs only. In addition to photocopying, item WMADM can be billed as an administration cost. Note: Where documents are provided via media (e.g. USB, disc, email), only the administration fee applies. | $0.30 |
|  | Note 1: A fee is only payable if the photocopying is at the request of a:—claims manager or self-insured employer—worker, worker’s representative or advocate—investigator.  Note 2: The number of pages should be stated on the account. Any accounts without the number of pages stated will be returned for amendment.  Note 3: Accounts must state the name of the doctor providing the photocopied information. Accounts with the practice name only will be returned for amendment. | |
| **TRAVEL TIME—EMERGENCY ATTENDANCE** | | |
| WMG58 | General practitioners: Travel time, for the purpose of an initial emergency attendance of a compensable injury, at a location other than consulting rooms, hospital or other healthcare institution, when ambulance services are either not readily available or unduly delayed. | $298.10  per hour |
| WMG59 | General practitioners: Travel time, (out of normal business hours) for the purpose of an initial emergency attendance of a compensable injury, at a location other than consulting rooms, hospital or other healthcare institution, when ambulance services are either not readily available or unduly delayed. Out of normal business hours means on a Sunday, public holiday in South Australia, after 1pm on Saturday or between 8pm and 8am on weekdays. | $433.60  per hour |
|  | Note 1: Where more than one worker is treated at the site of the emergency, the travel fee is to be apportioned accordingly.  Note 2: All invoices must include the distance travelled, the travel commencement location, place of emergency attendance and a brief reason for the attendance.  Note 3: Any part of an hour should be billed proportionately and rounded to the nearest six minutes. | |
| **TRAVEL TIME—EMERGENCY RETRIEVAL TEAM** | | |
| WMS51 | Specialists: Travel time by a retrieval team doctor in association with a professional attendance relating to item numbers 00160, 00161, 00162, 00163 and 00164, other than ‘out of hours’ travel (refer to item number WMS52). | $584.20  per hour |
| WMS52 | Specialists: Travel time by a retrieval team doctor on a Sunday, public holiday in South Australia, after 1pm on Saturday or between 8pm and 8am on weekdays, in addition to a professional attendance relating to item numbers 00160, 00161, 00162, 00163 and 00164. | $846.50  per hour |
|  | Note 1: Where more than one worker is treated at the site of the emergency, the travel fee is to be apportioned accordingly.  Note 2: Any part of an hour should be billed proportionately and rounded to the nearest six minutes. | |
| **EXTRA-CORPOREAL SHOCK WAVE THERAPY** | | |
| WMI11 | Specialists: Initial treatment of Extra-Corporeal Shock Wave Therapy provided by a specialist radiology practice. | $166.80  flat fee |
| WMI12 | Specialists: Subsequent treatments of Extra-Corporeal Shock Wave Therapy provided by a specialist radiology practice. | $136.60  flat fee |
| WMI13 | Specialists: Double treatments (bilateral or multiple) of Extra-Corporeal Shock Wave Therapy provided by a specialist radiology practice. | $227.60  flat fee |
|  | Note 1: The I in prefix WMI item number represents the letter ‘I’ not a numeral one (1).  Note 2: This treatment has been approved by ReturnToWorkSA for use in the following conditions:—heel pain/plantar fasciitis—calcific tendonitis of shoulder—lateral epicondylitis (tennis elbow)—medial epicondylitis—non-united fractures—patellar tendinopathy.  Note 3: Where Extra-Corporeal Shock Wave Therapy is delivered outside of the approved conditions it is recommended to seek claims manager authorisation prior to the provision of the service.  Note 4: Epicondylitis treatment is NOT payable by ReturnToWorkSA for treatment provided within three months or after five years from date of injury. | |
| **SERVICES DELIVERED BY EAR, NOSE AND THROAT SURGEONS** | | |
| WME24 | Otorhinolaryngologists: Cortical evoked response audiometry—verification. | $389.00  flat fee |
| WME25 | Otorhinolaryngologists: Sensonics smell identification test. | $169.10  flat fee |
| WME2A | Otorhinolaryngologists: Cortical evoked response audiometry—quantification. | $389.00  flat fee |
| **SERVICES DELIVERED BY MEDICAL PRACTITIONERS** | | |
| WMG26 | Medical practitioners: Fluids, intravenous drip infusion of—percutaneous. | $66.80  flat fee |
| WMG27 | Medical Practitioners: Fluids, intravenous drip infusion of—open exposure. | $110.90  flat fee |
|  | Note 1: Item WMG26 is only payable where the service is not in association with a surgical procedure. | |
| **SERVICES DELIVERED BY MEDICAL PRACTITIONERS IN THE PRACTICE OF HYPNOTHERAPY** | | |
| WMG28 | Hypnotherapy at consulting rooms, 16 to 30 minutes. | $99.60  flat fee |
| WMG29 | Hypnotherapy at consulting rooms, 31 to 45 minutes. | $149.60  flat fee |
| WMG30 | Hypnotherapy at consulting rooms, more than 46 minutes. | $203.70  flat fee |
| WMG31 | Hypnotherapy at consulting rooms, not more than 15 minutes. | $57.60  flat fee |
| **INDEPENDENT MEDICAL EXAMINER—REPORT, EXAMINATION AND READING** | | | |
| WMP28 | | Consultant physicians: Independent medical examiner report inclusive of the physical examination, reading up to 100 pages, and report writing—expected to be provided within 10 business days of the examination. | $1576.70  flat fee |
| WMS28 | | Specialists in a Surgical discipline: Independent medical examiner report inclusive of the physical examination, reading up to 100 pages, and report writing—expected to be provided within 10 business days of the examination. | $1576.70  flat fee |
| WMY60 | | Psychiatrists: Independent medical examiner report inclusive of the examination, reading up to 100 pages, and report writing—expected to be provided within 10 business days of the examination. | $1748.00  flat fee |
|  | | Note 1: The independent medical examination must be requested in writing and may be requested by a:—claims manager or self-insured employer—worker, worker’s representative or advocate.  Note 2: The independent medical examination report fee includes the physical examination and reading of up to 100 pages.  Note 3: Reading material that exceeds 500 pages should be referred back to the requestor and confirmed as necessary.  Note 4: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified.  Note 5: Payment will only be made following submission of the report. | |
| **INDEPENDENT MEDICAL EXAMINER—MEDICAL REPORT BASED UPON A REVIEW OF DOCUMENTATION (EXCLUDING PSYCHIATRISTS)** | | |
| WMP29 | Consultant physicians: Independent medical examiner report based upon a review of documentation supplied by the requestor. It is expected that the worker will have already been physically examined by more than one consultant physician/specialist. The report is expected to be provided within 10 business days of receipt of the initial request. | $700.40  flat fee |
| WMS29 | Specialists in a surgical discipline: Independent medical examiner report based upon a review of documentation supplied by the requestor. It is expected that the worker will have already been physically examined by more than one consultant physician/specialist. The report is expected to be provided within 10 business days of receipt of the initial request. | $700.40  flat fee |
|  | Note 1: A medical report based on a review of documentation is only for situations such as where there are two or more opposing medical opinions; clarification is sought regarding a point or points where the original examiner is unavailable, or to obtain an expert opinion, with a view to introducing the expert to give evidence in legal proceedings.  Note 2: A medical report based on a review of documentation must be requested in writing and may be requested by a:—claims manager or self-insured employer—worker, worker’s representative or advocate.  Note 3: Documentation can include information such as medical reports/information from professionals such as a consultant physicians, specialists, hospital doctors; hospital records; prescriptions, and other relevant information, such as x-rays, MRIs, CT Scans, and test results.  Note 4: The date of request is taken to be 2 business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.  Note 5: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the requestor and clarified.  Note 6: Payment will only be made following submission of the report. | |
| **INDEPENDENT MEDICAL EXAMINER—PSYCHIATRISTS MEDICAL REPORT BASED UPON A REVIEW OF DOCUMENTATION** | | |
| WMY61 | Psychiatrists: Independent medical examiner report based upon a review of documentation supplied by the requestor. It is expected that the worker will have already been physically examined by more than one consultant physician/specialist. The report is expected to be provided within 10 business days of receipt of the initial request. | $871.70  flat fee |
|  | Note 1: A medical report based on a review of documentation is only for situations such as where there are two or more opposing medical opinions; clarification is sought regarding a point or points where the original examiner is unavailable, or to obtain an expert opinion, with a view to introducing the expert to give evidence in legal proceedings.  Note 2: A medical report based on a review of documentation must be requested in writing and may be requested by a:—claims manager or self-insured employer—worker, worker’s representative or advocate.  Note 3: Documentation can include information such as medical reports/information from professionals such as a consultant physicians, specialists, hospital doctors; hospital records; prescriptions, and other relevant information, such as x-rays, MRIs, CT Scans, and test results.  Note 4: The date of request is taken to be 2 business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.  Note 5: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the requestor and clarified.  Note 6: Payment will only be made following submission of the report. | |
| **INDEPENDENT MEDICAL EXAMINER—SUPPLEMENTARY MEDICAL REPORT** | | |
| WMP33 | Consultant physicians: Supplementary medical report, where additional information or clarification is requested or by the report requestor, re-examination not required. A supplementary report fee is not payable if the report is requested as a result of an error, omission or failure by the medical practitioner to address the original questions in the letter of request. | $292.10  flat fee |
| WMS33 | Specialists in a surgical discipline: Supplementary medical report, where additional information or clarification is requested or by the report requestor, re-examination not required. A supplementary report fee is not payable if the report is requested as a result of an error, omission or failure by the medical practitioner to address the original questions in the letter of request. | $292.10  flat fee |
|  | Note 1: A supplementary medical report must be requested in writing and may be requested by a:—claims manager or self-insured employer—worker, worker’s representative or advocate.  Note 2: The requestor must specify that they are seeking a supplementary report relating to a previous medical report.  Note 3: The intention of this fee is to provide facilities for follow up questions or issues relating to prior independent medical examinations and additional consultations may not be required.  Note 4: Payment will only be made following submission of the report. | |
| **INDEPENDENT MEDICAL EXAMINER—ADDITIONAL READING TIME** | | | |
| WMP82 | | Consultant physicians: Independent medical examiner additional reading time, payable when:—there are more than 100 pages of reading material supplied by the report requestor (the first 100 pages are included in the report fee), or—reading material is supplied in conjunction with a supplementary report (WMP33) or a medical report based upon review of documentation (WMP29), or—a worker fails to attend or cancels less than 2 business days (excluding weekends and public holidays in South Australia) before an appointment and reading of supplied material has already occurred. | $584.20  per hour  Max 2 hours |
| WMS82 | | Specialists in a surgical discipline: Independent medical examiner additional reading time, payable when:—there are more than 100 pages of reading material supplied by the report requestor (the first 100 pages are included in the report fee), or—reading material is supplied in conjunction with a supplementary report (WMS33) or a medical report based upon review of documentation (WMS29), or—a worker fails to attend or cancels less than 2 business days (excluding weekends and public holidays in South Australia) before an appointment and reading of supplied material has already occurred. | $584.20  per hour  Max 2 hours |
| WMY90 | | Psychiatrists: Independent medical examiner additional reading time, payable when:—there are more than 100 pages of reading material supplied by the report requestor (the first 100 pages are included in the report fee), or—reading material is supplied in conjunction with a medical report based upon review of documentation (WMY61), or—a worker fails to attend or cancels less than 2 business days (excluding weekends and public holidays in South Australia) before an appointment and reading of supplied material has already occurred. | $584.20  per hour  Max 2 hours |
|  | | Note 1: Payment for the reading of written material will only be made where the reading is required for the medical practitioner to prepare a report, and where the reading is at the request or approval of a:—claims manager or self-insured employer,—worker, worker’s representative or advocate.  Note 2: A fee is not payable for the reading of case notes, clinical material or any other material that is not directly supplied or approved by the parties listed in note 1.  Note 3: Reading material that exceeds 500 pages should be referred back to the requestor and confirmed as necessary.  Note 4: ReturnToWorkSA expects that up to 200 pages are able to be read per hour.  Note 5: The number of pages read should be stated on the account. Any accounts without the number of pages stated will be returned for amendment.  Note 6: Any part of an hour should be billed proportionately and rounded to the nearest six 6 minutes.  Note 7: The reading of material supplied by the requestor can only be billed once. No additional charge can be submitted for re-reading of material. | |
| **INDEPENDENT MEDICAL EXAMINER—TRAVEL TIME: WORKSITE ASSESSMENT, CASE CONFERENCE, DISPUTE RESOLUTION OR THIRD PARTY CONSULTATION** | | |
| MP940 | Consultant physicians: Independent medical examiner travel time for the purpose of a worksite assessment, case conference, dispute resolution or third party consultation. | $584.20  per hour |
| MS940 | Specialists in a surgical discipline: Independent medical examiner travel time for the purpose of a worksite assessment, case conference, dispute resolution or third party consultation. | $584.20  per hour |
|  | Note 1: Travel will be approved for independent medical examiner services requested by a:—claims manager or self-insured employer—worker, worker’s representative or advocate.  Note 2: All accounts must include the total time spent travelling as well as the distance travelled.  Note 3: Where more than one service is conducted, the travel fee is to be apportioned accordingly.  Note 4: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.\ | |
| **INDEPENDENT MEDICAL EXAMINER—NON-ATTENDANCE OR CANCELLATION OF AN APPOINTMENT** | | |
| WMP34 | Consultant physicians: Independent medical examiner non-attendance at, or cancellation less than 2 business days (excluding weekends and public hospitals in South Australia) before an appointment. | $584.20  flat fee |
| WMS34 | Specialists in a surgical discipline: Independent medical examiner non-attendance at, or cancellation less than 2 business days (excluding weekends and public holidays in South Australia) before an appointment. | $584.20  flat fee |
| WMY88 | Psychiatrists: Independent medical examiner non-attendance at, or cancellation less than 2 business days (excluding weekends and public holidays in South Australia) before an appointment. | $584.20  flat fee |
|  | Note 1: Fees apply only to the cancellation of medical appointments arranged by a:—claims manager or self-insured employer—worker, worker’s representative or advocate.  Note 2: If the cancelled appointment or non-attendance is subsequently filled with any other earning activity, no cancellation fee will be payable. | |
| **INDEPENDENT MEDICAL EXAMINER—TRAVEL FOR EXAMINATIONS** | | |
| WMP64 | Consultant physicians: Independent medical examiner, a full day attendance at the venue more than 100 kilometres from the Adelaide GPO for the purpose of providing an independent medical examiner report. | $170.90  flat fee |
| WMP65 | Consultant physicians: Independent medical examiner cancellation of an attendance at a venue more than 100 kilometres from the Adelaide GPO. | $273.30  flat fee |
| WMP66 | Consultant physicians: Independent medical examiner overnight accommodation including meals and incidentals. | $361.90  flat fee |
| WMP67 | Consultant physicians: Independent medical examiner travel by motor vehicle, to and from a venue for the purposes of an appointment made by the report requestor. | ATO rates |
| WMP68 | Consultant physicians: Independent medical examiner travel by aircraft, to and from a venue for the purposes of an appointment made by the report requestor. | Economy airfare |
| WMS64 | Specialists in a surgical discipline: Independent medical examiner, a full day attendance at a venue more than 100 kilometres from the Adelaide GPO for the purpose of providing an independent medical examiner report. | $170.90  flat fee |
| WMS65 | Specialists in a surgical discipline: Independent medical examiner cancellation of an attendance at a venue more than 100 kilometres from the Adelaide GPO. | $273.30  flat fee |
| WMS66 | Specialists in a surgical discipline: Independent medical examiner overnight accommodation including meals and incidentals. | $361.90  flat fee |
| WMS67 | Specialists in a surgical discipline: Independent medical examiner travel by motor vehicle, to and from a venue for the purposes of an appointment made by the report requestor. | ATO rates |
| WMS68 | Specialists in a surgical discipline: Independent medical examiner travel by aircraft, to and from a venue for the purposes of an appointment made by the report requestor. | Economy airfare |
|  | Note 1: The first 50 kilometres of any travel is not billable.  Note 2: If more than one organisation has requested services from the provider at the travel destination then items WMP/S64, WMP/S66, WMP/S67 and/or WMP/S68 must be apportioned accordingly.  Note 3: A full day pursuant to item WMP/S64 refers to a stay of more than six hours at the venue including travel time.  Note 4: ATO rates means the rate, applicable to the type of motor vehicle in which the medical expert travelled, published by the Australian Taxation Office as the rate per kilometre that may be claimed as a deduction for business travel expenses incurred in the previous financial year.  Note 5: Economy airfare means the amount determined by ReturnToWorkSA to be the reasonable cost of undertaking the travel using a standard economy airfare. | |
| **INDEPENDENT MEDICAL EXAMINER -TELEPHONE CALL** | | |
| AIMP24 | Consultant physicians: Independent medical examiner telephone call (excluding calls made to or received from injured workers), up to and including 60 minutes duration. | $584.20  per hour |
| AIMS24 | Specialists in a surgical discipline: Independent medical examiner telephone call (excluding calls made to or received from injured workers), up to and including 60 minutes duration. | $584.20  per hour |
|  | Note 1: Telephone calls are chargeable if related to the management of the worker’s claim, or to progress their recovery and return to work, made to or received from:—a claims manager or self-insured employer,—a worker’s employer (including the employer’s return to work co-ordinator),—a worker’s representative or advocate,—a ReturnToWorkSA medical advisor,—an approved return to work service provider,—a worker’s referring/treating practitioner.  Note 2: There is no charge for a telephone call to or from a worker.  Note 3: A fee is payable if the telephone contact occurs during a consultation with the worker provided that the consultation duration excludes the duration of the telephone call. For example, if the consultation and telephone call duration is 20 minutes and the call duration alone is 10 minutes, the consultation should be charged as a 10 minute consultation.  Note 4: Invoices for telephone calls in accordance with this item must record the name of the other party and the duration of the phone call in minutes.  Note 5: Any part of an hour should be billed proportionately and rounded to the nearest six minutes. | |
| **INDEPENDENT MEDICAL EXAMINER—CASE CONFERENCE** | | |
| AIMP09 | Consultant physicians: Independent medical examiner case conference to determine details of limitations to work, recommendations facilitating a return to work and options for management of the injured worker’s recovery, including medical treatment strategies. | $584.20  per hour |
| AIMS09 | Specialists in a surgical discipline: Independent medical examiner case conference to determine details of limitations to work, recommendations facilitating a return to work and options for management of the injured worker’s recovery, including medical treatment strategies. | $584.20  per hour |
|  | Note 1: A case conference may be requested by:—a claims manager or self-insured employer,—a worker’s employer (including the employer’s return to work co-ordinator),—a worker or worker’s representative,—an approved return to work service provider,—a treating medical expert.  Note 2: The claims manager or self-insured employer should attend the case conference if at all possible. If the claims manager or self-insured employer is unable to attend, they should delegate a representative. No fee is payable for records made by any medical practitioner during the case conference unless delegated as the representative by the claims manager or self-insured employer. It is the responsibility of the claims manager, self-insured employer or delegated representative to make a written and signed record of the case conference that is to be distributed to all attendees. Differences of opinion should be noted in the record. The worker or worker’s representative must always be invited to attend the case conference.  Note 3: Case conferences conducted by telephone (teleconferencing) are chargeable under this item.  Note 4: Any part of an hour should be billed proportionately and rounded to the nearest six minutes. | |
| **INDEPENDENT MEDICAL EXAMINER—WORKSITE ASSESSMENT** | | |
| AIMP08 | Consultant physicians: Independent medical examiner worksite assessment, for the purpose of assessing and reporting the duties that are or can be made available, and the capacity of the worker to undertake these duties. | $584.20  per hour |
| AIMS08 | Specialists in a surgical discipline: Independent medical examiner worksite assessment, for the purpose of assessing and reporting the duties that are or can be made available, and the capacity of the worker to undertake these duties. | $584.20  per hour |
|  | Note 1: A worksite assessment may be requested by a:—claims manager or self-insured employer,—worker, worker’s representative or advocate.  Note 2: At worksite visits it is expected that the employer, worker or worker’s representative, claims manager or self-insured employer representative should be present.  Note 3: The claims manager or self-insured employer should contact the employer to ensure appropriate access to the worksite and to arrange for an employer representative to be available to help maximise the value of time spent in the workplace.  Note 4: The worksite assessment must include an assessment of the physical environment, mental work demands, human behaviour, working conditions, educational requirements and other conditions.  Note 5: The report of a worksite assessment is to be completed and distributed by the medical practitioner undertaking the assessment to relevant parties in attendance during the worksite assessment. A copy must also be provided to the claims manager, treating doctor and worker (if not present) within one week of the assessment. No additional fee is payable for completion of the form.  Note 6: Any part of an hour should be billed proportionately and rounded to the nearest six minutes. | |
| **INDEPENDENT MEDICAL EXAMINER—THIRD PARTY CONSULTATION** | | |
| AIMP14 | Consultant physicians: Independent medical examiner third party consultation at the doctor’s rooms where the worker is usually not present. | $584.20  per hour |
| AIMS14 | Specialists in a surgical discipline: Independent medical examiner third party consultation at the doctor’s rooms where the worker is usually not present. | $584.20  per hour |
|  | Note 1: A third party consultation must involve at least one of the following:—claims manager or self-insured employer,—worker, worker’s representative or advocate,—worker’s employer (including the employer’s return to work co-ordinator),—investigator,—approved return to work service provider.  Note 2: A third party consultation may include a video viewing of a worker’s normal duties, alternative duties or other activities.  Note 3: It is the responsibility of the claims manager or self-insured employer to ensure a written and signed record is made of the third party consultation that is to be distributed to all attendees. No fee is payable for records made by any medical practitioner during the third party consultation.  Note 4: If as a result of the third party consultation the medical practitioner has amended details regarding the worker’s limitations to work, capacity, recommendations for facilitating a return to work and/or options for management of the worker, the medical practitioner must consider the worker’s input into this decision.  Note 5: Any part of an hour should be billed proportionately and rounded to the nearest six minutes. | |
| **INDEPENDENT MEDICAL EXAMINER—ATTENDANCE AT A DISPUTE RESOLUTION** | | |
| AIMP15 | Consultant physicians: Independent medical examiner attendance at a dispute resolution. | $584.20  per hour |
| AIMS15 | Specialists in a surgical discipline: Independent medical examiner attendance at a dispute resolution. | $584.20  per hour |
|  | Note 1: Attendance at a dispute resolution must be at the request of a:—claims manager or self-insured employer,—worker, worker’s representative or advocate,—worker’s employer or employer’s representative.  Note 2: Court attendances can be charged under this item.  Note 3: A witness at a dispute resolution proceeding is entitled to reimbursement of any expense that the dispute resolution authority certifies has been, or is likely to be, reasonably incurred by the witness as a consequence of appearing before the authority.  Note 4: Any part of an hour should be billed proportionately and rounded to the nearest six minutes. | |
| **INDEPENDENT MEDICAL EXAMINATION—CANCELLATION OF A CASE CONFERENCE, WORKSITE ASSESSMENT, DISPUTE RESOLUTION OR THIRD PARTY CONSULTATION** | | |
| AIMP36 | Consultant physicians: Independent medical examiner cancellation of a case conference, worksite assessment, dispute resolution or third party consultation. | $584.20  per hour |
| AIMS36 | Specialists in a surgical discipline: Independent medical examiner cancellation of a case conference, worksite assessment, dispute resolution or third party consultation. | $584.20  per hour |
|  | Note 1: Payment for cancellation will only be made when the attendance was at the request of a:—claims manager or self-insured employer,—worker, worker’s representative or advocate,—employer or employer’s representative.  Note 2: A cancellation fee is payable only if the cancellation occurs less than 48 hours (excluding weekends and public holidays in South Australia) before the time of the proposed attendance.  Note 3: A cancellation fee is not payable if the doctor is responsible for the cancellation.  Note 4: If the cancelled appointment is subsequently filled with any other earning activity, no cancellation fee will be payable.  Note 5: Any part of an hour should be billed proportionately and rounded to the nearest six minutes. | |
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Permanent Impairment Assessments

In accordance with Section 22 of the *Return to Work Act 2014*, only medical practitioners who hold a current accreditation issued by the Minister for Industrial Relations can provide these services for the Return to Work scheme.

