

SUPPLEMENTARY GAZETTE



**THE SOUTH AUSTRALIAN
GOVERNMENT GAZETTE**

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All public Acts appearing in this gazette are to be considered official, and obeyed as such

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 29 May 2019 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* 30 April 2018, I, Rob Cordiner, 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 29 May 2019. This list will have effect from 1 July 2019.

| Provider ID | Name and Address |
|--------------------|---|
| 0067240H | Adelaide Ambulatory Day Surgery, 10A &10B, 50 Hutt Street SA 5000 |
| 0067180B | Adelaide City East Day Hospital, Level 1, 309 Wakefield Street, Adelaide SA 5000 |
| 0658181F | Adelaide Day Surgery, 18 North Terrace, Adelaide SA 5000 |
| 0067000A | Adelaide Eye and Laser Centre, 215 Greenhill Road, Eastwood SA 5063 |
| 0999771L | Adelaide Surgicentre, 89 King William Street, Kent Town SA 5067 |
| 0067120T | Bedford Day Surgery, 1284 South Road, Clovelly Park SA 5042 |
| 0931151B | Brighton Day Surgery, 1 Jetty Road, Brighton SA 5048 |
| 0930971X | Brighton Dialysis Clinic, 361-365 Brighton Road, Hove SA 5048 |
| 0067220K | Central Day Surgery, 235 Greenhill Road, Dulwich SA 5065 |
| 0999951J | Dextra Surgical, 341 South Road, Adelaide SA 5000 |
| 0067100X | Dextra Surgical Norwood, 83 Kensington Road, Norwood SA 5067 |
| 0879791H | Glen Osmond Surgicentre, 45 Glen Osmond Road, Eastwood SA 5063 |
| 0657221Y | Glenelg Day Surgery, 4 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 |
| 0067090F | Home Nurses Infusion Centre, 6 Watson Avenue, Rose Park SA 5067 |
| 0067150J | Icon Cancer Care Adelaide, Suite 10, Level 1, Tennyson Centre, 520 South Road, Kurralt Park SA 5037 |
| 0067250F | Icon Cancer Centre Windsor Gardens, Level 1, 480 North East Road, Windsor Gardens SA 5087 |
| 0065680Y | Kahlyn Day Centre, 40 Briant Road, Magill SA 5072 |
| 0067230J | Lift Cancer Care Services 7/506-520 South Road, Kurralt Park SA 5037 |
| 0067040T | NephroCare Payneham Dialysis Clinic, 2 Portrush Road, Payneham SA 5070 |
| 0873741Y | North Adelaide Day Surgery Centre, 174 Ward Street, North Adelaide SA 5006 |
| 0067020X | North Adelaide Gastroenterology Centre, 254 Melbourne Street, North Adelaide SA 5006 |
| 0834441A | Northern Endoscopy Centre, 127 Frost Road, Salisbury South SA 5106 |
| 0067140K | Oromax Day Surgery Pty Ltd, Level 3, Hutt Street, Adelaide, SA 5000 |
| 0899191Y | Oxford Day Surgery Centre, 54 Oxford Terrace, Unley SA 5061 |
| 0067080H | Repromed Day Surgery, 180 Fullarton Road, Dulwich SA 5065 |
| 0067260B | Seaford Day Surgery, 4 Vista Parade, Seaford Heights SA 5169 |
| 0657641A | South Terrace Urology Day Surgery, 326 South Terrace, Adelaide SA 5000 |
| 0067200T | Southern Endoscopy Centre, 271 Brighton Road, Somerton Park SA 5144 |
| 0067130L | Tennyson Centre Day Hospital, 520 South Road, Kurralt Park SA 5037 |
| 0067160H | Vista Day Surgery, Level 2, 57 Greenhill Road, Wayville SA 5034 |
| 0882301T | Waverley House Plastic Surgery Centre, 360 South Terrace, Adelaide SA 5000 |
| 0067110W | West Lakes Day Surgery, 151 Brebner Drive, West Lakes SA 5021 |
| 0067270A | Windsor Gardens Day Surgery, Suite 1, Level 1, 480 North East Road, Windsor Gardens SA 5087 |

Dated: 8 May 2019

ROB CORDINER
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 01 July 2019:

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 audiometrist;
10. scales of charges set out in Schedule 10 for the provision of services in private hospitals and day surgery facilities.
11. 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.
12. 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

13. 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*;

case 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 good, 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 includes 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.

14. If a charge prescribed in a scale of charges is expressed as an amount per hour—
- a charge is payable for services provided for less than or more than an hour; and
 - 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.
15. 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
16. 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.
17. 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: 26 April 2019

HON ROB LUCAS MLC
Treasurer

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 (not being a service to which any other item applies) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management - each attendance | \$40.00 |
| 00004 | Professional attendance by a general practitioner (not being an attendance at consulting rooms or a residential aged care facility and not being a service to which any other item in this table applies) that requires a short patient history and, if necessary, limited examination and management - an attendance on 1 or more patients at 1 place on 1 occasion - each patient | \$102.00 |
| 00020 | Professional attendance (not being a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in a residential aged care facility (not being accommodation in a self-contained unit) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management - an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion - each patient | \$102.00 |
| Level B | | |
| 00023 | Professional attendance at consulting rooms (not being a service to which any other item applies) by a general practitioner involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, or a professional attendance of less than 20 minutes duration involving components of a service to which item 36 or 44 applies - each attendance | \$81.00 |
| 00024 | Professional attendance by a general practitioner (not being an attendance at consulting rooms or a residential aged care facility and not being a service to which any other item in this 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 1 or more health-related issues, with appropriate documentation - an attendance on 1 or more patients at 1 place on 1 occasion - each patient | \$140.00 |
| 00035 | Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (not being a service to which any other item in this 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 1 or more health-related issues, with appropriate documentation - an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion - each patient | \$140.00 |
| Level C | | |
| 00036 | Professional attendance at consulting rooms (not being a service to which any other item applies) by a general practitioner involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, or a professional attendance of less than 40 minutes duration involving components of a service to which item 44 applies each attendance | \$148.00 |
| 00037 | Professional attendance by a general practitioner (not being an attendance at consulting rooms or a residential aged care facility and not being a service to which any other item in this 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 1 or more health-related issues, with appropriate documentation - an attendance on 1 or more patients at 1 place on 1 occasion - each patient | \$205.00 |

| Item No. | Description | Max fee (excl GST) |
|---|--|--------------------|
| 00043 | Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (not being a service to which any other item in this 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 1 or more health-related issues, with appropriate documentation - an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion - each patient | \$205.00 |
| Level D | | |
| 00044 | Professional attendance at consulting rooms (not being a service to which any other item applies) by a general practitioner involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, or a professional attendance of at least 40 minutes duration for implementation of a management plan each attendance | \$225.00 |
| 00047 | Professional attendance by a general practitioner (not being an attendance at consulting rooms or a residential aged care facility and not being a service to which any other item in this 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 1 or more health-related issues, with appropriate documentation an attendance on 1 or more patients at 1 place on 1 occasion - each patient | \$285.00 |
| 00051 | Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (not being a service to which any other item in this 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 1 or more health-related issues, with appropriate documentation - an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion - each patient | \$285.00 |
| GROUP A3 - SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES | | |
| 00099 | Professional attendance on a patient by a specialist practising in his or her specialty if:(a) the attendance is by video conference; and(b) the attendance is for a service: (i) provided with item 104 lasting more than 10 minutes; or (ii) provided with item 105; and (c) the patient is not an admitted patient; and(d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies. Derived Fee: 50% of the fee for the associated item. | DF |
| 00104 | Professional attendance by a specialist in the practice of his or her specialty where the patient is referred to him or her an attendance (other than a second or subsequent attendance in a single course of treatment) where that attendance is at consulting rooms or hospital, not being a service to which item 106 apply. Specialist, referred consultation of 25 minutes or LESS - surgery or hospital | \$155.80 |
| 00105 | Professional attendance by a specialist in the practice of his or her specialty following referral of the patient to him or her-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 | \$84.60 |
| 00106 | - initial specialist ophthalmologist attendance, referred consultation in a single course of treatment, being an attendance at which the sole service provided is refraction testing for the issue of a prescription for spectacles or contact lenses not being | \$139.30 |
| 00107 | Professional attendance by a specialist in the practice of his or her specialty where the patient is referred to him or her an attendance (other than a second or subsequent attendance in a single course of treatment) where that attendance is at a place other than consulting rooms or hospital | \$183.40 |
| 00108 | Professional attendance by a specialist in the practice of his or her specialty where the patient is referred to him or her each attendance subsequent to the first in a single course of treatment where that attendance is at a place other than consulting rooms or hospital or residential aged care facility | \$118.50 |
| 00109 | Initial specialist ophthalmologist paediatric attendance referred consultation in a single course of treatment, being an attendance at which a comprehensive eye examination, including pupil dilation, is performed on a child aged 9 years or under, or on a child aged 14 years or under with developmental delay, not being a service to which item 104, 106 or any of items 10801 to 10816 applies | \$223.60 |
| 00111 | Professional attendance at consulting rooms or in hospital by a specialist in the practice of his or her specialty following referral of the patient to him or her 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 \$300 or more For any particular patient, once only on the same day | \$66.00 |
| 00113 | Initial professional attendance of 10 minutes or less in duration on a patient by a specialist practising in his or her specialty if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19 (2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment. | \$107.80 |
| 0104A | Professional attendance at consulting rooms or hospital by a specialist in the practice of his or her specialty where the patient is referred to him or her. - Initial attendance in a single course of treatment, | \$178.40 |

| Item No. | Description | Max fee (excl GST) |
|---|--|--------------------|
| | not being a service to which item 106 applies Specialist, referred consultation of MORE THAN 25 minutes - surgery or hospital Note 1: Item number 0104A is not to be charged for in dependent medical examinations. Refer to Schedule B for IME consultation. Note 2: These item numbers are for initial consultations only. Doctors should bill l subsequent consultations in the usual manner. Note 3: The majority of consultations should fall into the 00104 category. The fact that a patient is a workers compensation claimant should not necessitate a longer consultation. Factor s that would extend the length of the consultation include: - the need to obtain a more detailed history or perform a more extensive examination than usual - additional time is required to review previous investigations, results or rep orts - previous intervention or other related medical complaints necessitate increased time and effort in order to determine appropriate treatment - extensive advice/counselling regarding ongoing treatment is required - a course of rehabilitation treatment is recommended to the worker for their discussion with t heir rehabilitation provider. | |
| 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 his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner - initial attendance in a single course of treatment | \$259.60 |
| 00112 | Professional attendance on a patient by a consultant physician practising in his or her specialty if: the attendance is by video conference; and the attendance is for a service: provided with item 110 lasting more than 10 minutes; or provided with item 116, 119, 132 or 133; and the patient is not an admitted patient; and the patient: (i) is located both: within a telehealth eligible area; and at the time of the attendance-at least 15 kms by road from the physician; or is a care recipient in a residential care service; or is a patient of: an aboriginal medical service; or an aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies. Extended Medicare safety net cap: 300% of the derived fee for this item, or \$500, whichever is the lesser amount Derived Fee: 50% of the fee for the associated item. | DF |
| 00114 | Initial professional attendance of 10 minutes or less in duration on a patient by a consultant physician practising in his or her specialty if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19 (2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment. | \$190.00 |
| 00116 | Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a medical practitioner - each attendance (not being a service to which item 119 applies) subsequent to the first in a single course of treatment | \$133.50 |
| 00117 | Professional attendance at consulting rooms or in hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her 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 \$300 or more For any particular patient, once only on the same day | \$115.80 |
| 00119 | Professional attendance at consulting rooms or hospital by a consultant physician in the practice of his or her specialty (other than psychiatry) where the patient is referred to him or her by a medical practitioner each minor attendance subsequent to the first in a single course of treatment | \$68.90 |
| 00120 | Professional attendance at consulting rooms or in hospital by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner an attendance after the first attendance in a single course of treatment, if: (a) the attendance is a minor attendance; and (b) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (c) the consultant physician subsequently performs the operation on the patient, on the same day; and (d) the operation is a service to which an item in Group T8 applies; and (e) the amount specified in the item in Group T8 as the fee for a service to which that item applies is \$300 or more For any particular patient, once only on the same day | \$66.00 |
| 00122 | Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) where the patient is referred to him or her by a referring practitioner initial attendance in a single course of treatment | \$290.00 |
| 00128 | Professional attendance at a place other than consulting rooms or hospital by a consultant physician in the practice of his or her specialty (other than psychiatry) where the patient is referred to him or her by a medical practitioner each attendance (other than a service to which item 131 applies) subsequent to the first in a single course of treatment | \$166.60 |
| 00131 | Professional attendance at a place other than consulting rooms or hospital by a consultant physician in the practice of his or her specialty (other than psychiatry) where the patient is referred to him or her by a medical practitioner each minor attendance subsequent to the first in a single course of treatment | \$130.10 |
| 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; | \$368.90 |