| **Item No.** | **Description** | **Max Fee (excl. GST)** |
| --- | --- | --- |
|  |  |  |
| **PERMANENT IMPAIRMENT ASSESSOR—STANDARD REPORT** | | |
| PIA10 | General practitioners: permanent impairment assessor standard report, simple assessment of one body system combined with one body part—reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $1548.20  flat fee |
| PIA30 | Specialists (excluding psychiatrists): permanent impairment assessor standard report, simple assessment of one body system combined with one body part—reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $1548.20  flat fee |
| PIA40 | Psychiatrists: permanent impairment assessor standard report for the assessment of psychiatric disorders; assessment where there is one disorder or condition related to the work injury—reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines and using the Guidelines for the Evaluation of Psychiatric Impairment by Clinicians (GEPIC). Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $1935.20  flat fee |
|  | Note 1: Reports will be requested by a claims manager or self-insured employer.  Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex or supplementary report is required.  Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor’s prior consent for an extension of time.  Note 4: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.  Note 5: ‘Specialist’ means a specialist in a surgical discipline or a consultant physician.  Note 6: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines. | |
| **PERMANENT IMPAIRMENT ASSESSOR—MODERATELY COMPLEX REPORT** | | |
| PIA11 | General practitioners: permanent impairment assessor moderately complex report, simple assessment of:—one body system combined with two body parts—one body system combined with three body parts—two body systems combined with two body parts—reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $1935.40  flat fee |
| PIA31 | Specialists: permanent impairment assessor moderately complex report, simple assessment of:—one body system combined with two body parts—one body system combined with three body parts—two body systems combined with two body parts—reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $1935.40  flat fee |
|  | Note 1: Reports will be requested by a claims manager or self-insured employer.  Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex or supplementary report is required.  Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor’s prior consent for an extension of time.  Note 4: Corrections, amendments, and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.  Note 5: ‘Specialist’ means a specialist in a surgical discipline or a consultant physician.  Note 6: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines. | |
| **PERMANENT IMPAIRMENT ASSESSOR—COMPLEX REPORT** | | |
| PIA12 | General practitioners: permanent impairment assessor complex report, complex assessment of:—one body system combined with four body parts—one body system combined with five body parts—two body systems combined with three body parts—two body systems combined with four body parts—three body systems combined with three body parts – reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $2451.50  flat fee |
| PIA32 | Specialists (excluding psychiatrists): permanent impairment assessor complex report, complex assessment of:—one body system combined with four body parts—one body system combined with five body parts—two body systems combined with three body parts—two body systems combined with four body parts—three body systems combined with three body parts—reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $2451.50  flat fee |
| PIA42 | Psychiatrists: permanent impairment assessor complex report for the assessment of psychiatric disorders or conditions; assessment where there is more than one disorder related to the work injury or pre-existing or non-work-related and/or neurological considerations—reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines and using the Guidelines for the Evaluation of Psychiatric Impairment by Clinicians (GEPIC). Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $2708.60  flat fee |
|  | Note 1: Reports will be requested by a claims manager or self-insured employer.  Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex or supplementary report is required.  Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor’s prior consent for an extension of time.  Note 4: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.  Note 5: ‘Specialist’ means a specialist in a surgical discipline or a consultant physician.  Note 6: The lead assessor may only bill for the final complete report including the sub-assessor’s report(s).  Note 7: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines. | |
| **PERMANENT IMPAIRMENT ASSESSOR—VERY COMPLEX REPORT** | | |
| PIA20 | General Practitioners: permanent impairment assessor very complex report, assessment of:—One body system combined with six body parts—One body system combined with seven body parts—Two body systems combined with five body parts—Two body systems combined with six body parts—Three body systems combined with four body parts—Three body systems combined with five body parts—Four body systems combined with four body parts—or lead assessor report—including reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $3142.80  flat fee |
| PIA70 | Specialists (excluding psychiatrists): permanent impairment assessor very complex report, assessment of:—One body system combined with six body parts—One body system combined with seven body parts—Two body systems combined with five body parts—Two body systems combined with six body parts—Three body systems combined with four body parts—Three body systems combined with five body parts—Four body systems combined with four body parts—or lead assessor report—including reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $3142.80  flat fee |
|  | Note 1: Reports will be requested by a claims manager or self-insured employer.  Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.  Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor’s prior consent for an extension of time.  Note 4: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.  Note 5: ‘Specialist’ means a specialist in a surgical discipline or a consultant physician.  Note 6: The lead assessor may only bill for the final complete report including the sub-assessor’s report(s).  Note 7: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines. | |
| **PERMANENT IMPAIRMENT ASSESSOR—HIGHLY COMPLEX REPORT** | | |
| PIA21 | General Practitioners: permanent impairment assessor highly complex report, assessment of:—One body system combined with eight body parts—One body system combined with nine body parts—Two body systems combined with seven body parts—Two body systems combined with eight body parts—Three body systems combined with six body parts—Three body systems combined with seven body parts—Four body systems combined with five body parts—Four body systems combined with six body parts—Five body systems combined with five body parts including reading up to 100 pages, examination, and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $3579.30  flat fee |
| PIA71 | Specialists (excluding psychiatrists): permanent impairment assessor highly complex report, assessment of:—One body system combined with eight body parts—One body system combined with nine body parts—Two body systems combined with seven body parts—Two body systems combined with eight body parts—Three body systems combined with six body parts—Three body systems combined with seven body parts—Four body systems combined with five body parts—Four body systems combined with six body parts—Five body systems combined with five body parts including reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $3579.30  flat fee |
|  | Note 1: Reports will be requested by a claims manager or self-insured employer.  Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.  Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor’s prior consent for an extension of time.  Note 4: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.  Note 5: ‘Specialist’ means a specialist in a surgical discipline or a consultant physician.  Note 6: The lead assessor may only bill for the final complete report including the sub-assessor’s report(s).  Note 7: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines. | |
| **PERMANENT IMPAIRMENT ASSESSOR—ENT REPORT** | | |
| PIA50 | ENT specialists: permanent impairment assessor ENT report—reading up to 100 pages, examination of ear, nose and/or throat only, including audiometric testing and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $1548.20  flat fee |
|  | Note 1: Reports will be requested by a claims manager or self-insured employer.  Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex or supplementary report is required.  Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor’s prior consent for an extension of time.  Note 4: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.  Note 5: ‘Specialist’ means a specialist in a surgical discipline or a consultant physician. | |
| **PERMANENT IMPAIRMENT ASSESSOR—STANDARD REPORT WHERE AN EXAMINATION IS CONDUCTED WITH THE ASSISTANCE OF AN INTERPRETER** | | |
| PIA13 | General practitioners: permanent impairment assessor standard report with interpreter, simple assessment of one body system combined with one body part—reading up to 100 pages, examination conducted with the assistance of an interpreter and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $1935.40  flat fee |
| PIA33 | Specialists (excluding psychiatrists): permanent impairment assessor standard report with interpreter, simple assessment of one body system combined with one body part—reading up to 100 pages, examination conducted with the assistance of an interpreter and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $1935.40  flat fee |
| PIA43 | Psychiatrists: permanent impairment assessor standard report with interpreter, for the assessment of psychiatric disorders; assessment where there is one disorder or condition related to the work injury—reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines and using the Guidelines for the Evaluation of Psychiatric Impairment by Clinicians (GEPIC). Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $2418.70  flat fee |
|  | Note 1: Reports will be requested by a claims manager or self-insured employer.  Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.  Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor’s prior consent for an extension of time.  Note 4: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.  Note 5: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.  Note 6: ‘Specialist’ means a specialist in a surgical discipline or a consultant physician.  Note 7: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines. | |
| **PERMANENT IMPAIRMENT ASSESSOR—MODERATELY COMPLEX REPORT WHERE AN EXAMINATION IS CONDUCTED WITH THE ASSISTANCE OF AN INTERPRETER** | | |
| PIA14 | General practitioners: permanent impairment assessor moderately complex report with interpreter, simple assessment of:—one body system combined with two body parts—one body system combined with three body parts—two body systems combined with two body parts—reading up to 100 pages, examination conducted with the assistance of an interpreter and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $2322.40  flat fee |
| PIA34 | Specialists: permanent impairment assessor moderately complex report with interpreter, simple assessment of:—one body system combined with two body parts—one body system combined with three body parts—two body systems combined with two body parts—reading up to 100 pages, examination conducted with the assistance of an interpreter and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $2322.40  flat fee |
|  | Note 1: Reports will be requested by a claims manager or self-insured employer.  Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.  Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor’s prior consent for an extension of time.  Note 4: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.  Note 5: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.  Note 6: ‘Specialist’ means a specialist in a surgical discipline or a consultant physician.  Note 7: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines. | |
| **PERMANENT IMPAIRMENT ASSESSOR—COMPLEX REPORT WHERE AN EXAMINATION IS CONDUCTED WITH THE ASSISTANCE OF AN INTERPRETER** | | |
| PIA15 | General practitioners: permanent impairment assessor complex report with interpreter, complex assessment of:—one body system combined with four body parts—one body system combined with five body parts—two body systems combined with three body parts—two body systems combined with four body parts—three body systems combined with three body parts – or lead assessor report—reading up to 100 pages, examination conducted with the assistance of an interpreter and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $2838.50  flat fee |
| PIA35 | Specialists (excluding psychiatrists): permanent impairment assessor complex report with interpreter, complex assessment of:—one body system combined with four body parts—one body system combined with five body parts—two body systems combined with three body parts—two body systems combined with four body parts—three body systems combined with three body parts – or lead assessor report— reading up to 100 pages, examination conducted with the assistance of an interpreter and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $2838.50  flat fee |
| PIA45 | Psychiatrists: permanent impairment assessor complex report, with interpreter, for the assessment of psychiatric disorders; assessment where there is more than one disorder related to the work injury or pre-existing or non-work-related and/or neurological considerations—reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines and using the Guidelines for the Evaluation of Psychiatric Impairment by Clinicians (GEPIC). Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $3385.80  flat fee |
|  | Note 1: Reports will be requested by a claims manager or self-insured employer.  Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.  Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor’s prior consent for an extension of time.  Note 4: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.  Note 5: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.  Note 6: ‘Specialist’ means a specialist in a surgical discipline or a consultant physician.  Note 7: The lead assessor may only bill for the final complete report including the sub-assessor’s report(s).  Note 8: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines. | |
| **PERMANENT IMPAIRMENT ASSESSOR—VERY COMPLEX REPORT WHERE AN EXAMINATION IS CONDUCTED WITH THE ASSISTANCE OF AN INTERPRETER** | | |
| PIA26 | General Practitioners: permanent impairment assessor very complex report with interpreter, assessment of:—One body system combined with six body parts—One body system combined with seven body parts—Two body systems combined with five body parts—Two body systems combined with six body parts—Three body systems combined with four body parts—Three body systems combined with five body parts—Four body systems combined with four body parts including reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $3514.20  flat fee |
| PIA76 | Specialists (excluding psychiatrists): permanent impairment assessor very complex report with interpreter, assessment of:—One body system combined with six body parts—One body system combined with seven body parts—Two body systems combined with five body parts—Two body systems combined with six body parts—Three body systems combined with four body parts—Three body systems combined with five body parts—Four body systems combined with four body parts including reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $3514.20  flat fee |
|  | Note 1: Reports will be requested by a claims manager or self-insured employer.  Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.  Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor’s prior consent for an extension of time.  Note 4: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.  Note 5: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.  Note 6: ‘Specialist’ means a specialist in a surgical discipline or a consultant physician.  Note 7: The lead assessor may only bill for the final complete report including the sub-assessor’s report(s). | |
| **PERMANENT IMPAIRMENT ASSESSOR—HIGHLY COMPLEX REPORT WHERE AN EXAMINATION IS CONDUCTED WITH THE ASSISTANCE OF AN INTERPRETER** | | |
| PIA27 | General Practitioners: permanent impairment assessor highly complex report with interpreter, assessment of:—One body system combined with eight body parts—One body system combined with nine body parts—Two body systems combined with seven body parts—Two body systems combined with eight body parts—Three body systems combined with six body parts—Three body systems combined with seven body parts—Four body systems combined with five body parts—Four body systems combined with six body parts—Five body systems combined with five body parts including reading up to 100 pages, examination, and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $3950.70  flat fee |
| PIA77 | Specialists (excluding psychiatrists): permanent impairment assessor highly complex report with interpreter, assessment of:—One body system combined with eight body parts—One body system combined with nine body parts—Two body systems combined with seven body parts—Two body systems combined with eight body parts—Three body systems combined with six body parts—Three body systems combined with seven body parts—Four body systems combined with five body parts—Four body systems combined with six body parts—Five body systems combined with five body parts including reading up to 100 pages, examination and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $3950.70  flat fee |
|  | Note 1: Reports will be requested by a claims manager or self-insured employer.  Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.  Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor’s prior consent for an extension of time.  Note 4: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.  Note 5: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.  Note 6: ‘Specialist’ means a specialist in a surgical discipline or a consultant physician.  Note 7: The lead assessor may only bill for the final complete report including the sub-assessor’s report(s).  Note 8: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines. | |
| **PERMANENT IMPAIRMENT ASSESSOR—ENT REPORT WHERE AN EXAMINATION IS CONDUCTED WITH THE ASSISTANCE OF AN INTERPRETER** | | |
| PIA51 | ENT specialists: permanent impairment assessor ENT report with interpreter, reading up to 100 pages, examination of ear, nose and/or throat only, conducted with the assistance of an interpreter, including audiometric testing and report in accordance with the Impairment Assessment Guidelines. Corrections, amendments and clarifications to a report after initial submission are covered in the fee and do not attract an additional fee. | $1935.40  flat fee |
|  | Note 1: Reports will be requested by a claims manager or self-insured employer.  Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex, very complex, highly complex or supplementary report is required.  Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor’s prior consent for an extension of time.  Note 4: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.  Note 5: Corrections, amendments and clarifications to a report after initial submission are covered in the fee above, and do not attract an additional fee.  Note 6: ‘Specialist’ means a specialist in a surgical discipline or a consultant physician. | |
| **PERMANENT IMPAIRMENT ASSESSOR—CANCELLATION OF AN APPOINTMENT OR NON-ATTENDANCE** | | |
| PIA16 | General practitioners: permanent impairment assessor non-attendance at, or cancellation with less than 48 hours notice (excluding weekends or public holidays in South Australia) before an appointment. | $420.90  flat fee |
| PIA36 | Specialists: permanent impairment assessor non-attendance at, or cancellation with less than 48 hours notice (excluding weekends or public holidays) before an appointment | $420.90  flat fee |
|  | |Note 1: A fee for a cancellation with more than 48 hours’ notice (excluding weekends and public holidays in South Australia) is not payable.  Note 2: A fee for a cancellation or non-attendance does not apply if the appointment is subsequently filled with any other earning activity. | |
| **PERMANENT IMPAIRMENT ASSESSOR—SUPPLEMENTARY REPORT** | | |
| PIA17 | General practitioners: permanent impairment assessor supplementary report, where additional information is requested by the report requestor. A supplementary report fee is not payable if additional work is required to respond to a clarification request from ReturnToWorkSA or a self-insured employer as a result of an error or omission on the part of the assessor. | $292.10  flat fee |
| PIA37 | Specialists (including psychiatrists): permanent impairment assessor supplementary report, where additional information is requested by the report requestor. A supplementary report fee is not payable if additional work is required to respond to a clarification request from ReturnToWorkSA or a self-insured employer as a result of an error or omission on the part of the assessor. | $292.10  flat fee |
|  | Note 1: A supplementary report fee will only be paid where either ReturnToWorkSA, a claims manager, or a self-insured employer specifically requests a separate report that addresses matters that are additional to the original report request. | |
| **PERMANENT IMPAIRMENT ASSESSOR—TRAVEL FOR EXAMINATIONS** | | |
| PIA60 | General practitioners or specialists (including psychiatrists): permanent impairment assessor travel, a full day attendance at a venue more than 100 kilometres from the Adelaide GPO for the purpose of providing a permanent impairment report. | $170.90  flat fee |
| PIA62 | General practitioners or specialists (including psychiatrists): permanent impairment assessor—cancellation of an attendance at a venue more than 100 kilometres from the Adelaide GPO. | $273.30  flat fee |
| PIA64 | General practitioners or specialists (including psychiatrists): permanent impairment assessor accommodation—overnight accommodation including meals and incidentals. | $361.90  flat fee |
| PIA66 | General practitioners or specialists (including psychiatrists): permanent impairment assessor motor vehicle travel—travel by motor vehicle, to and from a venue for the purpose of an appointment made by the report requestor. | ATO rates |
| PIA68 | General practitioners and specialists (including psychiatrists): permanent impairment assessor aircraft travel—travel by aircraft, to and from a venue for the purpose of an appointment made by the report requestor. | Economy airfare |
|  | Note 1: The first 50 kilometres of any travel is not chargeable.  Note 2: If an assessor is travelling for the purpose of conducting more than one permanent impairment assessment, the travel fees must be apportioned accordingly.  Note 3: ‘A full day’ as per item PIA60 refers to a stay of more than five hours at the venue including travel time.  Note 4: ATO rates means the rate, applicable to the type of motor vehicle in which the assessor travelled, published by the Australian Taxation Office as the rate per kilometre that may be claimed as a deduction for business travel expenses incurred in the previous financial year.  Note 5: Economy airfare means the amount determined by ReturnToWorkSA to be the reasonable cost of undertaking the travel using a standard economy airfare. | |
| **PERMANENT IMPAIRMENT ASSESSOR—ADDITIONAL READING TIME** | | |
| PIA29 | General Practitioners: permanent impairment assessor additional reading time, payable when:—there are more than 100 pages of reading material supplied by the report requestor (the first 100 pages are included in the report fee), or—reading material is supplied in conjunction with a supplementary report request, or—a worker fails to attend or cancels less than 2 business days (excluding weekends and public holidays in South Australia) before an appointment and reading of supplied material has already occurred. | $584.20  per hour  Max 2 hours |
| PIA79 | Specialists (excluding ENT) and (including psychiatrists): permanent impairment assessor additional reading time, payable when:—there are more than 100 pages of reading material supplied by the report requestor (the first 100 pages are included in the report fee), or—reading material is supplied in conjunction with a supplementary report request, or—a worker fails to attend or cancels less than 2 business days (excluding weekends and public holidays in South Australia) before an appointment and reading of supplied material has already occurred. | $584.20  per hour  Max 2 hours |
|  | Note 1: Payment for the reading of written material will only be made where the reading is required for the medical practitioner to prepare a report, and where the reading is at the request or approval of a:—claims manager or self-insured employer,—worker, worker’s representative or advocate.  Note 2: A fee is not payable for the reading of case notes, clinical material or any other material that is not directly supplied or approved by the parties listed in note 1.  Note 3: Reading material that exceeds 500 pages should be referred back to the requestor and confirmed as necessary. If greater than 500 pages remain, prior approval from ReturnToWorkSA must be sought for reading time exceeds 2-hours.  Note 4: ReturnToWorkSA expects that up to 200 pages are able to be read per hour.  Note 5: The number of pages read should be stated on the account. Any accounts without the number of pages stated will be returned for amendment.  Note 6: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.  Note 7: The reading of material supplied by the requestor can only be billed once. No additional charge can be submitted for re-reading of material. | |
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Schedule 2

*Scale of Charges─Chiropractic Services*

This Schedule must be read in conjunction with the Chiropractic Fee Schedule and Policy.

| **Item No.** | **Description** | **Max Fee (excl. GST)** |
| --- | --- | --- |
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| **INITIAL CONSULTATIONS** | | |
| CH002 | Initial consultation of not more than 30 minutes duration. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. | $78.10  flat fee |
| CH003 | Initial consultation of more than 30 minutes duration. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. | $136.10  flat fee |
| **SUBSEQUENT CONSULTATIONS** | | |
| CH042 | Subsequent consultation of not more than 30 minutes duration. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. | $61.60  flat fee |
| CH043 | Subsequent consultation of more than 30 minutes duration. Re-assessment planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Due to the complexity of the injury, extra time is required for history taking, examination, treatment, documenting and liaison. This type of consultation is expected in only a limited number of cases for example, major trauma. | $126.90  flat fee |
| **CHIROPRACTIC MANAGEMENT PLAN** | | |
| CHMP | Chiropractic management plan. A chiropractic management plan completed and submitted by the treating chiropractor. For claims managed by ReturnToWorkSA or their claims agents, the chiropractor is expected to submit a plan:—prior to the 11th treatment if more than 10 treatments are likely to be required, or—prior to the expiry of an existing chiropractic management plan if additional treatment is required, or—at the request of the claims manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer. | $54.60  flat fee |
| **INDEPENDENT CLINICAL ASSESSMENT AND REPORT** | | |
| CH780 | Independent clinical assessment and report. An assessment of a worker by a chiropractor, other than the treating chiropractor, and provision of a report for the purpose of providing a clinical opinion on current treatment, comment on the worker’s functional ability and make recommendations on future chiropractic management. This service must be requested in writing by the claims manager, self-insured employer, worker or worker’s representative. Maximum 4 hours. | $217.70  per hour  Max 4 hours |
| **TELEPHONE CALLS** | | |
| CH552 | Telephone calls relating to the management of the worker’s claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator), worker’s representative, ReturnToWorkSA advisor, approved return to work service provider\* or worker’s referring/treating medical practitioner. Any time spent on communication directly related to an independent clinical assessment and report is included within the total time invoiced for that service.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $30.20  flat fee |
| **TREATING CHIROPRACTOR REPORT** | | |
| CH820 | Treating chiropractor report. A written clinical opinion, statement or response to questions relating to the medical status and treatment of a worker, requested in writing by the claims manager, self-insured employer, worker or worker’s representative. | $217.70  flat fee |
| **CASE CONFERENCE** | | |
| CH870 | Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator) or an approved return to work service provider\*.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $217.70  per hour |
| **TRAVEL TIME** | | |
| CH905 | Travel time. Travel by a chiropractor for the purpose of a case conference, home or hospital visit or an independent clinical assessment. | $184.80  per hour |
| **RADIOLOGICAL SERVICES (INCLUDING INTERPRETATION BY A CHIROPRACTOR)** | | |
| CHT11 | Cervical spine—2 views | $169.00  flat fee |
| CHT13 | Thoracic spine—2 views | $143.60  flat fee |
| CHT15 | Lumbo-sacral spine—3-6 views | $198.20  flat fee |
| CHT16 | Sacro-coccygeal area—2 views | $119.60  flat fee |
| CHT27 | Hip joint | $129.20  flat fee |
| CHT28 | Pelvic girdle | $163.00  flat fee |
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Schedule 3

*Scale of Charges─Exercise Physiology Services*

This Schedule must be read in conjunction with the Exercise Physiology Fee Schedule and Policy.