| Item No. | Description | Max fee (excl GST) |
|--|---|--------------------|
| | <ul style="list-style-type: none"> - comprehensive multi or detailed single organ system assessment; - the formulation of differential diagnoses; and <p>b) a treatment and management plan is developed and provided to the referring practitioner that involves:</p> <ul style="list-style-type: none"> - an opinion on diagnosis and risk assessment - treatment options and decisions including suggestions to facilitate a return to work - medication recommendations. <p>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.</p> <p>Note 1: Item 132 is only available once in the preceding 12 months.</p> <p>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."</p> | |
| 00133 | <p>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</p> <p>a) a review is undertaken that covers:</p> <ul style="list-style-type: none"> - 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 <p>b) a modified treatment and management plan is provided to the referring practitioner (see Note 3) that involves, where appropriate:</p> <ul style="list-style-type: none"> - a revised opinion on the diagnosis and risk assessment - treatment options and decisions including suggestions to facilitate a return to work - revised medication recommendations. <p>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.</p> <p>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.</p> <p>Note 1: Item 133 is only available twice in the preceding 12 months.</p> <p>Note 2: Should further reviews of the treatment and management plan be required, the appropriate item for such service/s is 116.</p> <p>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.</p> | \$192.90 |
| GROUP A29 - EARLY INTERVENTION SERVICES FOR CHILDREN WITH AUTISM PERVASIVE DEVELOPMENTAL DISORDER OR DISABILITY | | |
| 00135 | <p>Consultant paediatrician, referred consultation for assessment, diagnosis and development of a treatment and management plan for autism or any other pervasive developmental disorder - surgery or hospital professional attendance of at least 45 minutes duration at consulting rooms or hospital, by a consultant physician in his or her specialty of paediatrics, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with autism or any other pervasive developmental disorder, who has been referred to the consultant paediatrician by a referring practitioner, if the consultant paediatrician does the following:(a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate)(b) develops a treatment and management plan which must include the following: (i) the outcomes of the assessment; (ii) the diagnosis or diagnoses; (iii) opinion on risk assessment; (iv) treatment options and decisions; (v) appropriate medication recommendations, where necessary.(c) provides a copy of the treatment and management plan to the: (i) referring practitioner; and (ii) relevant allied health providers (where appropriate).not being an attendance on a child in respect of whom payment has previously been made under this item or items 137, 139 or 289.</p> | \$368.90 |
| 00137 | <p>Specialist or consultant physician, referred consultation for assessment, diagnosis and development of a treatment and management plan for a child with an eligible disability - surgery or hospital professional attendance of at least 45 minutes duration, at consulting rooms or hospital, by a specialist or consultant physician, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with an eligible disability, who has been referred to the specialist or consultant physician by a referring practitioner, if the specialist or consultant physician does the following:(a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate)(b) develops a treatment and management plan which must include the following: (i) the outcomes of the assessment; (ii) the diagnosis or diagnoses; (iii) opinion on risk assessment; (iv) treatment options and decisions; (v) appropriate medication recommendations, where necessary.(c) provides a copy of the treatment and management plan to the: (i) referring practitioner; and (ii) relevant allied health providers (where appropriate).not being an attendance on a child in respect of whom payment has previously been made under this item or items 135, 139 or 289.</p> | \$368.90 |
| 00139 | <p>General practitioner consultation for assessment, diagnosis and development of a treatment and management plan for a child with an eligible disability professional attendance of at least 45 minutes duration, at consulting rooms, by a general practitioner, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with an eligible disability, if the general practitioner does the following:(a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate)(b) develops a treatment and management plan which must include the following: (i) the outcomes of the assessment; (ii) the diagnosis or diagnoses; (iii) opinion on risk assessment; (iv) treatment options and</p> | \$226.20 |

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| | decisions; (v) appropriate medication recommendations, where necessary.(c) provides a copy of the treatment and management plan to the: (i) relevant allied health providers (where appropriate).not being an attendance on a child in respect of whom payment has previously been made under this item or items 135, 139 or 289. | |
| GROUP A28 - CONSULTANT PHYSICIAN OR SPECIALIST IN GERIATRIC MEDICINE | | |
| 00141 | Consultant physician or specialist in geriatric medicine, referred patient, initial comprehensive assessment and management - surgery or hospital. Professional attendance of more than 60 minutes in duration at consulting rooms or hospital by a consultant physician or specialist in the practice of his or her 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. | \$580.40 |
| 00143 | Consultant physician or specialist in geriatric medicine, review of referred patient, initial comprehensive assessment and management - surgery or hospital. Professional attendance of more than 30 minutes in duration at consulting rooms or hospital by a consultant physician or specialist in the practice of his or her 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. | \$362.80 |
| 00145 | Consultant physician or specialist in geriatric medicine, referred patient, initial comprehensive assessment and management - home visit. 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 his or her 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. | \$703.50 |
| 00147 | Consultant physician or specialist in geriatric medicine, review of referred patient, initial comprehensive assessment and management - home visit. 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 his or her 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. | \$439.80 |

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| 00149 | Professional attendance on a patient by a consultant physician or specialist practising in his or her specialty of geriatric medicine if: (a) the attendance is by video conference; and (b) item 141 or 143 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the physician or specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an Aboriginal Medical Service; or (b) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the act applies. Derived Fee: 50% of the fee for the associated item. | DF |
| 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 | \$336.40 |
| 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 | \$543.70 |
| 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 | \$734.50 |
| 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 | \$913.90 |
| 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 | \$1081.50 |
| 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 his or her specialty of psychiatry) involving members of a family and persons with close personal relationships with that family-each Group of 2 patients | \$229.90 |
| 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 his or her specialty of psychiatry) involving members of a family and persons with close personal relationships with that family-each Group of 3 patients | \$236.10 |
| 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 his or her specialty of psychiatry) involving members of a family and persons with close personal relationships with that family-each Group of 4 or more patients | \$271.60 |
| GROUP A7 - ACUPUNCTURE | | |
| 00173 | Attendance at which acupuncture is performed by a medical practitioner by application of stimuli on or through the surface of the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed | \$43.20 |
| 00193 | Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, on one occasion, involving either: (i) taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems; or (ii) a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies and at which acupuncture is performed by the general practitioner by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed | \$68.40 |
| 00195 | Professional attendance by a general practitioner who is a qualified medical acupuncturist, on 1 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 1 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 any other attendance on the same day related to the condition for which the acupuncture is performed. Derived fee: The fee for Item 193 (\$68.40), plus \$46.50 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 193 plus \$2.80 per patient. | DF |
| 00197 | professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, involving either:(i) taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes; or(ii) a professional attendance of at least 20 minutes but less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies and at which acupuncture is performed by the general practitioner by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed | \$108.90 |
| 00199 | professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, involving either: (i) taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems and lasting a least 40 minutes; or (ii) a professional attendance | \$182.20 |