| **Item No.** | **Description** | **Max Fee (excl. GST)** |
| --- | --- | --- |
|  |  |  |
| **INITIAL ASSESSMENT** | | |
| EP101 | Initial assessment. History, planning, education, assessment and prescription of functional exercises specific to a worker’s injury, work tasks and/or work demands, in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1 hour. | $172.70  per hour  Max 1 hour |
| **INDIVIDUAL SESSION** | | |
| EP102 | Individual session. Review, planning, education, instruction, supervision and upgrade of prescribed functional and work-related exercise activities, in accordance with the Clinical Framework for the Delivery of Health Services. Maximum of 10 sessions (inclusive of initial assessment and any group sessions). Maximum 1 hour per session. | $172.70  per hour  Max 1 hour |
| **GROUP SESSION** | | |
| EP103 | Group session. A session (including aquatic) during which a maximum of 8 participants are constantly and directly supervised and assessed by the exercise physiologist. | $28.70  per participant |
| **WORKPLACE VISIT** | | |
| EP216 | Workplace visit. Review of the worker and workplace demands in accordance with the Clinical Framework for the Delivery of Health Services, for the purpose of determining ongoing treatment needs and where appropriate, reviewing movement patterns and techniques with work duties. The worker is to be present at the visit and for the best outcomes, the claims manager, supervisor/employer should also be present to facilitate a team approach. Maximum 1 hour. | $172.70  per hour  Max 1 hour |
| **EXERCISE PHYSIOLOGY MANAGEMENT PLAN** | | |
| EPMP | A ReturnToWorkSA exercise physiology management plan completed and submitted by the treating exercise physiologist. This plan is available on our website at [www.rtwsa.com](http://www.rtwsa.com). For claims managed by ReturnToWorkSA or their claims agents, the exercise physiologist is expected to submit a plan:  • prior to the 11th treatment if more than 10 treatments are likely to be required and have been approved by the claims manager, or  • prior to the expiry of an existing exercise physiology management plan if additional treatment is required and approved by the claims manager, or  • at the request of the claims manager.  For claims managed by self-insured employers, the plan must be requested by the self-insured employer. | $43.20  flat fee |
| **TELEPHONE CALLS** | | |
| EP552 | Telephone calls relating to the management of the worker’s claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator), worker’s representative, ReturnToWorkSA advisor, approved return to work service provider or worker’s referring/treating medical practitioner.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $24.00  flat fee |
| **TREATING EXERCISE PHYSIOLOGY REPORT** | | |
| EP820 | Treating exercise physiology report. A written clinical opinion, statement or response to questions relating to the progress and status of a worker’s functional and work-related exercise activities, requested in writing by the claims manager, self-insured employer, worker or worker’s representative. | $172.70  flat fee |
| **CASE CONFERENCE** | | |
| EP870 | Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator) or an approved return to work service provider\*.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $172.70  per hour |
| **TRAVEL TIME** | | |
| EP905 | Travel time. Travel by an exercise physiologist for the purpose of a case conference, home, hospital or workplace visit. | $146.60  per hour |
| **TELEHEALTH INITIAL ASSESSMENT** | | |
| EPTE9 | Telehealth/telephone initial assessment. History, planning, education, assessment and prescription of functional exercises specific to a worker’s injury, work tasks and/or work demands, in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1 hour. Where possible, video consultations are preferred. Exercise Physiologists are expected to refer on if the required treatment cannot adequately be provided via telehealth and a face-to-face consultation is not possible. | $172.70  per hour  Max 1 hour |
| **TELEHEALTH INDIVIDUAL SESSION** | | |
| EPTE2 | Telehealth/telephone individual session. Review, planning, education, instruction, supervision and upgrade of prescribed functional and work-related exercise activities. Maximum of 10 sessions, up to a maximum of 1 hour per session. An Exercise Physiology Management Plan is required on commencement of this service. | $172.70  per hour  Max 1 hour |
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Schedule 4

*Scale of Charges─Occupational Therapy Services*

This Schedule must be read in conjunction with the Occupational Therapy Fee Schedule and Policy.

| **Item No.** | **Description** | **Max Fee (excl. GST)** |
| --- | --- | --- |
|  |  |  |
| **CONSULTATIONS** | | |
| OT105 | Initial consultation. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. | $217.70  per hour |
| OT205 | Subsequent consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. | $217.70  per hour |
| **OCCUPATIONAL THERAPY MANAGEMENT PLAN** | | |
| OTMP | Occupational therapy management plan. An occupational therapy management plan completed and submitted by the treating occupational therapist. For claims managed by ReturnToWorkSA or their claims agents, the occupational therapist is expected to submit a plan:—prior to the 11th treatment if more than 10 treatments are likely to be required, or—prior to the expiry of an existing occupational therapy management plan if additional treatment is required, or—at the request of the claims manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer. | $54.60  flat fee |
| **WORKPLACE VISIT** | | |
| OT216 | Workplace visit. Review of the worker and workplace demands in accordance with the Clinical Framework for the Delivery of Health Services, for the purpose of determining ongoing treatment needs and where appropriate, reviewing movement patterns and techniques with work duties. The worker is to be present at the visit and for the best outcomes, the claims manager, supervisor/employer should also be present to facilitate a team approach. Maximum 1 hour. | $217.70  per hour  Max 1 hour |
| **CORRECTIVE/SERIAL SPLINTING** | | |
| OT300 | Fabrication/fitting/adjustment of splint | $217.70  per hour |
| **INDEPENDENT CLINICAL ASSESSMENT AND REPORT** | | |
| OT780 | Independent clinical assessment and report. An assessment of a worker by an occupational therapist, other than the treating occupational therapist, and provision of a report for the purpose of providing a clinical opinion on current treatment, comment on the worker’s functional ability and make recommendations on future occupational therapy management. This service must be requested in writing by the claims manager, self-insured employer, worker or worker’s representative. Maximum 4 hours. | $217.70  per hour  Max 4 hours |
| **ACTIVITIES OF DAILY LIVING ASSESSMENT AND REPORT** | | |
| OT760 | Activities of daily living assessment and report. Assessment of a worker’s level of functioning in relation to personal care, household tasks, recreational and social activities. This service includes provision of a report and must be requested in writing by the claims manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the claims manager or self-insured employer. Maximum 5 hours. | $217.70  per hour  Max 5 hours |
| **ACTIVITIES OF DAILY LIVING RE-ASSESSMENT** | | |
| OT762 | Activities of daily living: implementation and review. Re-assessment and review of a worker’s progress in functional ability, the ongoing need for third party services or hired equipment, therapeutic aids or appliances. This service must be requested in writing by the claims manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the claims manager or self-insured employer. Maximum 2 hours. | $217.70  per hour  Max 2 hours |
| **DRIVER ASSESSMENT, REHABILITATION AND REPORT** | | |
| OTDVA | Driver assessment and report. Assessment of the impact of a worker’s injury/condition on their ability to return to safe and independent driving and where appropriate, develop a driver rehabilitation plan. This service must be requested in writing by the claims manager, self-insured employer or treating medical practitioner. Maximum 5 hours. | $217.70  per hour  Max 5 hours |
| OTDVR | Driver rehabilitation and report. Implementation of a driver rehabilitation plan. This service must be requested in writing by the claims manager, self-insured employer or treating medical practitioner. | $217.70  per hour |
| **TELEPHONE CALLS** | | |
| OT552 | Telephone calls relating to the management of the worker’s claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator), worker’s representative, ReturnToWorkSA advisor, approved return to work service provider\* or worker’s referring/treating medical practitioner. Any time spent on communication directly related to an independent clinical assessment and report, activities of daily living assessment and report, an activities of daily living re-assessment or driver assessment/rehabilitation and report, is included within the total time invoiced for that service.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $30.20  flat fee |
| **TREATING OCCUPATIONAL THERAPY REPORT** | | |
| OT820 | Treating occupational therapist report. A written clinical opinion, statement or response to questions relating to the medical status and treatment of a worker, requested in writing by the claims manager, self-insured employer, worker or worker’s representative. | $217.70  flat fee |
| **CASE CONFERENCE** | | |
| OT870 | Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator) or an approved return to work service provider\*.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $217.70  per hour |
| **TRAVEL TIME** | | |
| OT905 | Travel time. Travel by an occupational therapist for the purpose of a case conference, home, hospital or worksite visit, independent clinical or activities of daily living assessment. | $184.80  per hour |
| **TELEHEALTH INITIAL CONSULTATION** | | |
| OTTE0 | Telehealth/telephone initial consultation. History, assessment, planning and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1 hour. Where possible, video consultations are preferred. Occupational Therapists are expected to refer on if the required treatment cannot adequately be provided via telehealth and a face-to-face consultation is not possible. | $217.70  per hour  Max 1 hour |
| **TELEHEALTH SUBSEQUENT CONSULTATION** | | |
| OTTE2 | Telehealth/telephone subsequent consultation. Review, planning, education, and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 10 sessions. An Occupational Therapy Management Plan is required on commencement of this service. Occupational Therapists are expected to refer on if the required treatment cannot adequately be provided via telehealth and a face-to-face consultation is not possible. | $217.70  per hour |
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Schedule 5

*Scale of Charges─Osteopathy Services*

This Schedule must be read in conjunction with the Osteopathy Fee Schedule and Policy.

| **Item No.** | **Description** | **Max Fee (excl. GST)** |
| --- | --- | --- |
|  |  |  |
| **CONSULTATIONS** | | |
| OS200 | Initial consultation. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. | $143.30  flat fee |
| OS220 | Subsequent consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. | $105.70  flat fee |
| **OSTEOPATHY MANAGEMENT PLAN** | | |
| OSMP | Osteopathy management plan. An osteopathy management plan completed and submitted by the treating osteopath. For claims managed by ReturnToWorkSA or their claims agents, the osteopath is expected to submit a plan:—prior to the 11th treatment if more than 10 treatments are likely to be required, or—prior to the expiry of an existing osteopathy management plan if additional treatment is required, or—at the request of the claims manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer. | $54.60  flat fee |
| **INDEPENDENT CLINICAL ASSESSMENT AND REPORT** | | |
| OS780 | Independent clinical assessment and report. An assessment of a worker by an osteopath, other than the treating osteopath, and provision of a report for the purpose of providing a clinical opinion on current treatment, comment on the worker’s functional ability and make recommendations on future osteopathy management. This service must be requested in writing by the claims manager, self-insured employer, worker or worker’s representative. Maximum 4 hours. | $217.70  per hour  Max 4 hours |
| **TELEPHONE CALLS** | | |
| OS552 | Telephone calls relating to the management of the worker’s claim, or to progress their recovery and return to work, made to or received from, a claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator), worker’s representative, ReturnToWorkSA advisor, approved return to work service provider\* or worker’s referring/treating medical practitioner. Any time spent on communication directly related to an independent clinical assessment and report is included within the total time invoiced for that service.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $30.20  flat fee |
| **TREATING OSTEOPATH REPORT** | | |
| OS820 | Treating osteopath report. A written clinical opinion, statement or response to questions relating to the medical status and treatment of a worker, requested in writing by the claims manager, self-insured employer, worker or worker’s representative. | $217.70  flat fee |
| **CASE CONFERENCE** | | |
| OS870 | Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator) or an approved return to work service provider\*.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $217.70  per hour |
| **TRAVEL TIME** | | |
| OS905 | Travel time. Travel by an osteopath for the purpose of a case conference, home or hospital visit or an independent clinical assessment. | $184.80  per hour |
| **RADIOLOGICAL SERVICES (INCLUDING INTERPRETATION BY AN OSTEOPATH)** | | |
| OST11 | Cervical spine—2 views | $169.00  flat fee |
| OST13 | Thoracic spine—2 views | $143.60  flat fee |
| OST15 | Lumbo-sacral spine 3—6 views | $198.20  flat fee |
| OST16 | Sacro-coccygeal area—2 views | $119.60  flat fee |
| OST27 | Hip joint | $129.20  flat fee |
| OST28 | Pelvic girdle | $163.00  flat fee |
|  |  |  |

Schedule 6

*Scale of Charges─Physiotherapy Services*

This Schedule must be read in conjunction with the Physiotherapy Fee Schedule and Policy.

| **Item No.** | **Description** | **Max Fee (excl. GST)** |
| --- | --- | --- |
|  |  |  |
| **CONSULTATIONS** | | |
| PT108 | Initial consultation. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. | $109.00  flat fee |
| PT210 | Subsequent consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. | $90.70  flat fee |
| PT212 | Long subsequent consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Due to the complexity of the presentation, extra time is required for history taking, examination, treatment, documenting and liaison. This type of consultation is expected in only a limited number of cases for example, the requirement of an interpreter, injuries following extensive burns, major trauma and major surgery requiring intensive post-operative treatment. | $109.10  flat fee |
| **RESTRICTED CONSULTATION** | | |
| PT214 | Restricted consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Due to the nature of the injury, extra time (up to one hour) is required for history taking, examination, treatment, documenting and liaison. A restricted consultation can only be requested by the treating physiotherapist where a prior consultation has been delivered. Up to 6 sessions may be requested and approval is granted by the claims manager on a case-by-case basis. Maximum 1 hour. | $217.70  per hour  Max 1 hour |
| **WORKPLACE VISIT** | | |
| PT216 | Workplace visit. Review of the worker and workplace demands in accordance with the Clinical Framework for the Delivery of Health Services, for the purposes of determining ongoing treatment needs and where appropriate, review movement patterns and techniques with work duties. The worker is to be present at the visit and for the best outcomes, the claims manager, supervisor/employer should also be present to facilitate a team approach. Maximum 1 hour. | $217.70  per hour  Max 1 hour |
| **CORRECTIVE/SERIAL SPLINTING** | | |
| PT300 | Fabrication/fitting/adjustment of a splint. | $217.70  per hour |
| PT390 | Materials used to construct or modify a splint. | Reasonable cost |
| **INDIVIDUAL AQUATIC SESSION** | | |
| PT415 | Individual aquatic session. A session during which an individual worker is constantly and directly supervised and assessed by the physiotherapist. Maximum 4 sessions. | $76.30  flat fee |
| **GROUP AQUATIC SESSION** | | |
| PT420 | Group aquatic session. A session during which a maximum of six participants are constantly and directly supervised and assessed by the physiotherapist. | $34.20  per worker |
| **INDIVIDUAL EXERCISE SESSION** | | |
| PT455 | Individual exercise session. A session during which an individual worker is constantly and directly supervised and assessed by the physiotherapist. Maximum 4 sessions. | $76.30  flat fee |
| **GROUP EXERCISE** | | |
| PT460 | Group exercise session. A session during which a maximum of six participants are constantly and directly supervised and assessed by the physiotherapist. | $34.20  per worker |
| **ENTRY FEE, AQUATIC OR EXERCISE FACILITY** | | |
| PT429 | Entry fee to an aquatic or exercise facility. Reimbursement to the physiotherapist for an entry fee paid to the aquatic or exercise facility by the physiotherapist, on behalf of a worker. Where a physiotherapist is employed by the facility, item PT429 cannot be charged. | Reasonable cost |
| **PHYSIOTHERAPY MANAGEMENT PLAN** | | |
| PTMP | Physiotherapy management plan. A physiotherapy management plan completed and submitted by the treating physiotherapist. For claims managed by ReturnToWorkSA or their claims agents, the physiotherapist is expected to submit a plan:—prior to the 11th treatment if more than 10 treatments are likely to be required, or—prior to the expiry of an existing physiotherapy management plan if additional treatment is required, or—at the request of the claims manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer. | $54.60  flat fee |
| **INDEPENDENT CLINICAL ASSESSMENT AND REPORT** | | |
| PT780 | Independent clinical assessment and report. An assessment of a worker, by a physiotherapist, other than the treating physiotherapist, and provision of a report for the purpose of providing a clinical opinion on current treatment, comment on the worker’s functional ability and make recommendations on future physiotherapy management. This service must be requested in writing by the claims manager, self-insured employer, worker or worker’s representative. Maximum 4 hours. | $217.70  per hour  Max 4 hours |
| **ACTIVITIES OF DAILY LIVING ASSESSMENT AND REPORT** | | |
| PT760 | Activities of daily living assessment and report. Assessment of a worker’s level of functioning in relation to personal care, household tasks, recreational and social activities. This service includes provision of a report and must be requested in writing by the claims manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the claims manager or self-insured employer. Maximum 5 hours. | $217.70  per hour  Max 5 hours |
| **ACTIVITIES OF DAILY LIVING RE-ASSESSMENT** | | |
| PT762 | Activities of daily living: Implementation and review. Re-assessment and review of a worker’s progress in functional ability, the ongoing need for third party services or hired equipment, therapeutic aids or appliances. This service must be requested in writing by the claims manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the claims manager or self-insured employer. Maximum 2 hours. | $217.70  per hour  Max 2 hours |
| **TELEPHONE CALLS** | | |
| PT552 | Telephone calls relating to the management of the worker’s claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator), worker’s representative, ReturnToWorkSA advisor, approved return to work service provider\* or worker’s referring/treating medical practitioner. Any time spent on communication directly related to an independent clinical assessment and report, activities of daily living assessment and report or an activities of daily living re-assessment, is included within the total time invoiced for that service.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $30.20  flat fee |
| **TREATING PHYSIOTHERAPY REPORT** | | |
| PT820 | Treating physiotherapist report. A written clinical opinion, statement or response to questions relating to the medical status and treatment of a worker, requested in writing by the claims manager, self-insured employer, worker or worker’s representative. A report may be initiated by the treating physiotherapist when barriers have been identified that need further explanation to facilitate claims progress, or when surgery has been requested and further information could assist the assessment process. When initiated by the physiotherapist, a copy should be provided to the claims manager, treating medical practitioner and where appropriate, all relevant parties. | $217.70  flat fee |
| **CASE CONFERENCE** | | |
| PT870 | Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator) or an approved return to work service provider\*.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $217.70  per hour |
| **TRAVEL TIME** | | |
| PT905 | Travel time. Travel by a physiotherapist for the purpose of a case conference, home, hospital or worksite visit, independent clinical or activities of daily living assessment. | $184.80  per hour |
| **TRAVEL EXPENSES** | | |
| PT907 | Travel expenses. Travel expenses incurred for a medical service delivered at the request of the claims manager or self-insured employer, where the provider is required to travel to a destination greater than 100km from the provider’s principal place of business or residential address. Car hire can only be charged where the provider travels by aircraft to deliver the service. | Reasonable cost |
| **TELEHEALTH INITIAL CONSULTATION** | | |
| PTTE9 | Telehealth/Telephone initial consultation. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Where possible, video consultations are preferred. Physiotherapists are expected to refer on if the required treatment cannot adequately be provided via telehealth and a face-to-face consultation is not possible. | $109.00  flat fee |
| **TELEHEALTH SUBSEQUENT CONSULTATION** | | |
| PTTE0 | Telehealth/telephone subsequent consultation. Review, planning, education, and exercise prescription/monitoring. Maximum 10 sessions. A Physiotherapy management plan is required on commencement of this service. | $90.70  flat fee |
| **TELEHEALTH LONG SUBSEQUENT CONSULTATION** | | |
| PTTE2 | Telehealth/telephone long subsequent consultation. Review, planning, education, and exercise prescription/monitoring. This type of consultation is expected in only a limited number of cases where longer physiotherapy treatment is required, for example to engage an interpreter or for education purposes. Maximum 10 sessions. A Physiotherapy management plan is required on commencement of this service. | $109.10  flat fee |
| **TELEHEALTH RESTRICTED CONSULTATION** | | |
| PTTE4 | Telehealth/telephone restricted consultation. Review, planning, education, and exercise prescription/monitoring. This type of consultation is expected in only a limited number of cases where longer physiotherapy treatment is required, for example to engage an interpreter or for education purposes. Prior approval from the claims manager is required. Maximum 10 sessions up to a maximum of 1 hour per session. A Physiotherapy management plan is required on commencement of this service. | $217.70  per hour  Max 1 hour |
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Schedule 7

*Scale of Charges─Psychology Services*

This Schedule must be read in conjunction with the Psychology Fee Schedule and Policy.

| **Item No.** | **Description** | **Max Fee (excl. GST)** |
| --- | --- | --- |
|  |  |  |
| **CONSULTATIONS** | | |
| PS200 | Initial consultation. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1.5 hours. | $242.40  per hour  Max 1.5 hours |
| PS220 | Subsequent consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1.5 hours. | $242.40  per hour  Max 1.5 hours |
| **PSYCHOLOGICAL ASSESSMENT** | | |
| PS230 | Psychological assessment. Clinical or psychometric assessment and interpretation of results. Maximum 2 hours. | $242.40  per hour  Max 2 hours |
| **NEUROPSYCHOLOGICAL ASSESSMENT AND REPORT** | | |
| PS232 | Neuropsychological assessment and report. Neuropsychological assessment of a worker and provision of a report by a clinical neuropsychologist. This service must be requested in writing by the claims manager or self-insured employer. Maximum 12 hours. | $242.40  per hour |
| **INTERVIEW WITH ANOTHER PERSON(S) OTHER THAN A WORKER** | | |
| PS240 | Interview with a person(s) other than a worker. Interview with a person(s) other than a worker (e.g. spouse, employer, supervisor, rehabilitation and return to work coordinator) which forms part of treatment and management of the worker’s injury. Maximum 1.5 hours. | $242.40  per hour  Max 1.5 hours |
| **GROUP THERAPY** | | |
| PS250 | Group therapy. Treatment in a group context where attendance includes a group of workers or family members under the continuous and direct supervision of a psychologist. ‘Group’ means attendance by a minimum of 2 persons and maximum of 15 persons. | $48.00  per participant |
| **WORKPLACE VISIT** | | |
| PS256 | Workplace visit. Review of the worker and workplace demands in accordance with the Clinical Framework for the Delivery of Health Services, for the purpose of determining ongoing treatment needs and where appropriate, reviewing techniques with work duties. The worker is to be present at the visit and for the best outcomes, the claims manager, supervisor/employer should also be present (where appropriate) to facilitate a team approach. Maximum 1 hour. | $242.40  per hour  Max 1 hour |
| **PSYCHOLOGY MANAGEMENT PLAN** | | |
| PSMP | Psychology management plan. A psychology management plan completed and submitted by the treating psychologist. For claims managed by ReturnToWorkSA or their claims agents, the psychologist is expected to submit a plan:—after every 6th consultation, or—prior to the expiry of an existing psychology management plan if additional treatment is required, or—at the request of the claims manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer. | $60.70  flat fee |
| **INDEPENDENT CLINICAL ASSESSMENT AND REPORT** | | |
| PS780 | Independent clinical assessment and report. An assessment of a worker by a psychologist, other than the treating psychologist, and provision of a report for the purpose of providing a clinical opinion on current treatment, comment on the worker’s functional ability and make recommendations on future psychology and/or mental health management. This service must be requested in writing by the claims manager, self-insured employer, worker or worker’s representative. | $242.40  per hour |
| **TELEPHONE CALLS** | | |
| PS552 | Telephone calls. Telephone calls relating to the management of the worker’s claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator), worker’s representative, ReturnToWorkSA advisor, approved return to work service provider\* or worker’s referring/treating medical practitioner. Any time spent on communication directly related to an independent clinical assessment and report is included within the total time invoiced for that service. Maximum 0.5 hours.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $242.40  per hour  Max 0.5 hours |
| **TREATING PSYCHOLOGY REPORTS** | | |
| PS810 | Treating psychologist comprehensive report. A comprehensive written clinical opinion, statement or response to questions relating to the diagnosis, medical status and treatment of a worker. This report must be requested in writing by the claims manager, self-insured employer, worker or worker’s representative. Maximum 4 hours. | $242.40  per hour  Max 4 hours |
| PS820 | Treating psychologist summary report. A brief written clinical opinion, statement or response to a limited number of questions relating to the diagnosis, medical status and treatment of a worker. This report can either be requested in writing by the claims manager, self-insured employer, worker or worker’s representative or initiated by the psychologist after every 6th consultation. When initiated by the psychologist, a copy should be provided to the claims manager, treating medical practitioner and where appropriate, all relevant parties. | $242.40  flat fee |
| **CASE CONFERENCE** | | |
| PS870 | Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator) or an approved return to work service provider\*.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $242.40  per hour |
| **TRAVEL TIME** | | |
| PS905 | Travel time. Travel by a psychologist for the purpose of a case conference, home or hospital visit or an independent clinical assessment. | $205.70  per hour |
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Schedule 8

*Scale of Charges─Speech Pathology Services*

This Schedule must be read in conjunction with the Speech Pathology Fee Schedule and Policy.

| **Item No.** | **Description** | **Max Fee (Excl. GST)** |
| --- | --- | --- |
|  |  |  |
| **INITIAL CONSULTATION** | | |
| E0300 | Initial consultation. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 2.5 hours. | $217.70  per hour  Max 2.5 hours |
| **SUBSEQUENT CONSULTATION** | | |
| E0320 | Subsequent consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1 hour. | $217.70  per hour  Max 1 hour |
| **SPEECH PATHOLOGY MANAGEMENT PLAN** | | |
| E0MP | Speech pathology management plan. A speech pathology management plan completed and submitted by the treating speech pathologist. For claims managed by ReturnToWorkSA or their claims agents, the speech pathologist is expected to submit a plan:—prior to the 11th treatment if more than 10 treatments are likely to be required, or—prior to the expiry of an existing speech pathology management plan if additional treatment is required, or—at the request of the claims manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer. | $54.60  flat fee |
| **TELEPHONE CALLS** | | |
| E0552 | Telephone calls relating to the management of the worker’s claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator), worker’s representative, ReturnToWorkSA advisor, approved return to work service provider\* or worker’s referring/treating medical practitioner.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $30.20  flat fee |
| **TREATING SPEECH PATHOLOGY REPORT** | | |
| E0820 | Treating speech pathologist report. A written clinical opinion, statement or response to questions relating to the medical status and treatment of a worker, requested in writing by the claims manager, self-insured employer, worker or worker’s representative. | $326.70  flat fee |
| **CASE CONFERENCE** | | |
| E0870 | Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator) or an approved return to work service provider\*.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $217.70  per hour |
| **TRAVEL TIME** | | |
| E0905 | Travel time. Travel by a speech pathologist for the purpose of case conference, home or hospital visit. | $184.80  per hour |
|  |  |  |

Schedule 9

*Scale of Charges─Audiology Services*

This Schedule must be read in conjunction with the Audiology Fee Schedule and Policy.

| **Item No.** | **Description** | **Max Fee (excl. GST)** |
| --- | --- | --- |
|  |  |  |
| **ASSESSMENT** | | |
| AU101 | Assessment: An assessment determines the worker’s hearing requirements and independence level as a result of their work injury. This includes obtaining a clinical history, diagnostic testing including appropriately masked air and bone conduction audiometry, collaborative rehabilitative goal setting, reasonable cost effective recommendations, clinical justification and a brief written summary to the claims manager inclusive of the above. The Audiologist/Audiometrist must refer the worker to another clinician if the patient presents with issues outside of their scope of practice. | Audiologist: $226.70  Audiometrist: $203.50  flat fee |
| **MONAURAL FITTING** | | |
| AU102 | Monaural Fitting: Inclusive of the supply and fitting of the hearing aid, instructions around appropriate use of the hearing aid, use of relevant outcome measures (such as the Client Oriented Scale of Improvement as an example), subsequent follow-up reviews to ensure optimal recovery and transition following the audiological intervention for 1 year and 1 year supply of batteries (where applicable). Hearing aid specifications and details (serial numbers and device codes) and completed outcome measures must be provided to the claims manager. | $831.70  flat fee |
| **BINAURAL FITTING** | | |
| AU103 | Binaural Fitting: Inclusive of the supply and fitting of the hearing aid, instructions around appropriate use of the hearing aid, use of relevant outcome measures (such as the Client Oriented Scale of Improvement as an example), subsequent follow-up reviews to ensure optimal recovery and transition following the audiological intervention for 1 year and 1 year supply of batteries (where applicable). Binaural Hearing packages will only be provided for demonstrated compensable hearing loss in both ears. Hearing aid specifications and details (serial numbers and device codes) and completed outcome measures must be provided to the claims manager. | $1220.80  flat fee |
| **HEARING AID** | | |
| AU201 | Hearing Aid: The worker is assigned the appropriate hearing aid depending upon the clinical need determined through audiogram findings, lifestyle and dexterity of the worker. The fee shall be the provider specific wholesale price of hearing aid + 5% mark-up to the maximum specified in the fee schedule. | $2020.00  maximum |
| AU206 | Rechargeable Hearing Aid: The worker is assigned the appropriate hearing aid depending upon the clinical need determined through audiogram findings, lifestyle and dexterity. The fee shall be the provider specific wholesale price of hearing aid + 5% mark-up to the maximum specified in the fee schedule. | $2020.00  maximum |
| **REHABILITATION AND ADJUSTMENT** | | |
| AU104 | Rehabilitation and adjustment: The monaural or binaural initial package fee covers rehabilitation and adjustment for 1 year following the initial fitting. Following this period, audiological services may be provided for hearing aid adjustment or rehabilitation to ensure optimal recovery and transition following the previous intervention. Only applicable 12 months after the fitting of a hearing device for a maximum of up to 6 hours of service during the life of the hearing aid, a brief summary of rehabilitation/adjustment to be provided to the claims manager and each service to be rounded to the nearest 6 minutes. | Audiologist: $226.70  Audiometrist: $203.50  per hour  Max 6 hours |
| **HEARING AID REPAIRS** | | |
| AU203 | Hearing aid repairs: The claims manager will only consider payments for the repair and maintenance of hearing aids/devices as a result of normal wear and tear, that are not covered by the manufacturer or supplier warranty and following receipt of the request for repair or a replacement device form and the manufacturer’s quote for the repairs. | Reasonable cost |
| **BATTERIES** | | |
| AU204 | Batteries: The monaural or binaural package fee includes a one year supply of batteries. Only applicable 12 months after the fitting of a hearing device. Fee is per hearing device/year. | $101.00  maximum |
| **REPORT** | | |
| AU105 | Standard report: A standard report can only be requested by the claims manager, and should be provided within 10 days of the request. The report should be based on the provider’s notes/assessments carried out and would not usually require consultation with the patient. | Audiologist: $226.70  Audiometrist: $203.50  flat fee |
| **TELEHEALTH MONAURAL FITTING** | | |
| AUTE2 | Telehealth Monaural supply, fitting and subsequent follow up for 1 year. This fee is inclusive of supply and fitting of a like-for-like, pre-programmed, hearing aid when: the existing device has been lost or damaged and is not covered by warranty or insurance, or 5 years has elapsed and the workers hearing needs have not changed. Includes 1 year of subsequent follow-up reviews and 1 year supply of batteries. If a like-for-like device cannot be provided or is not suitable, this fee item cannot be charged and telehealth is not suitable. Claims manager approval is required prior to conducting telehealth services. Hearing aid specifications and details (serial numbers and device codes) and completed outcome measures must be provided to the claims manager. | $831.70  flat fee |
| **TELEHEALTH BINAURAL FITTING** | | |
| AUTE3 | Telehealth Binaural supply, fitting and subsequent follow up for 1 year. This fee is inclusive of supply and fitting of a like-for-like, pre-programmed, hearing aid when: the existing device has been lost or damaged and is not covered by warranty or insurance, or 5 years has elapsed and the workers hearing needs have not changed. Includes 1 year of subsequent follow-up reviews and 1 year supply of batteries. If a like-for-like device cannot be provided or is not suitable, this fee item cannot be charged and telehealth is not suitable. Binuaral hearing packages can only be provided for demonstrated compensable hearing loss in both ears. Claims manager approval is required prior to conducting telehealth services. Hearing aid specifications and details (serial numbers and device codes) and completed outcome measures must be provided to the claims manager. | $1220.80  flat fee |
| **TELEHEALTH REHABILITATION AND ADJUSTMENT** | | |
| AUTE4 | Telehealth rehabilitation and adjustment: The telehealth monaural or binaural initial package fee covers rehabilitation and adjustment for 1 year following the initial fitting. Following this period, telehealth audiological services may be provided for hearing aid adjustment or rehabilitation to ensure optimal recovery and transition following the previous intervention. Claims manager approval is required prior to conducting telehealth services. Only applicable 12 months after the fitting of a hearing device for a maximum of up to 6 hours of service during the life of the hearing aid, a brief summary of rehabilitation/adjustment to be provided to the case manager and each service to be rounded to the nearest 6 minutes. | Audiologist: $226.70  Audiometrist: $203.50  per hour  Max 1 hour |
|  |  |  |

Schedule 10

*Scale of Charges—Accredited Mental Health Social Work Services*

This Schedule must be read in conjunction with the Accredited Mental Health Social Worker Fee Schedule and Guidelines.

| **Item No.** | **Description** | **Max Fee (excl. GST)** |
| --- | --- | --- |
|  |  |  |
| **CONSULTATIONS** | | |
| MHSW01 | Initial consultation. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1.5 hours. | $172.70  per hour  Max 1.5 hours |
| MHSW02 | Subsequent consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1.5 hours. | $172.70  per hour  Max 1.5 hours |
| **STANDARDISED ASSESSMENT** | | |
| MHSW04 | Standardised assessment. Standardised clinical or psychometric assessment and interpretation of results. Maximum 2 hours. | $172.70  per hour  Max 2 hours |
| **INTERVIEW WITH ANOTHER PERSON(S) OTHER THAN A WORKER** | | |
| MHSW10 | Interview with a person(s) other than a worker. Interview with a person(s) other than a worker (e.g. spouse, employer, supervisor, rehabilitation and return to work coordinator) which forms part of treatment and management of the worker’s injury. Maximum 1.5 hours. | $172.70  per hour  Max 1.5 hours |
| **GROUP THERAPY** | | |
| MHSW20 | Group therapy. Treatment in a group context where attendance includes a group of workers or family members under the continuous and direct supervision of an accredited mental health social worker. ‘Group’ means attendance by a minimum of 2 persons and maximum of 15 persons. | $34.60  per participant |
| **WORKPLACE VISIT** | | |
| MHSW26 | Workplace visit. Review of the worker and workplace demands in accordance with the Clinical Framework for the Delivery of Health Services, for the purpose of determining ongoing treatment needs and where appropriate, reviewing techniques with work duties. The worker is to be present at the visit and for the best outcomes, the claims manager, supervisor/employer should also be present (where appropriate) to facilitate a team approach. Maximum 1 hour. | $172.70  per hour  Max 1 hour |
| **MENTAL HEALTH MANAGEMENT PLAN** | | |
| MHSWMP | Mental health management plan. A mental health management plan completed and submitted by the treating accredited mental health social worker. For claims managed by ReturnToWorkSA or their claims agents, the AMHSW is expected to submit a plan: after every 6th consultation, or prior to the expiry of an existing mental health management plan if additional treatment is required, or at the request of the claims manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer. | $43.20  flat fee |
| **TELEPHONE CALLS** | | |
| MHSW52 | Telephone calls. Telephone calls relating to the management of the worker’s claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator), worker’s representative, ReturnToWorkSA advisor, approved return to work service provider\* or worker’s referring/treating medical practitioner. Maximum 0.5 hours.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $172.70  per hour  Max 0.5 hours |
| **TREATING ACCREDITED MENTAL HEALTH SOCIAL WORKER REPORTS** | | |
| MHSW60 | Treating accredited mental health social work summary report. A brief written clinical opinion, statement or response to a limited number of questions relating to the diagnosis, medical status and treatment of a worker. This report can either be requested in writing by the claims manager, self-insured employer, worker or worker’s representative or initiated by the accredited mental health social worker after every 6th consultation. When initiated by the accredited mental health social worker, a copy should be provided to the claims manager, treating medical practitioner and where appropriate, all relevant parties. | $172.70  per hour  Max 1 hour |
| MHSW62 | Treating accredited mental health social work comprehensive report. A comprehensive written clinical opinion, statement or response to questions relating to the diagnosis, medical status and treatment of a worker. This report must be requested in writing by the claims manager, self-insured employer, worker or worker’s representative. Maximum 2 hours. | $172.70  per hour  Max 2 hours |
| **CASE CONFERENCE** | | |
| MHSW70 | Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator) or an approved return to work service provider\*.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $172.70  per hour |
| **TRAVEL TIME** | | |
| MHSW90 | Travel time. Travel by an accredited mental health social worker for the purpose of a case conference, home, hospital or workplace visit. | $146.60  per hour |
|  |  |  |

Schedule 11

Scale of Charges—Counsellor Services

This Schedule must be read in conjunction with the Counselling Fee Schedule and Guidelines.

| **Item No.** | **Description** | **Max Fee (excl. GST)** |
| --- | --- | --- |
|  |  |  |
| **CONSULTATIONS** | | |
| MHC01 | Initial consultation. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1.5 hours. | $172.70  per hour  1.5 hours |
| MHC02 | Subsequent consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1.5 hours. | $172.70  per hour  Max 1.5 hours |
| **INTERVIEW WITH ANOTHER PERSON(S) OTHER THAN A WORKER** | | |
| MHC10 | Interview with a person(s) other than a worker. Interview with a person(s) other than a worker (e.g. spouse, employer, supervisor, rehabilitation and return to work coordinator) which forms part of treatment and management of the worker’s injury. Maximum 1.5 hours. | $172.70  per hour  Max 1.5 hours |
| **GROUP THERAPY** | | |
| MHC20 | Group therapy. Treatment in a group context where attendance includes a group of workers or family members under the continuous and direct supervision of a counsellor. ‘Group’ means attendance by a minimum of 2 persons and maximum of 15 persons. | $34.60  per participant |
| **WORKPLACE VISIT** | | |
| MHC26 | Workplace visit. Review of the worker and workplace demands in accordance with the Clinical Framework for the Delivery of Health Services, for the purpose of determining ongoing treatment needs and where appropriate, reviewing techniques with work duties. The worker is to be present at the visit and for the best outcomes, the claims manager, supervisor/employer should also be present (where appropriate) to facilitate a team approach. Maximum 1 hour. | $172.70  per hour  Max 1 hour |
| **MENTAL HEALTH MANAGEMENT PLAN** | | |
| MHCMP | Mental health management plan. A mental health management plan completed and submitted by the treating counsellor. For claims managed by ReturnToWorkSA or their claims agents, the counsellor is expected to submit a plan: after every 6th consultation, or prior to the expiry of an existing mental health management plan if additional treatment is required, or at the request of the claims manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer. | $43.20  flat fee |
| **TELEPHONE CALLS** | | |
| MHC52 | Telephone calls. Telephone calls relating to the management of the worker’s claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator), worker’s representative, ReturnToWorkSA advisor, approved return to work service provider\* or worker’s referring/treating medical practitioner. Maximum 0.5 hours.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $172.70  per hour  Max 0.5 hours |
| **TREATING COUNSELLOR REPORTS** | | |
| MHC60 | Treating counsellor summary report. A brief written clinical opinion, statement or response to a limited number of questions relating to the diagnosis, medical status and treatment of a worker. This report can either be requested in writing by the claims manager, self-insured employer, worker or worker’s representative or initiated by the counsellor after every 6th consultation. When initiated by the counsellor, a copy should be provided to the claims manager, treating medical practitioner and where appropriate, all relevant parties. Maximum 1 hour. | $172.70  per hour  Max 1 hour |
| MHC62 | Treating counsellor comprehensive report. A comprehensive written clinical opinion, statement or response to questions relating to the diagnosis, medical status and treatment of a worker. This report must be requested in writing by the claims manager, self-insured employer, worker or worker’s representative. Maximum 2 hours. | $172.70  per hour  Max 2 hours |
| **CASE CONFERENCE** | | |
| MHC70 | Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator) or an approved return to work service provider\*.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $172.70  per hour |
| **TRAVEL TIME** | | |
| MHC90 | Travel time. Travel by a counsellor for the purpose of a case conference, home, hospital or workplace visit. | $146.60  per hour |
|  |  |  |

Schedule 12

Scale of Charges—Mental Health Occupational Therapy Services

This Schedule must be read in conjunction with the Mental Health Occupational Therapy Fee Schedule and Guidelines.

| **Item No.** | **Description** | **Max Fee (excl. GST)** |
| --- | --- | --- |
|  |  |  |
| **CONSULTATIONS** | | |
| MHOT01 | Initial consultation. History, assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1.5 hours. | $217.70  per hour  Max 1.5 hours |
| MHOT02 | Subsequent consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1.5 hours. | $217.70  per hour  Max 1.5 hours |
| **STANDARDISED ASSESSMENT** | | |
| MHOT04 | Standardised assessment. Standardised clinical or psychometric assessment and interpretation of results. Maximum 2 hours. | $217.70  per hour  Max 2 hours |
| **INTERVIEW WITH ANOTHER PERSON(S) OTHER THAN A WORKER** | | |
| MHOT10 | Interview with a person(s) other than a worker. Interview with a person(s) other than a worker (e.g. spouse, employer, supervisor, rehabilitation and return to work coordinator) which forms part of treatment and management of the worker’s injury. Maximum 1.5 hours. | $217.70  per hour  Max 1.5 hours |
| **GROUP THERAPY** | | |
| MHOT20 | Group therapy. Treatment in a group context where attendance includes a group of workers or family members under the continuous and direct supervision of a mental health occupational therapist. ‘Group’ means attendance by a minimum of 2 persons and maximum of 15 persons. | $43.10  per participant |
| **WORKPLACE VISIT** | | |
| MHOT26 | Workplace visit. Review of the worker and workplace demands in accordance with the Clinical Framework for the Delivery of Health Services, for the purpose of determining ongoing treatment needs and where appropriate, reviewing techniques with work duties. The worker is to be present at the visit and for the best outcomes, the claims manager, supervisor/employer should also be present (where appropriate) to facilitate a team approach. Maximum 1 hour. | $217.70  per hour  Max 1 hour |
| **MENTAL HEALTH MANAGEMENT PLAN** | | |
| MHMP | Mental health management plan. A mental health management plan completed and submitted by the treating mental health occupational therapist. For claims managed by ReturnToWorkSA or their claims agents, the mental health occupational therapist is expected to submit a plan: after every 6th consultation, or prior to the expiry of an existing mental health management plan if additional treatment is required, or at the request of the claims manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer. | $54.60  flat fee |
| **INDEPENDENT CLINICAL ASSESSMENT AND REPORT** | | |
| MHOT30 | Independent clinical assessment and report. An assessment of a worker by a mental health occupational therapist, other than the treating mental health occupational therapist, and provision of a report for the purpose of providing a clinical opinion on current treatment, comment on the worker’s functional ability and make recommendations on future mental health management. This service must be requested in writing by the claims manager, self-insured employer, worker or worker’s representative. Maximum 4 hours. | $217.70  per hour  Max 4 hours |
| **ACTIVITIES OF DAILY LIVING ASSESSMENT AND REPORT** | | |
| MHOT40 | Activities of daily living assessment and report. Assessment of a worker’s level of functioning in relation to personal care, household tasks, recreational and social activities. This service includes provision of a report and must be requested in writing by the claims manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the claims manager or self-insured employer. Maximum 5 hours. | $217.70  per hour  Max 5 hours |
| **ACTIVITIES OF DAILY LIVING IMPLEMENTATION AND REPORT** | | |
| MHOT42 | Activities of daily living: implementation and review. Re-assessment and review of a worker’s progress in functional ability, the ongoing need for third party services or hired equipment, therapeutic aids or appliances. This service must be requested in writing by the claims manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the claims manager or self-insured employer. Maximum 2 hours. | $217.70  per hour  Max 2 hours |
| **TELEPHONE CALLS** | | |
| MHOT52 | Telephone calls. Telephone calls relating to the management of the worker’s claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator), worker’s representative, ReturnToWorkSA advisor, approved return to work service provider\* or worker’s referring/treating medical practitioner. Any time spent on communication directly related to an independent clinical assessment and report is included within the total time invoiced for that service. Maximum 0.5 hours.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $217.70  per hour  Max 0.5 hours |
| **TREATING MENTAL HEALTH OCCUPATIONAL THERAPY REPORTS** | | |
| MHOT60 | Treating mental health occupational therapist summary report. A brief written clinical opinion, statement or response to a limited number of questions relating to the diagnosis, medical status and treatment of a worker. This report can either be requested in writing by the claims manager, self-insured employer, worker or worker’s representative or initiated by the treating mental health occupational therapist after every 6th consultation. When initiated by the mental health occupational therapist, a copy should be provided to the claims manager, treating medical practitioner and where appropriate, all relevant parties. Maximum 1 hour. | $217.70  per hour  Max 1 hour |
| MHC62 | Treating mental health occupational therapist comprehensive report. A comprehensive written clinical opinion, statement or response to questions relating to the diagnosis, medical status and treatment of a worker. This report must be requested in writing by the claims manager, self-insured employer, worker or worker’s representative. Maximum 4 hours. | $217.70  per hour  Max 4 hours |
| **CASE CONFERENCE** | | |
| MHOT70 | Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker’s employer (including the employer’s return to work coordinator) or an approved return to work service provider\*.  \*An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider. | $217.70  per hour |
| **TRAVEL TIME** | | |
| MHOT90 | Travel time. Travel by a mental health occupational therapist for the purpose of a case conference, home, hospital or workplace visit, independent clinical or activities of daily living assessment or re-assessment. | $184.80  per hour |
|  |  |  |

Schedule 13

*Scale of Charges─Private Hospital and Day Surgery Facility Services*

This Schedule must be read in conjunction with the Private Hospital Fee Schedule and Guidelines.

Part 1—Preliminary

**1—Intepretations**

(1) In this Schedule, unless the contrary intention appears—

***admission*** means the formal administrative process of a private hospital or day surgery facility by which the hospital or facility commences the provision of treatment, care, accommodation and other services to a patient.

***admitted*** in relation to a patient in a private hospital or day surgery facility, means that the patient has undergone the formal admission process of the hospital or facility and has not been discharged.

***AR-DRG*** means Australian Refined Diagnosis Related Group.

***criteria for admission*** means the criteria for admission set out in subclause (5) below.

***day*** means a calendar day.

***Day Only Procedures Manual*** means the *Day Only Procedures Manual* published by the Commonwealth Department of Health and Aged Care, as in force at time of service.

***discharge*** means the formal administrative process of a private hospital or day surgery facility by which the hospital or facility ceases the provision of treatment, care, accommodation and other services to a patient.

***discharged*** in relation to a person who has been a patient in a private hospital or day surgery facility, means that the person has undergone the formal discharge process of the hospital or facility.

***inlier patient*** means an admitted patient whose length of stay in a private hospital for a service identified in Table 2 falls within the range of the Upper Trim point days and the Lower Trim point days (inclusive) specified in Table 2 corresponding to that service.

***inpatient*** in relation to a private hospital, means an admitted patient who, following a clinical decision, requires or is expected to require overnight treatment for a minimum of one night.

***length of stay***, in relation to an admitted patient in a private hospital, means the number of days between the day of admission of the patient to the hospital and the day of discharge of the patient from the hospital—

(a) counting the day of admission as one day; and

(b) excluding the day of discharge (unless it is also the day of admission).

***long stay outlier patient*** means an admitted patient whose length of stay in a private hospital for a service identified in Table 2, is greater than the Upper Trim point days specified in Table 2 corresponding to that service.

***Manual*** means the *Australian Refined Diagnosis Related Groups, Version 7.0 (as amended)*, produced by the Commonwealth Department of Health and Ageing.

***short stay outlier patient*** means an admitted patient whose length of stay in a private hospital for a service identified in Table 2 for which the Lower Trim point days specified in Table 2 in respect of that service is 2 or more, is less than that Lower Trim point days but greater than zero.

(2) A reference in this Schedule to a Table of a specified number is a reference to the Table of that number in Part 4.

(3) For the purposes of this Schedule—

(a) AR-DRG reference numbers or descriptions are as set out in the Manual; and

(b) terms and abbreviations used in AR-DRG descriptions have the meanings given by the Manual.

(4) For the purposes of this Schedule—

(a) A charge determined in accordance with Part 2 or 3 for a service includes (where applicable) the cost of the following:

(i) accommodation;

(ii) intensive care unit;

(iii) theatre;

(iv) common use theatre items;

(v) pharmaceutical items directly related to the condition being treated;

(vi) television;

(vii) newspapers;

(viii) local telephone calls;

(ix) all hotel services (e.g. meals etc);

(x) consumable items.

(b) A charge determined in accordance with Part 2 or 3 for a service does not include the following costs:

(i) the cost of prostheses;

(ii) the cost of substituted high cost single use items not commonly used in Australian clinical practice for delivery of the service where the substitution for the usual item can be demonstrated to have been necessary for the treatment of the patient;

(iii) the cost of allied health treatment (such as physiotherapy, dietetics, podiatry, psychology, social work, speech pathology etc);

(iv) the cost of pharmaceutical items provided on discharge of a patient;

(v) the cost of pharmaceutical items required for a patient for maintenance of an unrelated condition;

(vi) the cost of splints and braces required for the discharge of a patient;

(vii) transfer costs;

(viii) boarder fees.

(5) For the purposes of this Schedule, a patient qualifies for admission to a private hospital or day surgery facility if he or she satisfies 1 of the following criteria:

(a) The patient is to receive Day Only Band 1, 2, 3 and 4 services (excluding uncertified Type C professional attention procedures) as specified in the *Day Only Procedures Manual*.

(b) The patient is to receive a Type C professional attention procedure as specified in the Day Only Procedures Manual and there is an accompanying certification by a medical practitioner that an admission is necessary on the grounds of the medical condition of the patient or other special circumstances relating to the patient.

(c) The patient, following a clinical decision, is expected to require overnight treatment for a minimum of one night.

(d) The patient is to receive a Type B professional attention procedure as specified in the *Day Only Procedures Manual* and there is an accompanying certification by a medical practitioner that an overnight admission is necessary on the grounds of the medical condition of the patient or other special circumstances relating to the patient.