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| | of at least 40 minutes duration for implementation of a management plan and at which acupuncture is performed by the general practitioner by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed | |
| GROUP A8 - CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES | | |
| 00288 | Professional attendance on a patient by a consultant physician practising in his or her specialty of psychiatry if: the attendance is by video conference; and item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 348, 350 or 352 applies to the attendance; and the patient is not an admitted patient; and the patient: is located both: within a telehealth eligible area; and at the time of the attendance - at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: an aboriginal medical service; or an aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies. Derived Fee: 50% of the fee for item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 348, 350 or 352. | DF |
| 00289 | Consultant psychiatrist, referred consultation for assessment, diagnosis and development of a treatment and management plan for autism or any other pervasive developmental disorder - surgery or hospital professional attendance of at least 45 minutes duration, at consulting rooms or hospital, by a consultant physician in his or her specialty of psychiatry, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with autism or any other pervasive developmental disorder, who has been referred to the consultant psychiatrist by a referring practitioner, if the consultant psychiatrist does the following:(a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate)(b) develops a treatment and management plan which must include the following: (i) the outcomes of the assessment; (ii) the diagnosis or diagnoses; (iii) opinion on risk assessment; (iv) treatment options and decisions; (v) appropriate medication recommendations, where necessary.(c) provides a copy of the treatment and management plan to the: (i) referring practitioner; and (ii) relevant allied health providers (where appropriate).not being an attendance on a child in respect of whom payment has previously been made under this item or items 135, 137 or 139. | \$459.40 |
| 00291 | Consultant psychiatrist, referred patient assessment and management Professional attendance by a consultant physician in the practice of his or her speciality of psychiatry where the patient is referred for the provision of an assessment and management plan by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or participating nurse practitioner, where the attendance is initiated by the referring practitioner and where the consultant psychiatrist provides the referring medical practitioner with an assessment and management plan to be undertaken by that practitioner for the patient, where clinically appropriate. An attendance of more than 45 minutes duration at consulting rooms during which: - An outcome tool is used where clinically appropriate - a mental state examination is conducted - a psychiatric diagnosis is made - The consultant psychiatrist decides that the patient can be appropriately managed by the referring practitioner without the need for ongoing treatment by the psychiatrist - a 12 month management plan, appropriate to the diagnosis, is provided to the referring practitioner which must: a) comprehensively evaluate biological, psychological and social issues; b) address diagnostic psychiatric issues; c) make management recommendations addressing biological, psychological and social issues; and d) be provided to the referring practitioner within two weeks of completing the assessment of the patient. - The diagnosis and management plan is explained and provided, unless clinically inappropriate, to the patient and/or the carer (with the patient's agreement) - The diagnosis and management plan is communicated in writing to the referring practitioner Not being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under this item | \$580.40 |
| 00293 | Consultant psychiatrist, review of referred patient assessment and management professional attendance by a consultant physician in the practice of his or her speciality of psychiatry to review a management plan previously prepared by that consultant psychiatrist for a patient and claimed under item 291, where the review is initiated by the referring medical practitioner practising in general practice or participating nurse practitioner.an attendance of more than 30 minutes but not more than 45 minutes duration at consulting rooms where that attendance follows item 291 and during which:- an outcome tool is used where clinically appropriate- a mental state examination is conducted- a psychiatric diagnosis is made- a management plan provided under item 291 is reviewed and revised- the reviewed management plan is explained and provided, unless clinically inappropriate, to the patient and/or the carer (with the patient's agreement)- the reviewed management plan is communicated in writing to the referring medical practitioner or participating nurse practitioner being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under item 291, and no payment has been made under item 359, payable no more than once in any 12 month period. | \$362.80 |
| 00296 | Consultant psychiatrist, initial consultation on a new patient, consulting rooms professional attendance of more than 45 minutes by a consultant physician in the practice of his or her speciality of psychiatry where a patient is referred to him or her by a referring practitioner, and where the patient: - is a new patient for this consultant psychiatrist; or- is a patient who has not received a professional attendance from this consultant psychiatrist in the preceding 24 months. not being an attendance on a patient in respect of whom payment has been made under this item, items 297 or 299, or any of items 300 to 346 or 353 to 358 or 361 to 370 in the preceding 24 month period | \$397.80 |
| 00297 | Consultant psychiatrist, initial consultation on a new patient, hospital. Professional attendance of more than 45 minutes at hospital by a consultant physician in the practice of his or her speciality of psychiatry where a patient is referred to him or her by a referring practitioner, and where the patient: - is a new patient for this consultant psychiatrist; or- is a patient who has not received a professional attendance from this consultant psychiatrist in the preceding 24 months. not being an attendance on a patient in respect of whom payment has been made under this item, items 296 or 299 or any of items 300 to 346 or 353 to 358 or 361 to 370 in the preceding 24 month period | \$397.80 |
| 00299 | Consultant psychiatrist, initial consultation on a new patient, home visits Professional attendance of more than 45 minutes at a place other than consulting rooms or hospital by a consultant physician in the | \$472.00 |

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| | practice of his or her speciality of psychiatry where a patient is referred to him or her by a referring practitioner, and where the patient: - is a new patient for this consultant psychiatrist; or - is a patient who has not received a professional attendance from this consultant psychiatrist in the preceding 24 months. not being an attendance on a patient in respect of whom payment has been made under this item, items 296 or 297, or any of items 300 to 346 or 353 to 358 or 361 to 370 in the preceding 24 month period | |
| 00300 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a referring practitioner an attendance of not more than 15 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 358 or 361 to 370 apply have not exceeded the sum of 50 attendances in a calendar year. | \$86.00 |
| 00302 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 15 minutes duration but not more than 30 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 358 or 361 to 370 apply have not exceeded the sum of 50 attendances in a calendar year | \$170.00 |
| 00304 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 30 minutes duration but not more than 45 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 358 or 361 to 370 apply have not exceeded the sum of 50 attendances in a calendar year | \$256.70 |
| 00306 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 45 minutes duration but not more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 358 or 361 to 370 apply have not exceeded the sum of 50 attendances in a calendar year | \$363.30 |
| 00308 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 358 or 361 to 370 apply have not exceeded the sum of 50 attendances in a calendar year | \$417.40 |
| 00310 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of not more than 15 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 318 and items 353 to 358 or 361 to 370 apply exceed 50 attendances in a calendar year. | \$89.30 |
| 00312 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 15 minutes duration but not more than 30 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 318 and items 353 to 358 or 361 to 370 apply exceed 50 attendances in a calendar year. | \$138.50 |
| 00314 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 30 minutes duration but not more than 45 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 318 and items 353 to 358 or 361 to 370 apply exceed 50 attendances in a calendar year. | \$188.80 |
| 00316 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 45 minutes duration but not more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 318 and items 353 to 358 or 361 to 370 apply exceed 50 attendances in a calendar year. | \$241.80 |
| 00318 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 318 and items 353 to 358 or 361 to 370 apply exceed 50 attendances in a calendar year. | \$247.00 |
| 00319 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner - an attendance of more than 45 minutes duration at consulting rooms, where the patient has: (a) been diagnosed as suffering severe personality disorder, anorexia nervosa, bulimia nervosa, dysthymic disorder, substance-related disorder, somatoform disorder or a pervasive development disorder; and (b) for persons 18 years and over, been rated with a level of functional impairment within the range 1 to 50 according to the Global Assessment of Functioning Scale - where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 358 or 361 to 370 apply do not exceed 160 attendances in a calendar year. | \$313.40 |
| 00320 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a referring practitioner an attendance of not more than 15 minutes duration at hospital | \$86.00 |
| 00322 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 15 minutes duration but not more than 30 minutes duration at hospital | \$170.00 |
| 00324 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 30 minutes duration but not more than 45 minutes duration at hospital | \$256.70 |
| 00326 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 45 minutes duration but not more than 75 minutes duration at hospital | \$363.30 |