Part 2—Private Hospital Services

**2—Rehabilitation, psychiatric and pain assessment or management services by a private hospital**

The charges for the provision to a patient by a private hospital of the rehabilitation, psychiatric and pain assessment or management services specified in Table 1 are as specified in that table.

**3—Other private hospital services**

(1) Subject to Clause 2, the charges for the provision to an admitted patient by a private hospital of the services specified in Table 2 are as determined in accordance with this clause.

(2) Subject to subclause (5), the maximum charge for a service identified in Table 2 for an inlier patient is the Maximum Charge specified in Column 3 of Table 2 corresponding to that service.

(3) Subject to subclause (5), the maximum charge for a service identified in Table 2 for a short stay outlier patient is calculated as follows:

Maximum Charge = Rate per day x LOS

where—

(a) the ***Rate per day*** is the Maximum Charge per day rate specified in Column 6 of Table 2 corresponding to that service; and

(b) ***LOS*** is the length of stay of the patient in the hospital.

(4) Subject to subclause (5), the maximum charge for a service identified in Table 2 for a long stay outlier patient is calculated as follows:

Maximum Charge = Schedule Charge + (rate per day x (LOS – Upper trim point))

where—

(a) the ***Schedule Charge*** is the Maximum Charge specified in Column 3 of Table 2 corresponding to that service;

(b) the ***Rate per day*** is the Maximum Charge per day rate specified in Column 6 of Table 2 corresponding to that service;

(c) ***LOS*** is the length of stay of the patient in the hospital; and

(d) the ***Upper trim point*** is the Upper Trim point days specified in Column 4 of Table 2 corresponding to that service.

(5) Where the patient is transferred from the private hospital to another hospital, the maximum charge for the service provided by the transferor hospital is 80% of the maximum charge determined in accordance with subclauses (2), (3) or (4) above (as applicable).

Part 3—Day Surgery Facility Services

**4—Day Surgery Facility Services**

The charges for the provision to an admitted patient by a day surgery facility of same day services included in Table 3 are the accommodation and theatre charges determined in accordance with Table 3.

Part 4—Tables

**Table 1**

A charge applicable to an admitted patient is not payable unless the patient is admitted in accordance with the criteria for admission.

Private rooms are allocated on the basis of clinical need and the cost of such rooms is, unless otherwise stated, included in the fees set out below. Where a patient requests a private room, ReturnToWorkSA will not be responsible for or accept any additional fee or surcharge.

| **Item No.** | **Description** | **Max Fee (excl. GST)** |
| --- | --- | --- |
|  |  |  |
| **HOSPITAL REHABILITATION SERVICES** | | |
| **Rehabilitation orthopaedic program for inpatients**  Orthopaedic programs involve referral and assessment by the rehabilitation coordinator of the program. It is a defined program with intense service provision. Rapid improvement is expected and there are specific outcome goals. The program includes physiotherapy, aquatic therapy, occupational therapy, case conferences and discharge planning. | | |
| PR600 | Rehabilitation orthopaedic program: 1 or more days but not more than 16 days | $910.40 per day |
| PR605 | Rehabilitation orthopaedic program: 17 or more days | $763.40 per day |
| **Rehabilitation trauma program for inpatients**  Trauma programs involve referral and assessment by the rehabilitation coordinator of the program. It is a defined program with intense service provision. Rapid improvement is expected and there are specific outcome goals. The program includes physiotherapy, aquatic therapy, occupational therapy, speech therapy, case conferences and discharge planning. | | |
| PR610 | Rehabilitation trauma program: 1 or more days but not more than 20 days | $1,085.60 per day |
| PR615 | Rehabilitation trauma program: 21 or more days | $980.10 per day |
| **PSYCHIATRIC SERVICES** | | |
| **Inpatient services** | | |
| PR800 | Psych inpatient: 1 or more days but not more than 14 days | $873.50 per day |
| PR803 | Psych inpatient: 15 or more days | $672.20 per day |
| PR822 | Psych inpatient: Electro-convulsive therapy (ECT) | $373.80 per day |
| PR850 | Psych inpatient private room allocated on the basis of clinical need | Extra $21.80 per day |
| **Drug and alcohol programs—inpatient**  This program provides specialised treatment and care for patients with alcohol or drug dependencies (including analgesics/narcotics/ opiates and Benzodiazepine). The program is managed by a multi-disciplinary team including a medical director and consultant psychiatrists. Where required, the program involves a medically controlled, safe withdrawal of drugs or alcohol. | | |
| PR990 | Drug & alcohol program—inpatient, 1 or more days but not more than 10 days | $990.20 per day |
| PR991 | Drug & alcohol program—inpatient, 11 or more days | $724.80 per day |
| **Same-day psychiatric services**  A day program is usually available to provide ongoing support and care to patients after discharge from treatment as inpatients. It is managed by a multi-disciplinary team of health care professionals and is tailored to the individual needs of the patient. It can include specialised therapy modules including cognitive behavioural therapy, relaxation, assertiveness skills and anxiety management.  Outreach is treatment or care provided by the hospital to a non-admitted patient at a location outside the hospital premises (being treatment or care provided as a direct substitute for treatment or care that would normally be provided on the hospital premises).  Please note, for billing purposes, the O in item numbers for same day services is an alphabetical letter not the number zero. | | |
| PRO81 | Psych same day group session | $119.10 |
| PRO82 | Psych same day ECT day program | $620.80 |
| PRO83 | Psych same day half-day program | $317.90 |
| PRO84 | Psych same day—day program | $503.00 |
| PRO95 | Psych same day outreach | $287.10 |
| **OTHER SERVICES** | | |
| **Inpatient pain assessment/management** | | |
| PR700 | Inpatient pain assess/mgmt: 1 or more days but not more than 7 days | $798.90 per day |
| PR705 | Inpatient pain assess/mgmt: 8 or more days but not more than 14 days | $750.60 per day |
| PR710 | Inpatient pain assess/mgmt: 15 or more days | $487.90 per day |
| **Pain pumps for non-admitted patients** | | |
| PR720 | 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 for a non-admitted patient. | $277.30 |
|  |  |  |

Other Services

**Table 2**

A charge applicable to an admitted patient is not payable unless the patient is admitted in accordance with the criteria for admission.

Private rooms are allocated on the basis of clinical need and the cost of such rooms is included in the charges set out below. Where a patient requests a private room, ReturnToWorkSA will not be responsible, or accept any additional fee or surcharge.