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| 00328 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 75 minutes duration at hospital | \$421.40 |
| 00330 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a referring practitioner an attendance of not more than 15 minutes duration where that attendance is at a place other than consulting rooms or hospital | \$116.80 |
| 00332 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 15 minutes duration but not more than 30 minutes duration where that attendance is at a place other than consulting rooms or hospital | \$189.90 |
| 00334 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 30 minutes duration but not more than 45 minutes duration where that attendance is at a place other than consulting rooms or hospital | \$259.60 |
| 00336 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 45 minutes duration but not more than 75 minutes duration where that attendance is at a place other than consulting rooms or hospital | \$370.90 |
| 00338 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner an attendance of more than 75 minutes duration where that attendance is at a place other than consulting rooms or hospital | \$493.30 |
| 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 hours duration given under the continuous direct supervision of a consultant physician in the practice of his or her specialty of psychiatry, involving a group of 2 to 9 unrelated patients or a family group of more than 3 patients, each of whom is referred to the consultant physician by a referring practitioner each patient. | \$88.00 |
| 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 hours duration given under the continuous direct supervision of a consultant physician in the practice of his or her specialty of psychiatry, involving a family group of 3 patients, each of whom is referred to the consultant physician by a medical practitioner each patient | \$121.20 |
| 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 hours duration given under the continuous direct supervision of a consultant physician in the practice of his or her specialty of psychiatry, involving a family group of 2 patients, each of whom is referred to the consultant physician by a medical practitioner each patient | \$172.90 |
| 00348 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, where the patient is referred to him or her by a referring practitioner, involving an interview of a person other than the patient of not less than 20 minutes duration but less than 45 minutes duration, in the course of initial diagnostic evaluation of a patient | \$232.40 |
| 00350 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, where the patient is referred to him or her by a medical practitioner, involving an interview of a person other than the patient of not less than 45 minutes duration, in the course of initial diagnostic evaluation of a patient | \$337.10 |
| 00352 | Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, where the patient is referred to him or her by a referring practitioner, involving an interview of a person other than the patient of not less than 20 minutes duration, in the course of continuing management of a patient - payable not more than 4 times in any 12 month period | \$162.50 |
| 00353 | A telepsychiatry consultation by a consultant physician in the practice of his or her specialty of psychiatry (not being an attendance to which items 291 to 319 apply), where: -the patient is referred to him or her by a referring practitioner for assessment, diagnosis and/or treatment and is located in a regional, rural or remote area (rrma3-7), -that consultation and any other consultation to which items 353 to 361 apply, have not exceeded 12 consultations in a calendar year, - any other attendance to which items 300 to 308 and 353 to 358 or 361 to 370 apply, have not exceeded the sum of 50 attendances in a calendar year. A telepsychiatry consultation of not more than 15 minutes duration. | \$89.90 |
| 00355 | A telepsychiatry consultation of more than 15 minutes duration but not more than 30 minutes duration. | \$179.40 |
| 00356 | A telepsychiatry consultation of more than 30 minutes duration but not more than 45 minutes duration. | \$263.30 |
| 00357 | A telepsychiatry consultation of more than 45 minutes duration but not more than 75 minutes duration | \$363.30 |
| 00358 | A telepsychiatry consultation of more than 75 minutes duration | \$442.50 |
| 00359 | A telepsychiatry consultation of more than 30 minutes but not more than 45 minutes duration by a consultant physician in the practice of his or her specialty of psychiatry where: the patient is located in a regional, rural or remote area (rrma 3-7)in the preceding 12 months, payment has been made under item 291 an outcome tool is used where clinically appropriate a mental state examination is conducted a psychiatric diagnosis is made a management plan provided under item 291 is reviewed and revised the reviewed management plan is explained and provided, unless clinically inappropriate, to the patient and/or the carer (with the patient's agreement)the reviewed management plan is communicated in writing to the referring practitioner not being an attendance on a patient in respect of whom payment has been made under this item or item 293 in the preceding 12 month period. | \$501.20 |
| 00361 | A telepsychiatry consultation of more than 45 minutes by a consultant physician in the practice of his or her specialty of psychiatry where: the patient is a new patient for this consultant psychiatrist, or a patient who has not received a professional attendance from this consultant psychiatrist in the preceding 24 months the patient is located in a regional, rural or remote area (rrma3-7)not being an | \$383.50 |

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| | attendance on a patient in respect of whom payment has been made under this item, items 296 to 299, or any of items 300 to 346 or 353 to 370 in the preceding 24 month period. | |
| 00364 | Consultant psychiatrist, referred consultation for assessment, diagnosis and treatment following professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, where: - the patient is referred to him or her by a referring practitioner, - that attendance occurs following a telepsychiatry consultation (items 353 to 361), - that attendance and any other attendance to which items 300 to 308 and 353 to 358 or 361 to 370 apply, have not exceeded the sum of 50 attendances in a calendar year. These items may only be used after telepsychiatry consultation(s) have been conducted in accordance with items 353 to 361. A face-to-face attendance of not more than 15 minutes duration. | \$76.70 |
| 00366 | A face-to-face attendance of more than 15 minutes duration but not more than 30 minutes duration | \$156.00 |
| 00367 | A face-to-face attendance of more than 30 minutes duration but not more than 45 minutes duration. | \$228.50 |
| 00369 | A face-to-face attendance of more than 45 minutes duration but not more than 75 minutes duration | \$346.90 |
| 00370 | A face-to-face attendance of more than 75 minutes duration. | \$377.50 |
| GROUP A13 - PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES | | |
| 00410 | Professional attendance at consulting rooms by a public health physician in the practice of his or her speciality of public health medicine - attendance for a n obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management | \$34.50 |
| 00411 | Professional attendance at consulting rooms by a public health physician in the practice of his or her speciality of public health medicine - attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, or an attendance of less than 20 minutes duration involving components of a service to which item 412 applies | \$75.40 |
| 00412 | Professional attendance at consulting rooms by a public health physician in the practice of his or her speciality of public health medicine - attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR an attendance of less than 40 minutes duration involving components of a service to which item 413 applies | \$142.10 |
| 00413 | Professional attendance at consulting rooms by a public health physician in the practice of his or her speciality of public health medicine - attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, or an attendance of at least 40 minutes duration for implementation of a management plan | \$210.30 |
| 00414 | Attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management. Derived Fee: The fee for item 410 (\$34.50), plus \$46.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 410 plus \$2.80 per patient | DF |
| 00415 | Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant:(a) taking a patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation. Derived Fee: The fee for item 411 (\$75.40), plus \$46.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 411 plus \$2.80 per patient | DF |
| 00416 | Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant:(a) taking a detailed patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation. Derived Fee: The fee for item 412 (\$142.10), plus \$46.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 412 plus \$2.80 per patient | DF |
| 00417 | Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant:(a) taking an extensive patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation. Derived Fee: The fee for item 413 (\$210.30), plus \$46.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 413 plus \$2.80 per patient | DF |
| GROUP A21 - MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES | | |
| Consultations | | |
| 00501 | Medical practitioner (emergency physician) attendances emergency department level 1 professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine - attendance for the unscheduled evaluation and management of a patient requiring the taking of a problem focussed history, limited examination, diagnosis and initiation of appropriate treatment interventions involving straightforward medical decision making. | \$67.70 |
| 00503 | Medical practitioner (emergency physician) attendances emergency department level 2 professional attendance on a patient at a recognised emergency department of a private hospital by a medical | \$113.60 |

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| | practitioner who is an emergency medicine physician in the practice of emergency medicine - attendance for the unscheduled evaluation and management of a patient requiring the taking of an expanded problem focussed history, expanded examination of one or more systems and the formulation and documentation of a diagnosis and management plan in relation to one or more problems, and the initiation of appropriate treatment interventions involving medical decision making of low complexity. | |
| 00507 | Medical practitioner (emergency physician) attendances emergency department level 3 professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine - attendance for the unscheduled evaluation and management of a patient requiring the taking of an expanded problem focussed history, expanded examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, and the initiation of appropriate treatment interventions involving medical decision making of moderate complexity. | \$192.50 |
| 00511 | Medical practitioner (emergency physician) attendances emergency department level 4 professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine - attendance for the unscheduled evaluation and management of a patient requiring the taking of a detailed history, detailed examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives, involving medical decision making of moderate complexity. | \$269.10 |
| 00515 | Medical practitioner (emergency physician) attendances emergency department level 5 professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine - attendance for the unscheduled evaluation and management of a patient requiring the taking of a comprehensive history, comprehensive examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives, involving medical decision making of high complexity. | \$352.10 |
| Prolonged professional attendances | | |
| 00519 | Medical practitioner (emergency physician) attendances emergency department professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine - attendance for emergency evaluation of a critically ill patient with an immediately life threatening problem requiring immediate and rapid assessment, initiation of resuscitation and electronic vital signs monitoring, comprehensive history and evaluation whilst undertaking resuscitative measures, ordering and evaluation of appropriate investigations, transitional evaluation and monitoring, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives prior to admission to an in-patient hospital bed - for a period of not less than 30 minutes but less than 1 hour of total physician time spent with each patient | \$265.50 |
| 00520 | For a period of not less than 1 hour but less than 2 hours of total physician time spent with each patient. | \$411.90 |
| 00530 | For a period of not less than 2 hours but less than 3 hours of total physician time spent with each patient | \$652.80 |
| 00532 | For a period of not less than 3 hours but less than 4 hours of total physician time spent with each patient. | \$914.00 |
| 00534 | For a period of not less than 4 hours but less than 5 hours of total physician time spent with each patient. | \$1175.50 |
| 00536 | For a period of 5 hours or more of total physician time spent with each patient. | \$1110.10 |
| 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. | \$199.10 |
| 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. | \$199.10 |
| 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. | \$153.40 |
| 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. | \$64.30 |
| 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 | \$480.00 |

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| | 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. | |
| 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. | \$227.90 |
| GROUP A14 - HEALTH ASSESSMENTS | | |
| 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 | \$75.30 |
| 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 | \$173.40 |
| 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 | \$239.20 |
| 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 | \$337.90 |
| 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 | \$266.80 |
| 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. | \$181.70 |
| 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; ore. 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. | \$143.60 |
| 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. | \$90.90 |
| GROUP A17 - DOMICILIARY MEDICATION MANAGEMENT REVIEW | | |
| 00900 | Participation by a general practitioner in a Domiciliary Medication Management Review (DMMR) for a patient living in a community setting, in which the general practitioner, with the patient's consent: (a) assesses the patient as: (i) having a chronic medical condition or a complex medication regimen; and (ii) not having their therapeutic goals met; and (b) following that assessment: (i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and (ii) provides relevant clinical information required for the DMMR; and (c) discusses with the reviewing pharmacist the results of the DMMR including suggested medication management strategies; and (d) develops a written medication management plan following discussion with the patient; and (e) provides the written medication management plan to a community pharmacy chosen by the patient For any particular patient—applicable not more than once in each 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR | \$267.40 |

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| 00903 | Participation by a general practitioner in a residential medication management review (RMMR) for a patient who is a permanent resident of a residential aged care facility-other than an RMMR for a resident in relation to whom, in the preceding 12 months, this item has applied, unless there has been a significant change in the resident's medical condition or medication management plan requiring a new RMMR | \$183.00 |
| GROUP A30 - MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES | | |
| Telehealth attendance at consulting rooms, home visits or other institutions | | |
| 02100 | Level A - Telehealth attendance at consulting rooms professional attendance at consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: is participating in a video conferencing consultation with a specialist or consultant physician; and is not an admitted patient; and either: is located both: within a telehealth eligible area; and at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or is a patient of: an Aboriginal medical service; (B) or an Aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies | \$36.30 |
| 02122 | Level A - Telehealth attendance other than at consulting rooms professional attendance not in consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: is participating in a video conferencing consultation with a specialist or consultant physician; and is not an admitted patient; and is not a care recipient in a residential care service; and is located both: within a telehealth eligible area; and at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion-each patient. Derived Fee: The fee for item 2100 (\$36.30) plus \$41.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2100 plus \$3.20 per patient. | DF |
| 02126 | Level B - Telehealth attendance at consulting rooms. Professional attendance at consulting rooms of less than 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who:(a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and(c) either: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (a) an Aboriginal medical service; or (b) an Aboriginal community controlled health service for which a direction made under subsection 19 (2) of the Act applies | \$79.10 |
| 02137 | Level B - Telehealth attendance other than at consulting rooms. Professional attendance not in consulting rooms of less than 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion-each patient. Derived Fee: The fee for item 2126 (\$79.10) plus \$41.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2126 plus \$3.20 per patient. | DF |
| 02143 | Level C - Telehealth attendance at consulting rooms. Professional attendance at consulting rooms of at least 20 minutes in duration (whether or not continuous) by a medical practitioner who provides clinical support to a patient who: is participating in a video conferencing consultation with a specialist or consultant physician; and is not an admitted patient; and either: is located both: within a telehealth eligible area; and at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or is a patient of: an Aboriginal medical service; or an Aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies | \$153.20 |
| 02147 | Level C - Telehealth attendance other than at consulting rooms. Professional attendance not in consulting rooms of at least 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: is participating in a video conferencing consultation with a specialist or consultant physician; and is not an admitted patient; and is not a care recipient in a residential care service; and is located both: within a telehealth eligible area; and at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion-each patient. Derived Fee: The fee for item 2143 (\$153.20) plus \$41.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2143 plus \$3.20 per patient. | DF |
| 02195 | Level D - Telehealth attendance at consulting rooms. Professional attendance at consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: is participating in a video conferencing consultation; and is not an admitted patient; and either: is located both: within a telehealth eligible area; and at the time of the attendance-at least 15 kms by road from the specialist or consultant physician mentioned in paragraph (a); or is a patient of: an Aboriginal medical service; or an Aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies | \$225.60 |
| 02199 | Level D - Telehealth attendance other than at consulting rooms. Professional attendance not in consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: is participating in a video conferencing consultation with a specialist or consultant physician; and is not an admitted patient; and is not a care recipient in a residential care service; and is located both: within a telehealth eligible area; and at the time of the attendance - at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion - each patient. Derived Fee: The fee for item 2195 (\$225.60) plus \$41.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2195 plus \$3.20 per patient. | DF |