Inpatient services—Diagnostic Related Groups Version 7.0

| **Item No.** | **Description** | **Max Fee  (Ex GST)** | **Lower Trim  Point Days** | **Upper Trim  Point Days** | **Max Per Day  Rate (Ex GST)** |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| 801A | OR procedures unrelated to principal diagnosis w catastrophic cc | $22,171.70 | 7 | 35 | $1,043.80 |
| 801B | OR procedures unrelated to principal diagnosis w severe or modera | $9,690.00 | 2 | 15 | $1,140.50 |
| 801C | OR procedures unrelated to principal diagnosis w/o cc | $3,894.50 | 0 | 4 | $1,400.00 |
| 960Z | Ungroupable | $344.80 | 0 | 5 | $111.00 |
| 961Z | Unacceptable principal diagnosis | $893.20 | 0 | 4 | $337.40 |
| A06A | Tracheostomy w ventilation >=96hrs w catastrophic cc | $127,147.10 | 17 | 35 | $1,400.00 |
| A06B | Ventilation >=96hrs and OR procedure (w/o tracheostomy or w/o cat | $75,807.80 | 11 | 35 | $1,400.00 |
| A06C | Tracheostomy w/o ventilation >=96hrs, or ventilation >=96hrs w/o | $40,642.60 | 6 | 35 | $1,400.00 |
| A08A | Autologous bone marrow transplant w catastrophic cc | $30,865.40 | 8 | 35 | $1,196.50 |
| A08B | Autologous bone marrow transplant w/o catastrophic cc | $15,952.00 | 4 | 26 | $1,221.70 |
| A11B | Insertion of implantable spinal infusion device w/o catastrophic | $6,611.30 | 1 | 9 | $1,400.00 |
| A12Z | Insertion of neurostimulator device | $5,816.90 | 0 | 5 | $1,400.00 |
| A40B | Ecmo w/o Tracheostomy | $37,575.40 | 3 | 20 | $1,400.00 |
| B01A | Ventricular shunt revision w catastrophic or severe cc | $12,266.60 | 3 | 19 | $1,193.70 |
| B01B | Ventricular shunt revision w/o catastrophic or severe cc | $8,301.30 | 1 | 9 | $1,400.00 |
| B02A | Cranial procs w cerebral haemorrhage w cat cc | $48,704.20 | 9 | 35 | $1,400.00 |
| B02B | Cranial procs w/o cerebral haem w cat cc or (w cerebral haem w se | $27,717.70 | 6 | 35 | $1,400.00 |
| B02C | Cranial procs w/o cerebral haem w sev cc or w/o cat/sev cc | $16,020.30 | 2 | 13 | $1,400.00 |
| B03A | Spinal procedures w catastrophic or severe cc | $15,812.40 | 3 | 17 | $1,400.00 |
| B03B | Spinal procedures w/o catastrophic or severe cc | $8,921.40 | 1 | 6 | $1,400.00 |
| B04A | Extracranial vascular procedures w catastrophic cc | $19,893.10 | 5 | 29 | $1,286.10 |
| B04B | Extracranial vascular procedures w/o catastrophic cc | $9,773.30 | 1 | 7 | $1,400.00 |
| B05Z | Carpal Tunnel Release | $1,503.10 | 0 | 4 | $1,034.90 |
| B06A | Procs for cerebral palsy, muscular dystrophy, neuropathy w cat or | $11,988.10 | 4 | 24 | $912.20 |
| B06B | Procs for cerebral palsy, muscular dystrophy, neuropathy w/o cat | $3,849.40 | 0 | 4 | $1,400.00 |
| B06C | Procs for cerebral palsy, muscular dystrophy, neuropathy, sameday | $1,958.60 | 1 | 1 | $1,105.10 |
| B07A | Cranial or peripheral nerve and other nervous system procedures w | $11,047.70 | 4 | 25 | $815.60 |
| B07B | Cranial or peripheral nerve and other nervous system procedures w | $3,169.80 | 0 | 4 | $1,400.00 |
| B40Z | Plasmapheresis W Neurological Disease, Sameday | $565.40 | 1 | 1 | $562.50 |
| B41Z | Telemetric EEG monitoring | $2,791.80 | 1 | 7 | $872.10 |
| B42A | Nervous System Disorders W Ventilator Support W Catastrophic CC | $22,671.90 | 4 | 22 | $1,400.00 |
| B42B | Nervous System Disorders W Ventilator Support w/o Catastrophic CC | $12,538.90 | 3 | 15 | $1,400.00 |
| B60A | Acute paraplegia/quadriplegia w or w/o OR procs w catastrophic cc | $37,513.40 | 10 | 35 | $1,172.80 |
| B60B | Acute paraplegia/quadriplegia w or w/o OR procs w/o catastrophic | $1,626.40 | 0 | 5 | $650.60 |
| B61A | Spinal cord conditions w or w/o OR procedures w catastrophic or s | $12,983.40 | 4 | 27 | $892.40 |
| B61B | Spinal cord conditions w or w/o OR procedures w/o catastrophic or | $5,557.80 | 1 | 8 | $1,105.40 |
| B63Z | Dementia and other chronic disturbances of cerebral function | $8,408.30 | 4 | 24 | $724.00 |
| B64A | Delirium w catastrophic cc | $12,670.70 | 5 | 32 | $799.10 |
| B64B | Delirium w/o catastrophic cc | $6,183.30 | 2 | 15 | $833.10 |
| B65A | Cerebral palsy | $6,801.10 | 3 | 21 | $652.60 |
| B65B | Cerebral palsy, sameday | $436.90 | 1 | 1 | $370.00 |
| B66A | Nervous system neoplasms w radiotherapy | $11,796.70 | 5 | 32 | $745.80 |
| B66B | Nervous system neoplasms w/o radiotherapy w catastrophic or sever | $9,229.80 | 4 | 24 | $780.80 |
| B66C | Nervous system neoplasms w/o radiotherapy w/o catastrophic or sev | $3,753.70 | 2 | 11 | $715.40 |
| B67A | Degenerative nervous system disorders w catastrophic or severe cc | $13,635.60 | 6 | 34 | $819.30 |
| B67B | Degenerative nervous system disorders w/o catastrophic or severe | $7,323.50 | 3 | 18 | $809.50 |
| B67C | Degenerative nervous system disorders, sameday | $409.70 | 1 | 1 | $407.40 |
| B68A | Multiple sclerosis and cerebellar ataxia w cc | $6,659.60 | 3 | 18 | $769.90 |
| B68B | Multiple sclerosis and cerebellar ataxia w/o cc | $729.80 | 0 | 4 | $606.20 |
| B69A | TIA and precerebral occlusion w catastrophic or severe cc | $6,333.00 | 2 | 15 | $886.80 |
| B69B | TIA and precerebral occlusion w/o catastrophic or severe cc | $2,653.20 | 0 | 6 | $923.90 |
| B70A | Stroke & other cerebrovascular disorders w catastrophic cc | $14,130.50 | 6 | 35 | $791.90 |
| B70B | Stroke & other cerebrovascular disorders w severe cc | $5,316.50 | 2 | 14 | $804.20 |
| B70C | Stroke & other cerebrovascular disorders w/o catastrophic or seve | $2,457.00 | 1 | 7 | $755.20 |
| B70D | Stroke & other cerebrovascular disorders, died/trans acute facili | $2,060.80 | 0 | 4 | $1,014.10 |
| B71A | Cranial and peripheral nerve disorders w cc | $9,661.20 | 4 | 24 | $826.30 |
| B71B | Cranial and peripheral nerve disorders w/o cc | $5,106.00 | 2 | 12 | $863.60 |
| B71C | Cranial and peripheral nerve disorders, sameday | $607.60 | 1 | 1 | $532.30 |
| B72A | Nervous system infection except viral meningitis w catastrophic o | $10,591.30 | 5 | 29 | $731.00 |
| B72B | Nervous system infection except viral meningitis w/o catastrophic | $2,531.60 | 1 | 6 | $833.70 |
| B73Z | Viral Meningitis | $4,351.00 | 2 | 10 | $943.80 |
| B74A | Nontraumatic stupor and coma w catastrophic or severe cc | $6,697.60 | 3 | 17 | $815.50 |
| B74B | Nontraumatic stupor and coma w/o catastrophic or severe cc | $1,828.20 | 0 | 4 | $903.30 |
| B75Z | Febrile Convulsions | $1,368.50 | 0 | 4 | $1,368.50 |
| B76A | Seizures w catastrophic or severe cc | $9,355.50 | 4 | 23 | $839.80 |
| B76B | Seizures w/o catastrophic or severe cc | $3,852.90 | 1 | 8 | $982.70 |
| B76C | Seizures, sameday | $501.60 | 1 | 1 | $487.00 |
| B77Z | Headache | $2,837.10 | 0 | 6 | $871.90 |
| B78A | Intracranial injuries w catastrophic or severe cc | $16,394.90 | 6 | 35 | $940.10 |
| B78B | Intracranial injuries w/o catastrophic or severe cc | $4,489.20 | 2 | 12 | $801.30 |
| B78C | Intracranial injuries, died or transferred to acute facility <5 d | $2,874.30 | 0 | 5 | $1,297.50 |
| B79A | Skull Fractures W Catastrophic or Severe CC | $16,132.40 | 6 | 35 | $912.60 |
| B79B | Skull fractures w/o catastrophic or severe cc | $6,085.80 | 2 | 12 | $1,043.20 |
| B80A | Other head injuries w catastrophic or severe cc | $9,566.00 | 4 | 23 | $831.20 |
| B80B | Other head injuries w/o catastrophic or severe cc | $3,001.20 | 1 | 8 | $828.40 |
| B81A | Other disorders of the nervous system w catastrophic or severe cc | $8,581.70 | 4 | 22 | $792.40 |
| B81B | Other disorders of the nervous system w/o catastrophic or severe | $2,281.50 | 1 | 7 | $728.80 |
| B82B | Chronic and unspec para/quadriplegia w or w/o OR proc w catastrop | $25,544.20 | 10 | 35 | $827.80 |
| B82C | Chronic and unspec para/quadriplegia w or w/o OR proc w/o catastr | $5,340.10 | 2 | 11 | $913.80 |
| C01Z | Procedures for penetrating eye injury | $2,730.10 | 0 | 4 | $1,400.00 |
| C02Z | Enucleations and orbital procedures | $3,219.60 | 0 | 4 | $1,400.00 |
| C03Z | Retinal Procedures | $1,381.90 | 0 | 4 | $763.60 |
| C04Z | Major corneal, scleral and conjunctival procedures | $2,760.40 | 0 | 4 | $1,400.00 |
| C05Z | Dacryocystorhinostomy | $2,608.20 | 0 | 4 | $1,400.00 |
| C10Z | Strabismus Procedures | $1,824.00 | 0 | 4 | $1,046.30 |
| C11Z | Eyelid Procedures | $2,024.60 | 0 | 4 | $1,094.50 |
| C12Z | Other corneal, scleral and conjunctival procedures | $1,489.50 | 0 | 4 | $914.40 |
| C13Z | Lacrimal Procedures | $1,227.30 | 0 | 4 | $730.60 |
| C14Z | Other Eye Procedures | $1,308.00 | 0 | 4 | $733.20 |
| C15Z | Glaucoma and complex cataract procedures | $2,180.90 | 0 | 4 | $1,124.00 |
| C16Z | Lens procedures | $1,853.90 | 0 | 4 | $1,400.00 |
| C60A | Acute and major eye infections w cc | $7,053.40 | 3 | 18 | $770.60 |
| C60B | Acute and major eye infections w/o cc | $5,029.40 | 2 | 10 | $1,046.90 |
| C61A | Neurological and vascular disorders of the eye w cc | $4,321.20 | 2 | 10 | $865.10 |
| C61B | Neurological and vascular disorders of the eye w/o cc | $2,445.90 | 0 | 6 | $885.40 |
| C62A | Hyphaema and medically managed trauma to the eye, w cc | $5,037.60 | 2 | 14 | $738.80 |
| C62B | Hyphaema and medically managed trauma to the eye w/o cc | $2,568.60 | 1 | 6 | $822.80 |
| C63A | Other disorders of the eye w cc | $2,824.70 | 1 | 8 | $735.90 |
| C63B | Other disorders of the eye w/o cc | $998.90 | 0 | 4 | $596.70 |
| D01Z | Cochlear Implant | $7,095.00 | 0 | 4 | $1,400.00 |
| D02A | Head and neck procedures w microvascular tissue transfer or w cat | $14,521.50 | 2 | 15 | $1,400.00 |
| D02B | Head and neck procedures w malignancy or w mod cc | $6,985.10 | 0 | 5 | $1,400.00 |
| D02C | Head and neck procedures w/o malignancy w/o cc | $4,042.00 | 0 | 4 | $1,400.00 |
| D03Z | Surgical repair for cleft lip and palate disorders | $3,978.10 | 0 | 4 | $1,400.00 |
| D04Z | Maxillo surgery | $3,369.50 | 0 | 4 | $1,400.00 |
| D05Z | Parotid gland procedures | $6,045.80 | 0 | 4 | $1,400.00 |
| D06Z | Sinus and complex middle ear procedures | $3,329.30 | 0 | 4 | $1,400.00 |
| D10Z | Nasal procedures | $2,785.70 | 0 | 4 | $1,400.00 |
| D11Z | Tonsillectomy and/or adenoidectomy | $1,980.30 | 0 | 4 | $1,400.00 |
| D12A | Other ear, nose, mouth and throat procedures w cc | $3,819.50 | 0 | 6 | $1,134.30 |
| D12B | Other ear, nose, mouth and throat procedures w/o cc | $2,154.60 | 0 | 4 | $1,182.20 |
| D13Z | Myringotomy w tube insertion | $1,339.10 | 0 | 4 | $901.10 |
| D14A | Mouth and salivary gland procedures w cc | $2,466.30 | 0 | 4 | $1,228.30 |
| D14B | Mouth and salivary gland procedures w/o cc | $1,685.30 | 0 | 4 | $1,145.60 |
| D15Z | Mastoid procedures | $5,268.70 | 0 | 4 | $1,400.00 |
| D40Z | Dental extractions and restorations | $1,229.50 | 0 | 4 | $1,068.80 |
| D60A | Ear, nose, mouth and throat malignancy w catastrophic or severe c | $10,955.10 | 5 | 28 | $796.80 |
| D60B | Ear, nose, mouth and throat malignancy w/o catastrophic or severe | $4,065.20 | 2 | 11 | $720.30 |
| D60C | Ear, nose, mouth and throat malignancy, sameday | $1,109.00 | 1 | 1 | $671.30 |
| D61A | Dysequilibrium w cc | $5,523.30 | 2 | 14 | $818.00 |
| D61B | Dysequilibrium w/o cc | $3,318.70 | 1 | 7 | $940.40 |
| D61C | Dysequilibrium, sameday | $661.60 | 1 | 1 | $498.40 |
| D62A | Epistaxis | $3,036.10 | 1 | 7 | $924.80 |
| D62B | Epistaxis, sameday | $1,195.20 | 1 | 1 | $687.70 |
| D63A | Otitis media and upper respiratory infections w cc | $5,253.60 | 2 | 12 | $887.50 |
| D63B | Otitis media and upper respiratory infections w/o cc | $2,806.60 | 0 | 6 | $993.50 |
| D63C | Otitis media and upper respiratory infections, sameday | $979.80 | 1 | 1 | $670.10 |
| D64Z | Laryngotracheitis & Epiglottitis | $1,521.80 | 0 | 4 | $1,055.40 |
| D65Z | Nasal Trauma & Deformity | $1,890.70 | 0 | 4 | $732.90 |
| D66A | Other ear, nose, mouth and throat disorders w cc | $5,143.10 | 2 | 12 | $866.50 |
| D66B | Other ear, nose, mouth and throat disorders w/o cc | $1,242.50 | 0 | 4 | $837.70 |
| D66C | Other ear, nose, mouth and throat disorders, sameday | $1,074.70 | 1 | 1 | $630.60 |
| D67A | Oral and dental disorders | $4,829.20 | 2 | 11 | $859.50 |
| D67B | Oral and dental disorders, sameday | $1,005.40 | 1 | 1 | $689.40 |
| E01A | Major chest procedures w catastrophic cc | $21,138.10 | 4 | 25 | $1,400.00 |
| E01B | Major chest procedures w/o catastrophic cc | $12,492.90 | 2 | 13 | $1,400.00 |
| E02A | Other respiratory system OR procedures w catastrophic cc | $15,535.30 | 4 | 26 | $1,166.30 |
| E02B | Other respiratory system OR procedures w severe or moderate cc | $5,847.80 | 0 | 6 | $1,400.00 |
| E02C | Other respiratory system OR procedures w/o cc | $2,708.50 | 0 | 4 | $1,400.00 |
| E40A | Respiratory system disorders w ventilator support | $22,885.90 | 5 | 30 | $1,400.00 |
| E40B | Respiratory System Disorders W Vent Supp, Died/Trans Acute Facili | $5,691.90 | 0 | 6 | $1,400.00 |
| E41A | Respiratory system disorders w non-invasive ventilation w catastr | $20,021.80 | 6 | 34 | $1,181.20 |
| E41B | Respiratory system disorders w non-invasive ventilation w/o catas | $13,240.70 | 4 | 22 | $1,245.00 |
| E42A | Bronchoscopy w catastrophic cc | $12,276.00 | 5 | 29 | $843.80 |
| E42B | Bronchoscopy w/o catastrophic cc | $6,043.80 | 2 | 12 | $988.90 |
| E42C | Bronchoscopy, sameday | $1,370.10 | 1 | 1 | $747.50 |
| E60B | Cystic fibrosis w/o catastrophic or severe cc | $3,947.30 | 1 | 9 | $918.00 |
| E61A | Pulmonary embolism w catastrophic cc | $8,528.10 | 3 | 19 | $926.90 |
| E61B | Pulmonary embolism w/o catastrophic cc | $4,447.10 | 1 | 9 | $1,002.20 |
| E62A | Respiratory infections/inflammations w catastrophic cc | $10,289.70 | 4 | 24 | $851.80 |
| E62B | Respiratory infections/inflammations w severe or moderate cc | $6,489.80 | 2 | 14 | $924.00 |
| E62C | Respiratory infections/inflammations w/o cc | $4,124.50 | 1 | 9 | $934.70 |
| E63Z | Sleep Apnoea | $713.00 | 0 | 4 | $701.40 |
| E64A | Pulmonary oedema and respiratory failure | $7,844.90 | 3 | 18 | $867.60 |
| E64B | Pulmonary oedema and respiratory failure, died/transferred acute | $2,673.90 | 0 | 4 | $1,400.00 |
| E65A | Chronic obstructive airways disease w catastrophic cc | $10,106.70 | 4 | 25 | $828.70 |
| E65B | Chronic obstructive airways disease w/o catastrophic cc | $4,953.90 | 2 | 12 | $845.90 |
| E66A | Major chest trauma w catastrophic cc | $10,853.80 | 4 | 26 | $839.60 |
| E66B | Major chest trauma w severe or moderate cc | $6,985.90 | 3 | 17 | $840.50 |
| E66C | Major chest trauma w/o cc | $4,006.40 | 2 | 10 | $833.90 |
| E67A | Respiratory signs and symptoms | $5,008.30 | 2 | 12 | $854.90 |
| E67B | Respiratory signs and symptoms, <2 days | $1,835.70 | 0 | 4 | $1,264.30 |
| E68A | Pneumothorax w catastrophic or severe cc | $7,922.70 | 3 | 18 | $891.90 |
| E68B | Pneumothorax w/o catastrophic or severe cc | $3,441.90 | 1 | 7 | $1,047.70 |
| E69A | Bronchitis and asthma w cc | $6,167.30 | 2 | 14 | $899.00 |
| E69B | Bronchitis and asthma w/o cc | $2,378.50 | 0 | 6 | $874.80 |
| E70A | Whooping cough and acute bronchiolitis w cc | $6,384.30 | 2 | 12 | $1,100.70 |
| E70B | Whooping cough and acute bronchiolitis w/o cc | $3,023.50 | 0 | 5 | $1,313.00 |
| E71A | Respiratory neoplasms w catastrophic cc | $10,816.00 | 4 | 27 | $814.30 |
| E71B | Respiratory neoplasms w/o catastrophic cc | $5,116.40 | 2 | 14 | $721.00 |
| E71C | Respiratory neoplasms, sameday | $677.50 | 1 | 1 | $579.00 |
| E73A | Pleural effusion w catastrophic cc | $10,336.00 | 4 | 24 | $860.20 |
| E73B | Pleural effusion w severe or moderate cc | $5,315.60 | 2 | 12 | $895.50 |
| E73C | Pleural effusion w/o cc | $2,715.20 | 0 | 6 | $929.60 |
| E74A | Interstitial lung disease w catastrophic cc | $10,914.50 | 4 | 26 | $848.80 |
| E74B | Interstitial lung disease w severe or moderate cc | $5,343.30 | 2 | 13 | $812.00 |
| E74C | Interstitial lung disease w/o cc | $2,634.00 | 1 | 7 | $761.90 |
| E75A | Other respiratory system disorders w cc | $6,992.70 | 3 | 16 | $879.50 |
| E75B | Other respiratory system disorders w/o cc | $3,167.90 | 1 | 7 | $947.60 |
| F01A | Implantation or replacement of AICD, total system w catastrophic | $21,093.00 | 3 | 20 | $1,400.00 |
| F01B | Implantation or replacement of AICD, total system w/o catastrophi | $9,546.70 | 0 | 5 | $1,400.00 |
| F02Z | Other AICD procedures | $8,459.10 | 1 | 7 | $1,400.00 |
| F03A | Cardiac valve procedures w CPB pump w invasive cardiac investigat | $45,745.30 | 6 | 35 | $1,400.00 |
| F03B | Cardiac valve procedures w CPB pump w invasive cardiac investigat | $27,585.30 | 3 | 17 | $1,400.00 |
| F04A | Cardiac valve procs w CPB pump w/o invasive cardiac inves w cat c | $35,717.70 | 4 | 25 | $1,400.00 |
| F04B | Cardiac valve procs w CPB pump w/o invasive cardiac inves w/o cat | $21,401.30 | 2 | 12 | $1,400.00 |
| F05A | Coronary bypass w invasive cardiac investigation w catastrophic c | $41,870.10 | 5 | 30 | $1,400.00 |
| F05B | Coronary bypass w invasive cardiac investigation w/o catastrophic | $34,132.50 | 4 | 23 | $1,400.00 |
| F06A | Coronary bypass w/o invasive cardiac investigation w catastrophic | $31,560.50 | 4 | 23 | $1,400.00 |
| F06B | Coronary bypass w/o invasive cardiac investigation w/o catastroph | $26,147.30 | 3 | 18 | $1,400.00 |
| F07A | Other cardiothoracic/vascular procedures w CPB pump w catastrophi | $37,946.50 | 4 | 25 | $1,400.00 |
| F07B | Other cardiothoracic/vascular procedures w CPB pump w/o catastrop | $27,210.80 | 3 | 18 | $1,400.00 |
| F08A | Major reconstructive vascular procedures w/o CPB pump w cat cc | $27,202.90 | 5 | 27 | $1,400.00 |
| F08B | Major reconstructive vascular procedures w/o CPB pump w/o cat cc | $13,392.10 | 2 | 9 | $1,400.00 |
| F09A | Other cardiothoracic procedures w/o CPB pump w catastrophic cc | $25,105.20 | 4 | 25 | $1,400.00 |
| F09B | Other cardiothoracic procedures w/o CPB pump w/o catastrophic cc | $10,499.70 | 1 | 7 | $1,400.00 |
| F09C | Other cardiothoracic procedures w/o CPB pump, died/transferred ac | $9,891.60 | 0 | 4 | $1,400.00 |
| F10A | Interventional coronary procedures admitted for AMI w catastrophi | $16,176.00 | 3 | 18 | $1,400.00 |
| F10B | Interventional coronary procedures admitted for AMI w/o catastrop | $10,705.20 | 1 | 7 | $1,400.00 |
| F11A | Amputation, except upper limb and toe, for circulatory disorders | $45,851.80 | 12 | 35 | $1,155.60 |
| F11B | Amputation, except upper limb and toe, for circulatory disorders | $24,902.80 | 6 | 35 | $1,225.40 |
| F12A | Implantation or replacement of pacemaker, total system w catastro | $16,335.50 | 4 | 24 | $1,260.90 |
| F12B | Implantation or replacement of pacemaker, total system w/o catast | $7,633.30 | 0 | 5 | $1,400.00 |
| F13A | Amputation, upper limb and toe, for circulatory disorders w catas | $22,549.70 | 7 | 35 | $995.40 |
| F13B | Amputation, upper limb and toe, for circulatory disorders w/o cat | $10,120.70 | 2 | 12 | $1,400.00 |
| F14A | Vascular procs, except major reconstruction, w/o CPB pump w cat c | $18,172.70 | 4 | 25 | $1,266.40 |
| F14B | Vascular procs, except major reconstruction, w/o CPB pump w sev o | $8,024.10 | 0 | 5 | $1,400.00 |
| F14C | Vascular procs, except major reconstruction, w/o CPB pump w/o cc | $6,659.20 | 0 | 4 | $1,400.00 |
| F15A | Interventional coronary procs, not adm for AMI w stent implant w | $12,832.00 | 1 | 8 | $1,400.00 |
| F15B | Interventional coronary procs, not adm for AMI w stent implant w/ | $10,454.70 | 0 | 4 | $1,400.00 |
| F16A | Interventional coronary procs, not adm for AMI w/o stent implant | $10,154.90 | 1 | 7 | $1,400.00 |
| F16B | Interventional coronary procs, not adm for AMI w/o stent implant | $8,437.80 | 0 | 4 | $1,400.00 |
| F17Z | Insertion or replacement of pacemaker generator | $3,616.30 | 0 | 4 | $1,400.00 |
| F18A | Other pacemaker procedures w cc | $9,882.50 | 2 | 14 | $1,215.30 |
| F18B | Other pacemaker procedures w/o cc | $5,123.30 | 0 | 4 | $1,400.00 |
| F19A | Trans-vascular percutaneous cardiac intervention, age >=80 or w c | $11,519.70 | 2 | 11 | $1,400.00 |
| F19B | Trans-vascular percutaneous cardiac intervention, age <80 w/o cc | $7,230.50 | 0 | 4 | $1,400.00 |
| F20Z | Vein Ligation & Stripping | $4,063.30 | 0 | 4 | $1,400.00 |
| F21A | Other circulatory system OR procedures w catastrophic cc | $20,107.80 | 7 | 35 | $963.10 |
| F21B | Other circulatory system OR procedures w/o catastrophic cc | $6,406.10 | 2 | 11 | $1,036.10 |
| F40A | Circulatory disorders w ventilator support | $31,443.90 | 4 | 27 | $1,400.00 |
| F40B | Circulatory disorders w ventilator support, died/transferred acut | $14,233.60 | 0 | 6 | $1,400.00 |
| F41A | Circulatory disorders, adm for AMI w invasive cardiac inves w cat | $10,430.50 | 2 | 14 | $1,400.00 |
| F41B | Circulatory disorders, adm for AMI w invasive cardiac inves w/o c | $6,053.00 | 0 | 6 | $1,400.00 |
| F42A | Circulatory dsrds, not adm for AMI w invasive cardiac inves w cat | $9,758.50 | 2 | 14 | $1,251.80 |
| F42B | Circulatory dsrds, not adm for AMI w invasive cardiac inves w/o c | $6,286.80 | 0 | 4 | $1,400.00 |
| F42C | Circulatory disorders not adm for AMI w invasive cardiac investig | $3,669.60 | 1 | 1 | $1,400.00 |
| F43Z | Circulatory disorders w non-invasive ventilation | $21,838.50 | 5 | 31 | $1,397.50 |
| F60A | Circulatory dsrd, adm for AMI w/o invasive cardiac inves | $3,229.10 | 1 | 8 | $806.10 |
| F60B | Circulatory dsrd, adm for AMI w/o invas card inves, died/trans ac | $2,906.10 | 0 | 4 | $1,400.00 |
| F61A | Infective endocarditis w catastrophic cc | $19,843.80 | 8 | 35 | $810.30 |
| F61B | Infective endocarditis w/o catastrophic cc | $5,487.30 | 2 | 14 | $766.10 |
| F62A | Heart failure and shock w catastrophic cc | $11,731.80 | 4 | 27 | $873.00 |
| F62B | Heart failure and shock w/o catastrophic cc | $6,085.60 | 2 | 13 | $935.20 |
| F62C | Heart failure and shock, died or transferred to acute facility <5 | $3,320.00 | 0 | 5 | $1,400.00 |
| F63A | Venous thrombosis w catastrophic or severe cc | $7,419.90 | 3 | 17 | $868.60 |
| F63B | Venous thrombosis w/o catastrophic or severe cc | $3,369.90 | 1 | 7 | $952.60 |
| F64A | Skin ulcers in circulatory disorders w catastrophic or severe cc | $13,369.60 | 6 | 34 | $782.80 |
| F64B | Skin ulcers in circulatory disorders w/o catastrophic or severe c | $8,008.10 | 3 | 20 | $818.70 |
| F65A | Peripheral vascular disorders w catastrophic or severe cc | $8,249.80 | 3 | 21 | $802.30 |
| F65B | Peripheral vascular disorders w/o catastrophic or severe cc | $2,200.20 | 0 | 5 | $821.80 |
| F66A | Coronary atherosclerosis w catastrophic or severe cc | $5,110.80 | 2 | 13 | $796.80 |
| F66B | Coronary atherosclerosis w/o catastrophic or severe cc | $752.90 | 0 | 4 | $531.50 |
| F67A | Hypertension w catastrophic or severe cc | $7,417.40 | 3 | 17 | $868.60 |
| F67B | Hypertension w/o catastrophic or severe cc | $3,193.40 | 1 | 7 | $937.50 |
| F68Z | Congenital Heart Disease | $1,200.40 | 0 | 4 | $768.30 |
| F69A | Valvular disorders w catastrophic or severe cc | $6,334.70 | 3 | 15 | $838.90 |
| F69B | Valvular disorders w/o catastrophic or severe cc | $1,532.20 | 0 | 4 | $773.40 |
| F72A | Unstable angina w catastrophic or severe cc | $6,384.10 | 2 | 14 | $935.30 |
| F72B | Unstable angina w/o catastrophic or severe cc | $2,320.90 | 0 | 5 | $965.20 |
| F73A | Syncope and collapse w catastrophic or severe cc | $7,916.50 | 3 | 20 | $818.20 |
| F73B | Syncope and collapse w/o catastrophic or severe cc | $3,922.00 | 1 | 9 | $914.60 |
| F73C | Syncope and collapse, sameday | $1,576.20 | 1 | 1 | $824.50 |
| F74A | Chest pain | $3,215.10 | 1 | 8 | $862.80 |
| F74B | Chest pain, <2 days | $1,084.70 | 0 | 4 | $1,065.80 |
| F75A | Other circulatory disorders w catastrophic cc | $10,802.80 | 4 | 24 | $892.50 |
| F75B | Other circulatory disorders w severe or moderate cc | $5,155.30 | 2 | 11 | $958.90 |
| F75C | Other circulatory disorders w/o cc | $2,198.00 | 0 | 4 | $1,009.00 |
| F76A | Arrhythmia, cardiac arrest and conduction disorders w catastrophi | $7,440.80 | 3 | 17 | $903.10 |
| F76B | Arrhythmia, cardiac arrest and conduction disorders w/o catastrop | $3,327.50 | 0 | 6 | $1,172.10 |
| F76C | Arrhythmia, cardiac arrest and conduction disorders, sameday | $822.00 | 1 | 1 | $725.80 |
| G01A | Rectal resection w catastrophic cc | $24,139.60 | 5 | 29 | $1,400.00 |
| G01B | Rectal resection w/o catastrophic cc | $13,659.40 | 2 | 14 | $1,400.00 |
| G02A | Major small and large bowel procedures w catastrophic cc | $21,864.40 | 5 | 29 | $1,400.00 |
| G02B | Major small and large bowel procedures w/o catastrophic cc | $9,234.00 | 1 | 9 | $1,400.00 |
| G03A | Stomach, oesophageal and duodenal procedures w malignancy or w ca | $19,889.10 | 4 | 23 | $1,400.00 |
| G03B | Stomach, oesophageal and duodenal procedures w/o malignancy w sev | $9,109.50 | 0 | 6 | $1,400.00 |
| G03C | Stomach, oesophageal and duodenal procedures w/o malignancy w/o c | $6,631.20 | 0 | 5 | $1,400.00 |
| G04A | Peritoneal adhesiolysis w catastrophic cc | $16,208.50 | 4 | 21 | $1,400.00 |
| G04B | Peritoneal adhesiolysis w severe or moderate cc | $8,416.10 | 1 | 8 | $1,400.00 |
| G04C | Peritoneal adhesiolysis w/o cc | $5,668.10 | 0 | 5 | $1,400.00 |
| G05A | Minor small and large bowel procedures w catastrophic cc | $13,135.70 | 4 | 23 | $1,068.90 |
| G05B | Minor small and large bowel procedures w severe or moderate cc | $8,733.70 | 2 | 12 | $1,337.80 |
| G05C | Minor small and large bowel procedures w/o cc | $6,291.70 | 1 | 8 | $1,400.00 |
| G07A | Appendicectomy w malignancy or peritonitis or w catastrophic or s | $5,713.50 | 1 | 7 | $1,400.00 |
| G07B | Appendicectomy w/o malignancy or peritonitis w/o cat or sev cc | $4,288.40 | 0 | 4 | $1,400.00 |
| G10A | Hernia procedures w cc | $5,027.50 | 0 | 6 | $1,400.00 |
| G10B | Hernia procedures w/o cc | $3,210.80 | 0 | 4 | $1,400.00 |
| G11Z | Anal and stomal procedures | $2,168.20 | 0 | 4 | $1,213.60 |
| G12A | Other digestive system or procedures w catastrophic cc | $15,320.10 | 4 | 27 | $1,081.60 |
| G12B | Other digestive system or procedures w severe or moderate cc | $4,909.60 | 1 | 7 | $1,310.30 |
| G12C | Other digestive system or procedures w/o cc | $3,463.40 | 0 | 4 | $1,400.00 |
| G46A | Complex endoscopy w catastrophic cc | $12,589.70 | 5 | 28 | $870.60 |
| G46B | Complex endoscopy w/o catastrophic cc | $3,665.10 | 0 | 6 | $1,177.10 |
| G46C | Complex endoscopy, sameday | $1,084.10 | 1 | 1 | $988.70 |
| G47A | Gastroscopy w catastrophic cc | $10,340.50 | 4 | 27 | $765.00 |
| G47B | Gastroscopy w/o catastrophic cc | $3,741.70 | 1 | 8 | $967.80 |
| G47C | Gastroscopy, sameday | $751.10 | 1 | 1 | $691.10 |
| G48A | Colonoscopy w catastrophic or severe cc | $7,424.20 | 3 | 17 | $860.20 |
| G48B | Colonoscopy w/o catastrophic or severe cc | $2,511.50 | 0 | 5 | $1,108.10 |
| G48C | Colonoscopy, sameday | $946.00 | 1 | 1 | $888.70 |
| G60A | Digestive malignancy w catastrophic cc | $9,374.80 | 4 | 25 | $744.60 |
| G60B | Digestive malignancy w/o catastrophic cc | $3,304.60 | 2 | 9 | $718.50 |
| G61A | Gastrointestinal haemorrhage w catastrophic or severe cc | $7,335.70 | 3 | 19 | $776.10 |
| G61B | Gastrointestinal haemorrhage w/o catastrophic or severe cc | $2,770.70 | 1 | 7 | $881.90 |
| G64A | Inflammatory bowel disease w cc | $3,769.00 | 1 | 8 | $938.70 |
| G64B | Inflammatory bowel disease w/o cc | $593.20 | 0 | 4 | $592.60 |
| G65A | Gastrointestinal obstruction w catastrophic or severe cc | $7,564.20 | 3 | 19 | $818.00 |
| G65B | Gastrointestinal obstruction w/o catastrophic or severe cc | $3,557.60 | 1 | 8 | $957.10 |
| G66A | Abdominal pain and mesenteric adenitis | $2,952.10 | 1 | 7 | $884.00 |
| G66B | Abdominal pain and mesenteric adenitis, sameday | $826.80 | 1 | 1 | $649.70 |
| G67A | Oesophagitis and gastroenteritis w catastrophic or severe cc | $6,678.90 | 3 | 16 | $874.90 |
| G67B | Oesophagitis and gastroenteritis w/o catastrophic or severe cc | $2,862.60 | 1 | 7 | $920.20 |
| G70A | Other digestive system disorders w catastrophic or severe cc | $7,167.60 | 3 | 17 | $837.60 |
| G70B | Other digestive system disorders w/o catastrophic or severe cc | $3,291.00 | 1 | 8 | $905.30 |
| G70C | Other digestive system disorders, sameday | $812.60 | 1 | 1 | $611.90 |
| H01A | Pancreas, liver and shunt procedures w catastrophic cc | $27,299.90 | 5 | 29 | $1,400.00 |
| H01B | Pancreas, liver and shunt procedures w/o catastrophic cc | $12,981.60 | 2 | 11 | $1,400.00 |
| H02A | Major biliary tract procedures w catastrophic cc | $19,613.00 | 5 | 33 | $1,135.00 |
| H02B | Major biliary tract procedures w/o catastrophic cc | $7,504.40 | 1 | 8 | $1,400.00 |
| H05A | Hepatobiliary diagnostic procedures w catastrophic cc | $14,504.40 | 4 | 25 | $1,064.50 |
| H05B | Hepatobiliary diagnostic procedures w/o catastrophic cc | $3,601.80 | 0 | 4 | $1,400.00 |
| H06A | Other hepatobiliary and pancreas OR procedures w catastrophic cc | $18,675.50 | 6 | 35 | $1,026.00 |
| H06B | Other hepatobiliary and pancreas OR procedures w/o catastrophic c | $4,994.80 | 0 | 5 | $1,400.00 |
| H07A | Open cholecystectomy w closed cde or w catastrophic cc | $19,282.60 | 4 | 24 | $1,400.00 |
| H07B | Open cholecystectomy w/o closed cde w/o catastrophic cc | $8,450.80 | 1 | 9 | $1,400.00 |
| H08A | Laparoscopic cholecystectomy w closed cde or w catastrophic or se | $7,405.90 | 1 | 8 | $1,400.00 |
| H08B | Laparoscopic cholecystectomy w/o closed cde w/o catastrophic or s | $4,602.60 | 0 | 4 | $1,400.00 |
| H40B | Endoscopic procedures for bleeding oesophageal varices w/o catast | $3,832.60 | 0 | 5 | $1,400.00 |
| H43A | Ercp procedures w catastrophic or severe cc | $9,578.50 | 3 | 18 | $970.90 |
| H43B | Ercp procedures w/o catastrophic or severe cc | $4,426.20 | 0 | 6 | $1,184.10 |
| H43C | Ercp procedures, sameday | $2,339.80 | 1 | 1 | $931.90 |
| H60A | Cirrhosis and alcoholic hepatitis w catastrophic cc | $13,050.50 | 5 | 30 | $880.80 |
| H60B | Cirrhosis and alcoholic hepatitis w/o catastrophic cc | $5,783.90 | 2 | 14 | $822.00 |
| H60C | Cirrhosis and alcoholic hepatitis, sameday | $650.00 | 1 | 1 | $592.10 |
| H61A | Malignancy of hepatobiliary system and pancreas w catastrophic cc | $10,751.30 | 4 | 26 | $816.90 |
| H61B | Malignancy of hepatobiliary system and pancreas w/o catastrophic | $5,358.50 | 2 | 15 | $742.80 |
| H61C | Malignancy of hepatobiliary system and pancreas, sameday | $983.10 | 1 | 1 | $724.10 |
| H62A | Disorders of pancreas, except malignancy w catastrophic or severe | $8,512.80 | 3 | 19 | $900.30 |
| H62B | Disorders of pancreas, except malignancy w/o catastrophic or seve | $2,754.60 | 0 | 6 | $899.90 |
| H63A | Other disorders of liver w catastrophic cc | $10,043.60 | 4 | 24 | $833.30 |
| H63B | Other disorders of liver w/o catastrophic cc | $4,924.40 | 2 | 11 | $911.30 |
| H63C | Other disorders of liver, sameday | $862.90 | 1 | 1 | $757.80 |
| H64A | Disorders of the biliary tract w cc | $7,578.60 | 3 | 18 | $870.40 |
| H64B | Disorders of the biliary tract w/o cc | $3,126.80 | 1 | 7 | $990.70 |
| H64C | Disorders of the biliary tract, sameday | $774.90 | 1 | 1 | $620.10 |
| I01A | Bilateral and multiple major joint proc of lower limb w revision | $26,842.10 | 6 | 35 | $1,291.40 |
| I01B | Bilateral and multiple major joint proc of lower limb w/o revisio | $15,330.30 | 2 | 11 | $1,400.00 |
| I02A | Microvascular tissue transfers or (skin grafts w cat or sev cc), | $29,556.30 | 7 | 35 | $1,207.50 |
| I02B | Skin grafts w/o cat or sev cc, excluding hand | $5,484.40 | 0 | 6 | $1,400.00 |
| I03A | Hip replacement w catastrophic cc | $18,114.70 | 4 | 24 | $1,400.00 |
| I03B | Hip replacement w/o catastrophic cc | $11,329.70 | 1 | 9 | $1,400.00 |
| I04A | Knee replacement w catastrophic or severe cc | $12,892.90 | 2 | 14 | $1,400.00 |
| I04B | Knee replacement w/o catastrophic or severe cc | $10,751.40 | 1 | 9 | $1,400.00 |
| I05A | Other joint replacement w catastrophic or severe cc | $12,271.80 | 2 | 15 | $1,400.00 |
| I05B | Other joint replacement w/o catastrophic or severe cc | $7,927.30 | 1 | 6 | $1,400.00 |
| I06Z | Spinal fusion for deformity | $22,587.10 | 3 | 18 | $1,400.00 |
| I07Z | Amputation | $24,888.00 | 8 | 35 | $984.00 |
| I08A | Other hip and femur procedures w catastrophic cc | $20,894.40 | 6 | 35 | $1,062.70 |
| I08B | Other hip and femur procedures w/o catastrophic cc | $7,455.00 | 1 | 9 | $1,400.00 |
| I09A | Spinal fusion w catastrophic cc | $27,559.30 | 5 | 31 | $1,400.00 |
| I09B | Spinal fusion w/o catastrophic cc | $14,284.30 | 2 | 11 | $1,400.00 |
| I10A | Other back and neck procedures w catastrophic or severe cc | $11,961.00 | 2 | 14 | $1,400.00 |
| I10B | Other back and neck procedures w/o catastrophic or severe cc | $7,671.70 | 0 | 6 | $1,400.00 |
| I11Z | Limb Lengthening Procedures | $7,697.70 | 1 | 7 | $1,400.00 |
| I12A | Misc musculoskeletal procs for infect/inflam of bone/joint w cat | $21,192.90 | 7 | 35 | $971.90 |
| I12B | Misc musculoskeletal procs for infect/inflam of bone/joint w sev | $10,481.10 | 3 | 19 | $1,009.00 |
| I12C | Misc musculoskeletal procs for infect/inflam of bone/joint w/o cc | $4,563.40 | 0 | 6 | $1,256.20 |
| I13A | Humerus, tibia, fibula and ankle procedures w cc | $9,761.70 | 2 | 15 | $1,184.90 |
| I13B | Humerus, tibia, fibula and ankle procedures w/o cc, age >=17 | $4,532.50 | 0 | 4 | $1,400.00 |
| I13C | Humerus, tibia, fibula and ankle procedures w/o cc, age <17 | $3,950.70 | 0 | 4 | $1,400.00 |
| I15Z | Cranio-Facial Surgery | $11,397.40 | 2 | 11 | $1,400.00 |