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| Telehealth attendance at a residential aged care facility | | |
| 02125 | Professional attendance of at least 5 minutes in duration (whether or not continuous) by a general practitioner, specialist or consultant physician providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion-each patient. Derived Fee: The fee for item 2100 (\$36.30) plus \$74.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2100 plus \$5.30 per patient. | DF |
| 02138 | Professional attendance of less than 20 minutes in duration (whether or not continuous) by a general practitioner, specialist or consultant physician providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion-each patient. Derived Fee: The fee for item 2126 (\$79.10) plus \$74.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2126 plus \$5.30 per patient. | DF |
| 02179 | Professional attendance of at least 20 minutes in duration (whether or not continuous) by a general practitioner, specialist or consultant physician providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion-each patient. Derived Fee: The fee for item 2143 (\$153.20) plus \$74.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2143 plus \$5.30 per patient. | DF |
| 02220 | Professional attendance of at least 40 minutes in duration (whether or not continuous) by a general practitioner, specialist or consultant physician providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion-each patient. The fee for item 2195 (\$225.60) plus \$74.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2195 plus \$5.30 per patient. | DF |

GROUP A18 - GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS

Taking of a cervical smear from an unscreened or significantly underscreened woman

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| 02497 | Professional attendance at consulting rooms by a general practitioner: (a) involving taking a short patient history and, if required, limited examination and management; and (b) at which a specimen for a cervical screening service is collected from the patient; if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years. | \$29.10 |
| 02501 | Professional attendance by a general practitioner at consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years. | \$64.70 |
| 02503 | Professional attendance by a general practitioner at a place other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years. Derived Fee: The fee for item 2501 (\$64.70), plus \$46.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2501 plus \$2.80 per patient | DF |
| 02504 | Professional attendance by a general practitioner at consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years | \$121.60 |
| 02506 | Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years. Derived Fee: The fee for item 2504 (\$121.60), plus \$46.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2504 plus \$2.80 per patient | DF |
| 02507 | Professional attendance by a general practitioner at consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related | \$178.90 |

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| | issues, with appropriate documentation, and at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years | |
| 02509 | Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years Derived Fee: The fee for item 2507 (\$178.90), plus \$46.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2507 plus \$2.80 per patient | DF |
| Completion of a cycle of care for patients with established diabetes mellitus | | |
| 02517 | The minimum requirements of care needed to be assessed to complete a cycle of care for patients with established diabetes mellitus are: - Assess diabetes control by measuring HbA1c At least once every year - Ensure that a comprehensive eye examination is carried out* At least once every two years - Measure weight and height and calculate bmi** At least twice every cycle of care - Measure blood pressure At least twice every cycle of care - Examine feet*** At least twice every cycle of care - Measure total cholesterol, triglycerides and hdl cholesterol At least once every year - Test for microalbuminuria At least once every year - Provide self-care education Patient education regarding diabetes management - Review diet Reinforce information about appropriate dietary choices - Review levels of physical activity Reinforce information about appropriate levels of physical activity - Check smoking status Encourage cessation of smoking (if relevant) - Review of medication review * Not required if the patient is blind or does not have both eyes. ** Initial visit: measure height and weight and calculate bmi as part of the initial patient assessment. Subsequent visits: measure weight. *** Not required if the patient does not have both feet. level 'b' Professional attendance involving taking a selective history, examination of the patient with the implementation of a management plan in relation to one or more problems, or a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies; and which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus surgery consultation (Professional attendance at consulting rooms) | \$64.10 |
| 02518 | Professional attendance by a general practitioner at a place other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant:(a) taking a patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation, and completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus Derived Fee: The fee for item 2517 (\$64.10), plus \$46.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2517 plus \$2.80 per patient | DF |
| 02521 | Level 'c' Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 20 minutes, or a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies; and which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus surgery consultation (Professional attendance at consulting rooms) | \$121.60 |
| 02522 | Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant:(a) taking a detailed patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus Derived Fee: The fee for item 2521 (\$121.60), plus \$46.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2521 plus \$2.80 per patient | DF |
| 02525 | Level 'd' Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more complex problems and lasting at least 40 minutes, or a professional attendance of at least 40 minutes duration for implementation of a management plan and which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus surgery consultation (Professional attendance at consulting rooms) | \$178.90 |
| 02526 | Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant:(a) taking an extensive patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus Derived Fee: The fee for item 2525 (\$178.90), plus \$46.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2525 plus \$2.80 per patient | DF |
| Completion of the asthma cycle of care | | |
| 02546 | Note: Benefits are payable for only one service included in Subgroup 3 or a 19, Subgroup 3 in a 12-month period, unless a further Asthma Cycle of Care is clinically indicated. At a minimum the Asthma Cycle of Care must include: - at least 2 asthma related consultations within 12 months for a patient with moderate to severe asthma (at least 1 of which (the review consultation) is a consultation that was planned at a previous consultation) - documented diagnosis and assessment of level of asthma control and severity of asthma - review of the patient 's use of and access to asthma related medication and | \$64.10 |