| I16Z | Other Shoulder Procedures | $4,027.90 | 0 | 4 | $1,400.00 |
| I17A | Maxillo-facial surgery w cc | $7,973.90 | 1 | 9 | $1,400.00 |
| I17B | Maxillo-facial surgery w/o cc | $4,380.20 | 0 | 4 | $1,400.00 |
| I18Z | Other knee procedures | $2,286.80 | 0 | 4 | $1,385.40 |
| I19A | Other elbow and forearm procedures w cc | $5,924.80 | 1 | 8 | $1,299.70 |
| I19B | Other elbow and forearm procedures w/o cc | $3,424.40 | 0 | 4 | $1,400.00 |
| I20Z | Other foot procedures | $3,371.70 | 0 | 4 | $1,400.00 |
| I21Z | Local excision and removal of internal fixation devices of hip an | $2,688.40 | 0 | 4 | $1,400.00 |
| I23Z | Local excision and removal of internal fixation devices, except h | $1,974.00 | 0 | 4 | $1,171.40 |
| I24Z | Arthroscopy | $2,627.70 | 0 | 4 | $1,308.30 |
| I25A | Bone and joint diagnostic procedures including biopsy w cc | $7,152.20 | 3 | 18 | $781.60 |
| I25B | Bone and joint diagnostic procedures including biopsy w/o cc | $2,602.90 | 0 | 4 | $1,074.70 |
| I27A | Soft tissue procedures w catastrophic or severe cc | $11,998.60 | 4 | 23 | $968.90 |
| I27B | Soft tissue procedures w/o catastrophic or severe cc | $3,766.80 | 0 | 4 | $1,400.00 |
| I27C | Soft tissue procedures, sameday | $1,954.10 | 1 | 1 | $1,085.00 |
| I28A | Other musculoskeletal procedures w cc | $9,357.40 | 3 | 20 | $898.90 |
| I28B | Other musculoskeletal procedures w/o cc | $3,251.30 | 0 | 4 | $1,400.00 |
| I29Z | Knee reconstructions, and revisions of reconstructions | $3,944.90 | 0 | 4 | $1,400.00 |
| I30Z | Hand procedures | $2,127.70 | 0 | 4 | $1,161.60 |
| I31A | Revision of hip replacement for infect/inflam of joint prosth or | $24,562.20 | 6 | 33 | $1,347.00 |
| I31B | Revision of hip replacement not for infect/inflam of joint prosth | $14,857.40 | 2 | 13 | $1,400.00 |
| I32A | Revision of knee replacement for infect/inflam of joint prosth or | $21,044.40 | 5 | 32 | $1,180.00 |
| I32B | Revision of knee replacement not for infect/inflam of joint prost | $12,284.70 | 2 | 10 | $1,400.00 |
| I40Z | Infusions for musculoskeletal disorders, sameday | $1,181.60 | 1 | 1 | $731.60 |
| I60Z | Femoral shaft fractures | $14,570.40 | 6 | 35 | $791.80 |
| I61A | Distal femoral fractures w cc | $17,884.20 | 8 | 35 | $721.10 |
| I61B | Distal femoral fractures w/o cc | $12,234.90 | 5 | 33 | $759.40 |
| I63A | Sprains, strains and dislocations of hip, pelvis and thigh w cc | $10,246.80 | 4 | 27 | $765.70 |
| I63B | Sprains, strains and dislocations of hip, pelvis and thigh w/o cc | $6,108.50 | 2 | 14 | $863.10 |
| I64A | Osteomyelitis w catastrophic or severe cc | $14,112.60 | 6 | 35 | $798.60 |
| I64B | Osteomyelitis w/o catastrophic or severe cc | $9,146.30 | 4 | 24 | $767.70 |
| I65A | Musculoskeletal malignant neoplasms w radiotherapy or w cat cc | $12,417.40 | 5 | 32 | $793.50 |
| I65B | Musculoskeletal malignant neoplasms w/o radiotherapy w/o cat cc | $7,401.70 | 3 | 17 | $886.40 |
| I66A | Inflammatory musculoskeletal disorders w catastrophic or severe c | $11,516.80 | 5 | 28 | $835.00 |
| I66B | Inflammatory musculoskeletal disorders w/o catastrophic or severe | $5,256.00 | 2 | 12 | $859.30 |
| I67A | Septic arthritis w catastrophic or severe cc | $14,435.90 | 7 | 35 | $735.60 |
| I67B | Septic arthritis w/o catastrophic or severe cc | $9,154.40 | 4 | 24 | $757.40 |
| I68A | Non-surgical spinal disorders w cc | $10,391.50 | 4 | 26 | $806.00 |
| I68B | Non-surgical spinal disorders w/o cc | $5,874.00 | 2 | 13 | $876.00 |
| I69A | Bone diseases and arthropathies w catastrophic or severe cc | $10,402.40 | 4 | 27 | $780.90 |
| I69B | Bone diseases and arthropathies w/o catastrophic or severe cc | $7,489.50 | 3 | 19 | $812.80 |
| I71A | Other musculotendinous disorders w catastrophic or severe cc | $9,754.60 | 4 | 25 | $795.20 |
| I71B | Other musculotendinous disorders w/o catastrophic or severe cc | $4,868.40 | 2 | 11 | $857.50 |
| I72A | Specific musculotendinous disorders w catastrophic or severe cc | $12,776.80 | 6 | 35 | $724.90 |
| I72B | Specific musculotendinous disorders w/o catastrophic or severe cc | $7,305.00 | 3 | 18 | $807.90 |
| I73A | Aftercare of musculoskeletal implants or prostheses w cat or sev | $12,493.90 | 6 | 34 | $740.90 |
| I73B | Aftercare of musculoskeletal implants or prostheses w/o cat or se | $6,627.60 | 3 | 17 | $784.80 |
| I74A | Injuries to forearm, wrist, hand and foot w cc | $12,982.80 | 6 | 33 | $785.30 |
| I74B | Injuries to forearm, wrist, hand and foot w/o cc | $5,637.10 | 2 | 14 | $801.10 |
| I75A | Injuries to shoulder, arm, elbow, knee, leg and ankle w cc | $14,477.10 | 6 | 35 | $773.30 |
| I75B | Injuries to shoulder, arm, elbow, knee, leg and ankle w/o cc | $8,353.30 | 4 | 21 | $792.90 |
| I76A | Other musculoskeletal disorders w catastrophic or severe cc | $12,689.10 | 6 | 34 | $762.70 |
| I76B | Other musculoskeletal disorders w/o catastrophic or severe cc | $7,613.40 | 3 | 18 | $834.10 |
| I77A | Fractures of pelvis w catastrophic or severe cc | $14,507.60 | 6 | 35 | $800.80 |
| I77B | Fractures of pelvis w/o catastrophic or severe cc | $10,456.70 | 4 | 26 | $823.10 |
| I78A | Fractures of neck of femur w catastrophic or severe cc | $15,464.10 | 7 | 35 | $702.40 |
| I78B | Fractures of neck of femur w/o catastrophic or severe cc | $12,018.60 | 5 | 32 | $755.80 |
| I79A | Pathological fractures w catastrophic cc | $14,383.70 | 6 | 35 | $770.30 |
| I79B | Pathological fractures w/o catastrophic cc | $9,529.40 | 4 | 24 | $811.70 |
| I80Z | Femoral fractures, transferred to acute facility <2 days | $1,257.20 | 0 | 4 | $1,257.20 |
| I81Z | Musculoskeletal injuries, sameday | $287.70 | 1 | 1 | $275.80 |
| I82Z | Other sameday treatment for musculoskeletal disorders | $414.00 | 1 | 1 | $323.80 |
| J01A | Microvas tiss transf for skin, subcut tiss & breast dsrds w catas | $24,937.70 | 3 | 19 | $1,400.00 |
| J01B | Microvas tiss transf for skin, subcut tiss & breast dsrds w/o cat | $18,516.50 | 2 | 14 | $1,400.00 |
| J06A | Major procedures for malignant breast disorders | $5,141.00 | 0 | 5 | $1,400.00 |
| J06B | Major procedures for non-malignant breast disorders | $4,301.40 | 0 | 4 | $1,400.00 |
| J07A | Minor procedures for malignant breast disorders | $2,696.10 | 0 | 4 | $1,400.00 |
| J07B | Minor procedures for non-malignant breast disorders | $2,126.50 | 0 | 4 | $1,258.70 |
| J08A | Other skin grafts and debridement procedures w cc | $8,334.70 | 2 | 15 | $1,007.80 |
| J08B | Other skin grafts and debridement procedures w/o cc | $3,855.10 | 0 | 5 | $1,400.00 |
| J08C | Other skin grafts and debridement procedures, sameday | $2,218.80 | 1 | 1 | $1,152.80 |
| J09Z | Perianal and pilonidal procedures | $2,109.30 | 0 | 4 | $1,038.50 |
| J10Z | Plastic or procedures for skin, subcutaneous tissue and breast di | $2,785.90 | 0 | 4 | $1,242.20 |
| J11Z | Other skin, subcutaneous tissue and breast procedures | $1,589.00 | 0 | 4 | $825.80 |
| J12A | Lower limb procs w ulcer/cellulitis w catastrophic cc | $21,154.30 | 8 | 35 | $888.50 |
| J12B | Lower limb procs w ulcer/cellulitis w/o catastrophic cc w skin gr | $11,406.30 | 4 | 23 | $944.00 |
| J12C | Lower limb procs w ulcer/cellulitis w/o catastrophic cc w/o skin | $8,389.70 | 2 | 14 | $1,144.70 |
| J13A | Lwr limb procs w/o ulcer/cellulitis w (skin grafts and severe cc) | $9,542.60 | 3 | 19 | $921.70 |
| J13B | Lwr limb procs w/o ulcer/cellulitis w/o (skin grafts and severe c | $3,563.70 | 0 | 5 | $1,136.90 |
| J14Z | Major breast reconstructions | $10,943.50 | 2 | 10 | $1,400.00 |
| J60A | Skin ulcers w catastrophic cc | $15,004.70 | 6 | 35 | $801.20 |
| J60B | Skin ulcers w/o catastrophic cc | $10,200.50 | 4 | 24 | $846.50 |
| J60C | Skin ulcers, sameday | $474.90 | 1 | 1 | $379.90 |
| J62A | Malignant breast disorders | $5,180.80 | 2 | 14 | $758.70 |
| J62B | Malignant breast disorders, sameday | $277.10 | 1 | 1 | $261.60 |
| J63A | Non-malignant breast disorders | $3,468.30 | 1 | 7 | $926.50 |
| J63B | Non-malignant breast disorders, sameday | $1,067.40 | 1 | 1 | $628.70 |
| J64A | Cellulitis w catastrophic or severe cc | $9,658.90 | 4 | 24 | $820.20 |
| J64B | Cellulitis w/o catastrophic or severe cc | $4,320.90 | 2 | 10 | $877.00 |
| J65A | Trauma to skin, subcutaneous tissue and breast w cat or sev cc | $9,305.50 | 4 | 24 | $793.50 |
| J65B | Trauma to skin, subcutaneous tissue and breast w/o cat or sev cc | $5,024.60 | 2 | 12 | $883.60 |
| J65C | Trauma to skin, subcutaneous tissue and breast, sameday | $640.40 | 1 | 1 | $485.00 |
| J67A | Minor skin disorders | $5,664.10 | 2 | 13 | $900.90 |
| J67B | Minor skin disorders, sameday | $982.60 | 1 | 1 | $605.20 |
| J68A | Major skin disorders w catastrophic or severe cc | $8,712.80 | 3 | 20 | $880.40 |
| J68B | Major skin disorders w/o catastrophic or severe cc | $4,717.30 | 2 | 10 | $958.40 |
| J68C | Major skin disorders, sameday | $489.30 | 1 | 1 | $472.60 |
| J69A | Skin malignancy w catastrophic cc | $10,429.30 | 5 | 30 | $691.00 |
| J69B | Skin malignancy w/o catastrophic cc | $7,407.50 | 4 | 22 | $696.50 |
| J69C | Skin malignancy, sameday | $375.60 | 1 | 1 | $291.70 |
| K01A | OR procedures for diabetic complications w catastrophic cc | $29,922.00 | 10 | 35 | $982.90 |
| K01B | OR procedures for diabetic complications w/o catastrophic cc | $14,906.10 | 3 | 21 | $1,310.90 |
| K02A | Pituitary procedures w cc | $16,445.30 | 3 | 16 | $1,400.00 |
| K02B | Pituitary procedures w/o cc | $13,974.50 | 2 | 11 | $1,400.00 |
| K03Z | Adrenal Procedures | $8,940.10 | 0 | 6 | $1,400.00 |
| K05A | Parathyroid procedures w catastrophic or severe cc | $7,294.70 | 1 | 8 | $1,400.00 |
| K05B | Parathyroid procedures w/o catastrophic or severe cc | $4,285.70 | 0 | 4 | $1,400.00 |
| K06A | Thyroid procedures w catastrophic or severe cc | $7,323.50 | 0 | 6 | $1,400.00 |
| K06B | Thyroid procedures w/o catastrophic or severe cc | $4,934.10 | 0 | 4 | $1,400.00 |
| K08Z | Thyroglossal Procedures | $3,826.00 | 0 | 4 | $1,400.00 |
| K09A | Other endocrine, nutritional and metabolic or procs w catastrophi | $17,094.80 | 6 | 34 | $938.80 |
| K09B | Other endocrine, nutritional and metabolic or procs w severe or m | $10,105.70 | 2 | 13 | $1,344.60 |
| K09C | Other endocrine, nutritional and metabolic or procs w/o cc | $7,386.00 | 0 | 6 | $1,400.00 |
| K10A | Revisional and open bariatric procedures w cc | $8,564.70 | 1 | 7 | $1,400.00 |
| K10B | Revisional and open bariatric procedures w/o cc | $7,049.20 | 0 | 5 | $1,400.00 |
| K11A | Major laparoscopic bariatric procedures w cc | $7,813.70 | 0 | 5 | $1,400.00 |
| K11B | Major laparoscopic bariatric procedures w/o cc | $7,105.50 | 0 | 4 | $1,400.00 |
| K12Z | Other bariatric procedures | $3,182.10 | 0 | 4 | $1,400.00 |
| K13Z | Plastic or procedures for endocrine, nutritional and metabolic di | $7,331.00 | 1 | 7 | $1,400.00 |
| K40A | Endoscopic and investigative procs for metabolic disorders w cata | $14,978.30 | 6 | 35 | $830.30 |
| K40B | Endoscopic and investigative procs for metabolic disorders w/o ca | $3,229.80 | 0 | 6 | $1,031.70 |
| K40C | Endoscopic and investigative procs for metabolic disorders, samed | $1,009.20 | 1 | 1 | $928.60 |
| K60A | Diabetes w catastrophic or severe cc | $10,487.30 | 4 | 23 | $907.40 |
| K60B | Diabetes w/o catastrophic or severe cc | $5,451.80 | 2 | 12 | $918.90 |
| K60C | Diabetes, sameday | $629.70 | 1 | 1 | $546.90 |
| K61Z | Severe Nutritional Disturbance | $10,288.80 | 4 | 23 | $913.00 |
| K62A | Miscellaneous metabolic disorders w catastrophic or severe cc | $7,955.70 | 3 | 18 | $888.60 |
| K62B | Miscellaneous metabolic disorders w/o catastrophic or severe cc | $3,758.90 | 1 | 8 | $957.00 |
| K62C | Miscellaneous metabolic disorders, sameday | $460.30 | 1 | 1 | $458.00 |
| K63A | Inborn errors of metabolism w catastrophic or severe cc | $6,037.00 | 3 | 19 | $639.90 |
| K63B | Inborn errors of metabolism w/o catastrophic or severe cc | $1,090.60 | 0 | 4 | $817.20 |
| K64A | Endocrine disorders w catastrophic or severe cc | $9,619.50 | 4 | 24 | $826.70 |
| K64B | Endocrine disorders w/o catastrophic or severe cc | $4,255.80 | 1 | 9 | $965.90 |
| K64C | Endocrine disorders, sameday | $423.70 | 1 | 1 | $410.70 |
| L02A | Operative insertion of peritoneal catheter for dialysis w catastr | $7,566.10 | 2 | 11 | $1,400.00 |
| L02B | Operative insertion of peritoneal catheter for dialysis w/o catas | $3,108.30 | 0 | 4 | $1,400.00 |
| L03A | Kidney, ureter and major bladder procedures for neoplasm w cat cc | $21,981.20 | 4 | 25 | $1,400.00 |
| L03B | Kidney, ureter and major bladder procedures for neoplasm w sev cc | $13,973.20 | 2 | 11 | $1,400.00 |
| L03C | Kidney, ureter and major bladder procedures for neoplasm w/o cata | $9,321.40 | 1 | 7 | $1,400.00 |
| L04A | Kidney, ureter and major bladder procedures for non-neoplasm w ca | $16,593.30 | 5 | 28 | $1,152.20 |
| L04B | Kidney, ureter and major bladder procedures for non-neoplasm w/o | $4,695.40 | 0 | 4 | $1,400.00 |
| L04C | Kidney, ureter and major bladder procedures for non-neoplasm, sam | $2,278.40 | 1 | 1 | $1,400.00 |
| L05A | Transurethral prostatectomy for urinary disorder w cat or sev cc | $9,595.70 | 2 | 15 | $1,219.80 |
| L05B | Transurethral prostatectomy for urinary disorder w/o cat or sev c | $5,052.80 | 0 | 5 | $1,400.00 |
| L06A | Minor bladder procedures w catastrophic or severe cc | $8,973.10 | 3 | 16 | $1,103.10 |
| L06B | Minor bladder procedures w/o catastrophic or severe cc | $3,179.00 | 0 | 4 | $1,360.70 |
| L07A | Other transurethral procedures w cc | $3,546.10 | 0 | 6 | $1,145.20 |
| L07B | Other transurethral procedures w/o cc | $2,143.40 | 0 | 4 | $1,382.00 |
| L08A | Urethral procedures w cc | $3,592.20 | 0 | 6 | $1,144.90 |
| L08B | Urethral procedures w/o cc | $2,066.00 | 0 | 4 | $1,268.80 |
| L09A | Other procedures for kidney and urinary tract disorders w cat cc | $18,817.50 | 6 | 35 | $1,005.90 |
| L09B | Other procedures for kidney and urinary tract disorders w sev cc | $5,266.60 | 1 | 8 | $1,140.20 |
| L09C | Other procedures for kidney and urinary tract disorders w/o cat o | $3,152.70 | 0 | 4 | $1,400.00 |
| L40Z | Ureteroscopy | $2,376.70 | 0 | 4 | $1,228.80 |
| L41Z | Cystourethroscopy for urinary disorder, sameday | $987.30 | 1 | 1 | $754.80 |
| L42Z | ESW lithotripsy | $2,744.30 | 0 | 4 | $1,400.00 |
| L60A | Kidney failure w catastrophic cc | $11,767.50 | 4 | 26 | $909.90 |
| L60B | Kidney failure w severe cc | $6,743.70 | 2 | 15 | $928.80 |
| L60C | Kidney failure w/o catastrophic or severe cc | $3,576.90 | 1 | 9 | $859.70 |
| L61Z | Haemodialysis | $417.10 | 0 | 4 | $409.30 |
| L62A | Kidney and urinary tract neoplasms w catastrophic or severe cc | $9,183.00 | 4 | 25 | $753.70 |
| L62B | Kidney and urinary tract neoplasms w/o catastrophic or severe cc | $2,445.00 | 1 | 7 | $740.50 |
| L63A | Kidney and urinary tract infections w catastrophic or severe cc | $8,126.70 | 3 | 19 | $859.10 |
| L63B | Kidney and urinary tract infections w/o catastrophic or severe cc | $4,045.10 | 1 | 9 | $932.20 |
| L64A | Urinary stones and obstruction w catastrophic or severe cc | $5,464.90 | 2 | 12 | $839.40 |
| L64B | Urinary stones and obstruction w/o catastrophic or severe cc | $2,278.30 | 0 | 4 | $1,105.00 |
| L64C | Urinary stones and obstruction, sameday | $969.00 | 1 | 1 | $663.40 |
| L65A | Kidney and urinary tract signs and symptoms w catastrophic or sev | $7,091.20 | 3 | 17 | $843.00 |
| L65B | Kidney and urinary tract signs and symptoms w/o catastrophic or s | $2,096.80 | 0 | 5 | $854.70 |
| L66Z | Urethral Stricture | $1,899.90 | 0 | 4 | $1,068.10 |
| L67A | Other kidney and urinary tract disorders w catastrophic or severe | $7,385.20 | 3 | 17 | $871.80 |
| L67B | Other kidney and urinary tract disorders w/o catastrophic or seve | $2,410.50 | 0 | 5 | $906.20 |
| L67C | Other kidney and urinary tract disorders, sameday | $531.50 | 1 | 1 | $425.00 |
| M01A | Major male pelvic procedures w catastrophic or severe cc | $11,605.00 | 1 | 8 | $1,400.00 |
| M01B | Major male pelvic procedures w/o catastrophic or severe cc | $9,510.40 | 0 | 5 | $1,400.00 |
| M02A | Transurethral prostatectomy for reproductive system disorder w ca | $7,562.30 | 2 | 11 | $1,288.80 |
| M02B | Transurethral prostatectomy for reproductive system disorder w/o | $4,748.60 | 0 | 5 | $1,400.00 |
| M03Z | Penis procedures | $2,659.60 | 0 | 4 | $1,400.00 |
| M04Z | Testes procedures | $2,236.00 | 0 | 4 | $1,214.40 |
| M05Z | Circumcision | $1,368.00 | 0 | 4 | $982.50 |
| M06A | Other male reproductive system OR procedures w cc | $4,783.70 | 0 | 6 | $1,331.00 |
| M06B | Other male reproductive system OR procedures w/o cc | $3,283.00 | 0 | 4 | $1,400.00 |
| M40Z | Cystourethroscopy for male reproductive system disorder, sameday | $1,046.40 | 1 | 1 | $780.70 |
| M60A | Male reproductive system malignancy w catastrophic or severe cc | $7,118.30 | 3 | 20 | $721.00 |
| M60B | Male reproductive system malignancy w/o catastrophic or severe cc | $1,245.70 | 0 | 4 | $747.40 |
| M61A | Benign prostatic hypertrophy w cc | $4,503.40 | 2 | 11 | $830.50 |
| M61B | Benign prostatic hypertrophy w/o cc | $1,357.10 | 0 | 4 | $914.80 |
| M62A | Male reproductive system inflammation w cc | $5,593.40 | 2 | 13 | $866.60 |
| M62B | Male reproductive system inflammation w/o cc | $2,400.50 | 0 | 5 | $899.60 |
| M63Z | Male sterilisation procedures | $1,155.20 | 0 | 4 | $883.50 |
| M64Z | Other male reproductive system disorders | $1,141.70 | 0 | 4 | $782.10 |
| N01A | Pelvic evisceration and radical vulvectomy w catastrophic or seve | $15,243.40 | 3 | 19 | $1,400.00 |
| N01B | Pelvic evisceration and radical vulvectomy w/o catastrophic or se | $9,473.80 | 1 | 8 | $1,400.00 |
| N04A | Hysterectomy for non-malignancy w catastrophic or severe cc | $7,872.90 | 1 | 7 | $1,400.00 |
| N04B | Hysterectomy for non-malignancy w/o catastrophic or severe cc | $6,455.50 | 0 | 5 | $1,400.00 |
| N05A | Oophorectomy and complex fallopian tube procs for non-malig w cat | $6,485.90 | 0 | 5 | $1,400.00 |
| N05B | Oophorectomy and complex fallopian tube procs for non-malig w/o c | $4,170.50 | 0 | 4 | $1,400.00 |
| N06Z | Female reproductive system reconstructive procedures | $4,849.60 | 0 | 5 | $1,400.00 |
| N07A | Other uterus and adnexa procedures for non-malignancy | $3,639.80 | 0 | 4 | $1,400.00 |
| N07B | Other uterus and adnexa procedures for non-malignancy, sameday | $1,837.70 | 1 | 1 | $1,160.40 |
| N08Z | Endoscopic and laparoscopic procedures, female reproductive syste | $2,893.70 | 0 | 4 | $1,400.00 |
| N09Z | Other vagina, cervix and vulva procedures | $1,509.70 | 0 | 4 | $907.00 |
| N10Z | Diagnostic curettage and diagnostic hysteroscopy | $1,314.60 | 0 | 4 | $1,017.30 |
| N11Z | Other female reproductive system or procedures | $657.30 | 0 | 4 | $457.50 |
| N12A | Uterus and adnexa procedures for malignancy w catastrophic cc | $14,604.80 | 3 | 16 | $1,400.00 |
| N12B | Uterus and adnexa procedures for malignancy w/o catastrophic cc | $7,287.20 | 0 | 6 | $1,400.00 |
| N60A | Female reproductive system malignancy w catastrophic cc | $11,322.00 | 4 | 27 | $838.60 |
| N60B | Female reproductive system malignancy w/o catastrophic cc | $2,912.70 | 2 | 9 | $630.40 |
| N61Z | Female reproductive system infections | $2,827.40 | 1 | 6 | $926.50 |
| N62Z | Menstrual and other female reproductive system disorders | $1,095.60 | 0 | 4 | $671.10 |
| O01A | Caesarean delivery w catastrophic cc | $10,403.90 | 3 | 16 | $1,312.20 |
| O01B | Caesarean delivery w severe cc | $8,421.20 | 2 | 11 | $1,400.00 |
| O01C | Caesarean delivery w/o catastrophic or severe cc | $7,643.30 | 2 | 9 | $1,400.00 |
| O02A | Vaginal delivery w OR procedures w catastrophic or severe cc | $7,543.50 | 2 | 10 | $1,400.00 |
| O02B | Vaginal delivery w OR procedures w/o catastrophic or severe cc | $6,741.00 | 1 | 9 | $1,400.00 |
| O03A | Ectopic pregnancy w cc | $3,932.40 | 0 | 4 | $1,400.00 |
| O03B | Ectopic pregnancy w/o cc | $3,119.80 | 0 | 4 | $1,400.00 |
| O04A | Postpartum and post abortion w OR procedures w catastrophic or se | $5,702.30 | 2 | 11 | $966.90 |
| O04B | Postpartum and post abortion w OR procedures w/o catastrophic or | $3,344.50 | 0 | 5 | $1,400.00 |
| O04C | Postpartum and post abortion w OR procedures, sameday | $1,474.00 | 1 | 1 | $1,108.10 |
| O05Z | Abortion w OR procedures | $1,186.40 | 0 | 4 | $986.80 |
| O60A | Vaginal delivery w catastrophic or severe cc | $6,512.90 | 2 | 11 | $1,265.10 |
| O60B | Vaginal delivery w/o catastrophic or severe cc | $5,846.90 | 1 | 9 | $1,350.40 |
| O60C | Vaginal delivery, single uncomplicated | $5,570.00 | 1 | 8 | $1,400.00 |
| O61Z | Postpartum and post abortion w/o OR procedures | $2,568.80 | 0 | 6 | $913.20 |
| O63Z | Abortion w/o OR procedures | $1,070.00 | 0 | 4 | $800.30 |
| O66A | Antenatal and other obstetric admissions w catastrophic or severe | $3,225.90 | 1 | 8 | $875.40 |
| O66B | Antenatal and other obstetric admissions w/o catastrophic or seve | $1,929.80 | 0 | 4 | $1,008.00 |
| O66C | Antenatal and other obstetric admissions, sameday | $383.40 | 1 | 1 | $374.80 |
| P03B | Neonate, admwt 1000-1499g w significant OR proc w/o multiple majo | $39,436.40 | 7 | 35 | $1,400.00 |
| P06A | Neonate, admwt >=2500g w significant OR procedure w multiple majo | $42,284.30 | 8 | 35 | $1,400.00 |
| P06B | Neonate, admwt >=2500g w significant OR procedure w/o multiple ma | $13,969.90 | 4 | 22 | $1,245.50 |
| P60A | Neonate w/o sig OR proc, died or transferred to acute facility <5 | $1,645.40 | 0 | 4 | $1,096.90 |
| P60B | Neonate w/o sig OR proc, died or transferred to acute facility sa | $442.80 | 1 | 1 | $442.80 |
| P63A | Neonate, admwt 1000-1249g w/o sig OR proc <32 completed wks gesta | $22,993.50 | 9 | 35 | $867.70 |
| P64A | Neonate, admwt 1250-1499g w/o sig OR proc <32 completed wks gesta | $23,423.50 | 10 | 35 | $770.50 |
| P64B | Neonate, admwt 1250-1499g w/o sig OR proc >=32 completed wks gest | $22,591.60 | 9 | 35 | $801.10 |
| P65A | Neonate, admwt 1500-1999g w/o signif OR proc w multiple major pro | $19,932.80 | 10 | 35 | $640.90 |
| P65B | Neonate, admwt 1500-1999g w/o significant OR proc w major problem | $19,918.10 | 9 | 35 | $751.60 |
| P65C | Neonate, admwt 1500-1999g w/o significant OR proc w other problem | $16,769.90 | 7 | 35 | $769.30 |
| P65D | Neonate, admwt 1500-1999g w/o significant OR proc w/o problem | $15,250.80 | 6 | 35 | $866.50 |
| P66A | Neonate, admwt 2000-2499g w/o significant OR proc w multiple majo | $9,016.90 | 4 | 26 | $704.40 |
| P66B | Neonate, admwt 2000-2499g w/o significant OR proc w major problem | $12,959.00 | 5 | 32 | $825.40 |
| P66C | Neonate, admwt 2000-2499g w/o significant OR proc w other problem | $9,324.50 | 4 | 23 | $839.90 |
| P66D | Neonate, admwt 2000-2499g w/o significant OR proc w/o problem | $3,488.30 | 1 | 9 | $850.80 |
| P67A | Neonate, admwt >=2500g w/o sig OR proc <37 comp wks gestation w m | $9,375.70 | 4 | 22 | $852.30 |
| P67B | Neonate, admwt >=2500g w/o sig OR proc <37 comp wks gestation w m | $8,407.40 | 3 | 21 | $832.40 |
| P67C | Neonate, admwt >=2500g w/o sig OR proc <37 comp wks gestation w o | $6,850.50 | 3 | 18 | $796.40 |
| P67D | Neonate, admwt >=2500g w/o sig OR proc <37 comp wks gestation w/o | $2,459.70 | 1 | 7 | $722.60 |
| P68A | Neonate, admwt >=2500g w/o sig OR proc >=37 comp wks gestation w | $6,557.70 | 2 | 10 | $1,307.90 |
| P68B | Neonate, admwt >=2500g w/o sig OR proc >=37 comp wks gestation w | $4,132.00 | 1 | 8 | $1,086.70 |
| P 68C | Neonate, admwt >=2500g w/o sig OR proc >=37 comp wks gestation w | $2,404.50 | 0 | 5 | $960.80 |
| P68D | Neonate, admwt >=2500g w/o sig OR proc >=37 comp wks gestation w/ | $714.20 | 0 | 6 | $252.90 |
| Q01A | Splenectomy w catastrophic or severe cc | $14,940.10 | 3 | 21 | $1,252.20 |
| Q01B | Splenectomy w/o catastrophic or severe cc | $9,384.00 | 1 | 8 | $1,400.00 |
| Q02A | Blood and immune system disorders w other OR procedures w cat or | $13,863.90 | 4 | 25 | $1,058.00 |
| Q02B | Blood and immune system disorders w other OR procedures w/o cat o | $2,958.00 | 0 | 4 | $1,400.00 |
| Q60A | Reticuloendothelial and immunity disorders w catastrophic or seve | $8,272.10 | 3 | 18 | $909.20 |
| Q60B | Reticuloendothelial and immunity disorders w/o catastrophic or se | $3,462.40 | 1 | 8 | $944.50 |
| Q60C | Reticuloendothelial and immunity disorders, sameday | $587.00 | 1 | 1 | $555.10 |
| Q61A | Red blood cell disorders w catastrophic or severe cc | $6,535.40 | 3 | 15 | $844.30 |
| Q61B | Red blood cell disorders w/o catastrophic or severe cc | $2,701.20 | 0 | 6 | $893.80 |
| Q61C | Red blood cell disorders, sameday | $739.40 | 1 | 1 | $697.90 |
| Q62A | Coagulation disorders | $5,043.60 | 2 | 12 | $871.20 |
| Q62B | Coagulation disorders, sameday | $748.20 | 1 | 1 | $721.60 |
| R01A | Lymphoma and leukaemia w major OR procedures w catastrophic or se | $26,416.60 | 6 | 35 | $1,380.00 |
| R01B | Lymphoma and leukaemia w major OR procedures w/o catastrophic or | $8,606.70 | 2 | 10 | $1,400.00 |
| R02A | Other neoplastic disorders w major OR procedures w catastrophic c | $20,696.20 | 4 | 26 | $1,400.00 |
| R02B | Other neoplastic disorders w major OR procedures w severe or mode | $11,064.10 | 2 | 11 | $1,400.00 |
| R02C | Other neoplastic disorders w major OR procedures w/o cc | $7,118.70 | 1 | 7 | $1,400.00 |
| R03A | Lymphoma and leukaemia w other OR procedures w catastrophic or se | $20,445.20 | 5 | 33 | $1,223.10 |
| R03B | Lymphoma and leukaemia w other OR procedures w/o catastrophic or | $5,617.30 | 1 | 8 | $1,294.90 |
| R03C | Lymphoma and leukaemia w other OR procedures, sameday | $1,784.80 | 1 | 1 | $1,142.30 |
| R04A | Other neoplastic disorders w other OR procedures w cc | $6,691.70 | 2 | 10 | $1,139.20 |
| R04B | Other neoplastic disorders w other OR procedures w/o cc | $3,721.90 | 0 | 5 | $1,296.50 |
| R60A | Acute leukaemia w catastrophic cc | $22,958.00 | 7 | 35 | $1,031.50 |
| R60B | Acute leukaemia w/o catastrophic cc | $6,363.60 | 2 | 13 | $966.00 |
| R60C | Acute leukaemia, sameday | $679.30 | 1 | 1 | $634.00 |
| R61A | Lymphoma and non-acute leukaemia w catastrophic cc | $17,131.40 | 6 | 35 | $904.40 |
| R61B | Lymphoma and non-acute leukaemia w/o catastrophic cc | $4,712.80 | 2 | 10 | $945.10 |
| R61C | Lymphoma and non-acute leukaemia, sameday | $594.90 | 1 | 1 | $550.90 |
| R62A | Other neoplastic disorders w cc | $7,732.10 | 3 | 17 | $885.70 |
| R62B | Other neoplastic disorders w/o cc | $2,184.40 | 0 | 6 | $750.20 |
| R63Z | Chemotherapy | $553.40 | 0 | 4 | $542.50 |
| T01A | Infectious and parasitic diseases w OR procedures w catastrophic | $24,730.30 | 7 | 35 | $1,174.30 |
| T01B | Infectious and parasitic diseases w OR procedures w severe or mod | $11,272.60 | 3 | 18 | $1,147.80 |
| T01C | Infectious and parasitic diseases w OR procedures w/o cc | $6,134.80 | 1 | 9 | $1,217.90 |
| T40Z | Infectious and parasitic diseases w ventilator support | $35,052.90 | 6 | 35 | $1,400.00 |
| T60A | Septicaemia w catastrophic cc | $13,123.70 | 4 | 27 | $966.60 |
| T60B | Septicaemia w/o catastrophic cc | $6,644.50 | 2 | 14 | $935.60 |
| T61A | Postoperative and post-traumatic infections w catastrophic or sev | $8,411.70 | 3 | 20 | $828.00 |
| T61B | Postoperative and post-traumatic infections w/o catastrophic or s | $4,259.50 | 2 | 10 | $884.90 |
| T62A | Fever of unknown origin w cc | $5,451.40 | 2 | 12 | $949.60 |
| T62B | Fever of unknown origin w/o cc | $3,008.00 | 1 | 7 | $905.20 |
| T63A | Viral illnesses w cc | $5,495.40 | 2 | 15 | $756.60 |
| T63B | Viral illnesses w/o cc | $2,930.00 | 1 | 6 | $974.80 |
| T64A | Other infectious and parasitic diseases w catastrophic cc | $13,767.50 | 5 | 33 | $837.40 |
| T64B | Other infectious and parasitic diseases w severe or moderate cc | $7,114.90 | 3 | 17 | $815.60 |
| T64C | Other infectious and parasitic diseases w/o cc | $3,519.00 | 1 | 9 | $777.70 |
| U40Z | Mental health treatment w ECT, sameday | $440.00 | 1 | 1 | $401.80 |
| U60Z | Mental health treatment w/o ECT, sameday | $308.20 | 1 | 1 | $307.60 |
| U61A | Schizophrenia disorders, involuntary admission | $16,089.90 | 8 | 35 | $636.80 |
| U61B | Schizophrenia disorders | $14,692.80 | 6 | 35 | $760.10 |
| U62B | Paranoia & acute psyc disorders w/o cat or sev cc | $13,766.60 | 6 | 35 | $784.60 |
| U63A | Major affective disorders age >=70 or w catastrophic or severe cc | $16,795.40 | 7 | 35 | $746.70 |
| U63B | Major affective disorders age <70 w/o catastrophic or severe cc | $15,097.10 | 6 | 35 | $791.30 |
| U64Z | Other affective and somatoform disorders | $13,680.50 | 6 | 34 | $806.90 |
| U65Z | Anxiety Disorders | $13,156.00 | 5 | 33 | $801.40 |
| U66Z | Eating and obsessive-compulsive disorders | $21,032.10 | 8 | 35 | $839.90 |
| U67Z | Personality disorders and acute reactions | $15,072.40 | 6 | 35 | $812.10 |
| U68Z | Childhood mental disorders | $13,889.60 | 6 | 35 | $784.20 |
| V60A | Alcohol intoxication and withdrawal w cc | $10,165.40 | 4 | 24 | $854.00 |
| V60B | Alcohol intoxication and withdrawal w/o cc | $9,297.50 | 4 | 25 | $761.90 |
| V61Z | Drug intoxication and withdrawal | $12,332.00 | 6 | 34 | $742.40 |
| V62Z | Alcohol use and dependence | $12,988.00 | 5 | 33 | $791.60 |
| V63Z | Opioid use and dependence | $11,534.20 | 5 | 30 | $779.30 |
| V64Z | Other drug use and dependence | $12,596.00 | 6 | 34 | $754.20 |
| V65Z | Treatment for alcohol disorders, sameday | $304.70 | 1 | 1 | $304.70 |
| V66Z | Treatment for drug disorders, sameday | $272.50 | 1 | 1 | $272.50 |
| W02A | Hip, femur & lower limb procs for mult significant trauma w catas | $26,819.30 | 6 | 35 | $1,363.80 |
| W02B | Hip, femur & lower limb procs for mult significant trauma w/o cat | $16,237.60 | 3 | 17 | $1,400.00 |
| W04B | Multiple Significant Trauma W Other OR Procs w/o Catastrophic or | $22,195.90 | 4 | 21 | $1,400.00 |
| W60Z | Multiple Trauma, Died or Transferred to Acute Facility <5 Days | $2,667.20 | 0 | 4 | $1,333.60 |
| W61A | Multiple trauma w/o OR procedures w catastrophic or severe cc | $28,812.70 | 9 | 35 | $1,038.90 |
| W61B | Multiple trauma w/o OR procedures w/o catastrophic or severe cc | $3,002.60 | 1 | 8 | $810.70 |
| X02A | Microvascular tiss transfer or (skin graft w catastrophic or seve | $5,064.70 | 0 | 4 | $1,338.70 |
| X02B | Skin graft for injuries to hand w/o catastrophic or severe cc | $3,054.90 | 0 | 4 | $1,203.30 |
| X04A | Other procedures for injuries to lower limb w catastrophic or sev | $8,489.60 | 3 | 17 | $955.10 |
| X04B | Other procedures for injuries to lower limb w/o catastrophic or s | $3,530.30 | 0 | 4 | $1,345.50 |
| X05A | Other procedures for injuries to hand w cc | $3,931.70 | 0 | 5 | $1,202.90 |
| X05B | Other procedures for injuries to hand w/o cc | $2,457.20 | 0 | 4 | $1,050.00 |
| X06A | Other procedures for other injuries w catastrophic or severe cc | $8,747.40 | 2 | 15 | $1,106.40 |
| X06B | Other procedures for other injuries w/o catastrophic or severe cc | $3,405.10 | 0 | 4 | $1,357.10 |
| X07A | Skin graft for injuries excl hand w microvascular tiss trans or w | $13,985.90 | 4 | 24 | $1,040.10 |
| X07B | Skin graft for injuries excl hand w/o microvascular tiss trans w/ | $5,612.40 | 1 | 8 | $1,284.70 |
| X60A | Injuries w catastrophic or severe cc | $8,431.60 | 3 | 21 | $807.70 |
| X60B | Injuries w/o catastrophic or severe cc | $3,427.80 | 1 | 8 | $832.60 |
| X61Z | Allergic Reactions | $1,987.90 | 0 | 4 | $1,043.90 |
| X62A | Poisoning/toxic effects of drugs and other substances w cat or se | $6,935.90 | 2 | 14 | $987.90 |
| X62B | Poisoning/toxic effects of drugs and other substances w/o cat or | $2,851.50 | 0 | 6 | $1,014.60 |
| X63A | Sequelae of treatment w catastrophic or severe cc | $5,958.70 | 2 | 14 | $841.90 |
| X63B | Sequelae of treatment w/o catastrophic or severe cc | $2,529.20 | 0 | 6 | $844.80 |
| X64A | Other injuries, poisonings and toxic effects w catastrophic or se | $8,519.50 | 3 | 21 | $817.30 |
| X64B | Other injuries, poisonings and toxic effects w/o catastrophic or | $3,802.60 | 1 | 9 | $860.30 |
| Y02C | Skin grafts for other burns w/o catastrophic or severe cc, non em | $4,653.10 | 0 | 5 | $1,238.60 |
| Y03Z | Other or procedures for other burns | $4,936.60 | 1 | 7 | $939.10 |
| Y62A | Other burns w cc | $7,243.30 | 3 | 15 | $965.80 |
| Y62B | Other burns w/o cc | $5,299.90 | 2 | 12 | $883.30 |
| Y62C | Other Burns, Sameday | $1,055.40 | 1 | 1 | $520.40 |
| Z01A | Other contacts w health services w OR procedures | $3,509.80 | 0 | 4 | $1,400.00 |
| Z01B | Other contacts w health services w OR procedures, sameday | $1,546.20 | 1 | 1 | $1,024.10 |
| Z40Z | Other contacts w health services w endoscopy, sameday | $831.20 | 1 | 1 | $753.70 |
| Z61A | Signs and symptoms | $4,859.90 | 2 | 11 | $875.90 |
| Z61B | Signs and symptoms, sameday | $644.70 | 1 | 1 | $545.10 |
| Z63A | Other follow up after surgery or medical care w catastrophic cc | $8,441.90 | 5 | 28 | $619.70 |
| Z63B | Other follow up after surgery or medical care w/o catastrophic cc | $2,204.20 | 1 | 9 | $524.20 |
| Z64A | Other factors influencing health status | $3,731.20 | 2 | 11 | $650.30 |
| Z64B | Other factors influencing health status, sameday | $394.70 | 1 | 1 | $286.40 |
| Z65Z | Congenital anomalies and problems arising from neonatal period | $2,775.70 | 1 | 7 | $812.10 |
| Z66Z | Sleep disorders | $1,179.90 | 0 | 4 | $831.40 |
|  |  |  |  |  |  |

**Table 3**

A charge applicable to an admitted patient is not payable unless the patient is admitted in accordance with the criteria for admission.

| **Item No.** | **Description** | **Max Fee (excl. GST)** |
| --- | --- | --- |
|  |  |  |
| **SAME-DAY SERVICES DAY SURGERY FACILITY** | | |
| **Accommodation**  The band into which services fall will be determined in accordance with the Day Only Procedures Manual. | | |
| PR410 | Band 1: including gastrointestinal endoscopy, some minor surgical and non-surgical procedures not normally requiring anaesthetic. | $455.00 |
| PR420 | Band 2: including procedures other than Band 1 performed under local anaesthetic with no sedation. Theatre time less than 1 hour. | $541.50 |
| PR430 | Band 3: including procedures other than Band 1 performed under a general or regional anaesthesia or intravenous sedation. Theatre time less than 1 hour. | $632.50 |
| PR440 | Band 4: including procedures other than Band 1 performed under general or regional anaesthesia or intravenous sedation. Theatre time 1 hour or more. | $670.60 |
| **Theatre fee bands**  The band into which services fall will be determined in accordance with the Group Accommodation and Theatre Banding Schedule produced by the Commonwealth Department of Veterans Affairs, as in force at time of service.  Where more than 1 service is provided in a single theatre session, the theatre charge is?  (a) the theatre charge for the service with the highest theatre charge; plus  (b) 50% of the theatre charge for the service with the next highest theatre charge; plus  (c) 30% of the theatre charge for each of the other services so provided. | | |
| PRT01 | Theatre fee band: 1 | $522.50 |
| PRT02 | Theatre fee band: 2 | $666.80 |
| PRT03 | Theatre fee band: 3 | $927.20 |
| PRT04 | Theatre fee band: 4 | $1,341.20 |
| PRT05 | Theatre fee band: 5 | $1,721.10 |
| PRT06 | Theatre fee band: 6 | $2,266.40 |
| PRT07 | Theatre fee band: 7 | $3,100.50 |
| PRT08 | Theatre fee band: 8 | $3,309.20 |
| PRT09 | Theatre fee band: 9 | $4,414.60 |
| PRT10 | Theatre fee band: 10 | $5,779.00 |
| PRT11 | Theatre fee band: 11 | $8,200.70 |
| PRT12 | Theatre fee band: 12 | $8,805.10 |
| PRT13 | Theatre fee band: 13 | $8,326.20 |
| PRT1A | Theatre fee band: 1A | $261.20 |
| PRT50 | Theatre fee band: Dental minor | $493.90 |
| PRT55 | Theatre fee band: Dental major | $890.90 |
| PRT9A | Theatre fee band: 9A | $3,848.80 |
|  |  |  |

**All instruments appearing in this gazette are to be considered official, and obeyed as such**

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