| Item No. | Description | Max fee (excl GST) |
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| | devices - provision to the patient of a written asthma action plan (if the patient is unable to use a written asthma action plan - discussion with the patient about an alternative method of providing an asthma action plan, and documentation of the discussion in the patient's medical records - provision of asthma self-management education to the patient - review of the written or documented asthma action plan level 'b' Professional attendance involving taking a selective history, examination of the patient with the implementation of a management plan in relation to one or more problems, or a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies; and which completes the minimum requirements of the Asthma Cycle of Care. surgery consultation (Professional attendance at consulting room s) | |
| 02547 | Professional attendance by a general practitioner at a place other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant:(a) taking a patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health- related issues, with appropriate documentation, and that completes the minimum requirements of the asthma cycle of care Derived Fee: The fee for item 2546 (\$64.10), plus \$46.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2546 plus \$2.80 per patient | DF |
| 02552 | Level 'c' Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 20 minutes, or a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies; and which completes the minimum requirements of the Asthma Cycle of Care. surgery consultation (Professional attendance at consulting rooms) | \$121.60 |
| 02553 | Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant:(a) taking a detailed patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health- related issues, with appropriate documentation, and that completes the minimum requirements of the asthma cycle of care Derived Fee: The fee for item 2552 (\$121.60), plus \$46.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2552 plus \$2.80 per patient | DF |
| 02558 | Level 'd' Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more complex problems and lasting at least 40 minutes, or a professional attendance of at least 4 0 minutes duration for implementation of a management plan and which completes the minimum requirements of the Asthma Cycle of Care Plan. surgery consultation (Professional attendance at consulting rooms) | \$178.90 |
| 02559 | Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant:(a) taking an extensive patient history;(b) performing a clinical examination;(c) arranging any necessary investigation;(d) implementing a management plan;(e) providing appropriate preventive health care; for 1 or more health- related issues, with appropriate documentation, and that completes the minimum requirements of the asthma cycle of care Derived Fee: The fee or item 2558 (\$178.90), plus \$46.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2558 plus \$2.80 per patient | DF |
| 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 | \$124.80 |
| 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 | \$183.60 |
| 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 | \$138.40 |
| 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 | \$158.50 |
| 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 | \$233.30 |
| 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 | \$140.80 |
| 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 | DF |

| Item No. | Description | Max fee (excl GST) |
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| | 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. Derived fee: The fee for item 02721 (\$140.80), plus \$46.50 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for item 02721 plus \$2.80 per patient. | |
| 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 | \$188.90 |
| 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. The fee for item 02725 (\$188.90), plus \$46.50 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for item 02725 plus \$2.80 per patient. | DF |
| GROUP A24 - PAIN AND PALLIATIVE MEDICINE | | |
| Pain medicine attendances | | |
| 02799 | Initial professional attendance of 10 minutes or less in duration on a patient by a specialist or consultant physician practising in his or her specialty of pain medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19 (2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment | \$190.00 |
| 02801 | Medical practitioner (pain medicine specialist) attendance - surgery or hospital Professional attendance at consulting rooms or hospital by a consultant physician or specialist practising in the specialty of pain medicine, where the patient was referred to him or her by a referring practitioner - initial attendance in a single course of treatment | \$283.00 |
| 02806 | - each attendance (other than a service to which item 2814 applies) subsequent to the first in a single course of treatment | \$133.50 |
| 02814 | - each minor attendance subsequent to the first in a single course of treatment | \$68.90 |
| 02820 | Professional attendance on a patient by a specialist or consultant physician practising in his or her specialty of pain medicine if:(a) the attendance is by video conference; (b) and the attendance is for a service: (i) provided with item 2801 lasting more than 10 minutes; or (ii) provided with item 2806 or 2814; and (c) the patient is not an admitted patient; and(d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies. Derived Fee: 50% of the fee for the associated item. | DF |
| 02824 | Medical practitioner (pain medicine specialist) attendance - home visit Professional attendance at a place other than consulting rooms or hospital by a consultant physician or specialist practising in the specialty of pain medicine, where the patient was referred to him or her by a medical practitioner - initial attendance in a single course of treatment | \$290.00 |
| 02832 | - each attendance (other than a service to which item 2840 applies) subsequent to the first in a single course of treatment | \$166.60 |
| 02840 | - each minor attendance subsequent to the first in a single course of treatment | \$125.80 |
| Pain medicine case conferences | | |
| 02946 | Case conferences - pain medicine specialist Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to organise and coordinate a community case conference, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines | \$246.20 |
| 02949 | Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to organise and coordinate a community case conference, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines | \$369.40 |
| 02954 | Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to organise and coordinate a community case conference, where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines | \$492.20 |
| 02958 | Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to participate in a community case conference, (other than to organise and to coordinate the conference) where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines | \$128.20 |
| 02972 | Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to participate in a community case conference, (other than to organise and to coordinate the conference) where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines | \$268.40 |
| 02974 | Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to participate in a community case conference, (other than to organise and to coordinate the conference) where the conference time is at least 45 minutes, with a | \$280.50 |

| Item No. | Description | Max fee (excl GST) |
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| | multidisciplinary team of at least two other formal care providers of different disciplines | |
| 02978 | Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to organise and coordinate a discharge case conference, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines | \$267.80 |
| 02984 | Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to organise and coordinate a discharge case conference, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines | \$369.40 |
| 02988 | Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to organise and coordinate a discharge case conference, where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines | \$492.20 |
| 02992 | Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to participate in a discharge case conference, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines | \$167.10 |
| 02996 | Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to participate in a discharge case conference, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines | \$268.40 |
| 03000 | Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to participate in a discharge case conference, where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines | \$366.30 |
| Palliative medicine attendances | | |
| 03003 | Initial professional attendance of 10 minutes or less in duration on a patient by a specialist or consultant physician practising in his or her specialty of palliative medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19 (2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment | \$190.00 |
| 03005 | Medical practitioner (palliative medicine specialist) attendance - surgery or hospital Professional attendance at consulting rooms or hospital by a consultant physician or specialist practising in the specialty of palliative medicine, where the patient was referred to him or her by a referring practitioner - initial attendance in a single course of treatment | \$259.60 |
| 03010 | - each attendance (other than a service to which item 3014 applies) subsequent to the first in a single course of treatment | \$133.50 |
| 03014 | - each minor attendance subsequent to the first in a single course of treatment | \$68.90 |
| 03015 | Professional attendance on a patient by a specialist or consultant physician practising in his or her specialty of palliative medicine if:(a) the attendance is by video conference; and(b) the attendance is for a service: (i) provided with item 3005 lasting more than 10 minutes; or (ii) provided with item 3010 or 3014; and (c) the patient is not an admitted patient; and(d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (a) an aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies. Derived Fee: 50% of the fee for the associated item. | DF |
| 03018 | Medical practitioner (palliative medicine specialist) attendance - home visit Professional attendance at a place other than consulting rooms or hospital by a consultant physician or specialist practising in the specialty of palliative medicine, where the patient was referred to him or her by a referring practitioner - initial attendance in a single course of treatment | \$290.00 |
| 03023 | - each attendance (other than a service to which item 3028 applies) subsequent to the first in a single course of treatment | \$166.60 |
| 03028 | - each minor attendance subsequent to the first in a single course of treatment | \$125.80 |
| Palliative medicine case conferences | | |
| 03032 | Case conferences - palliative medicine specialist Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a community case conference, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines | \$246.20 |
| 03040 | Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a community case conference, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines | \$369.40 |
| 03044 | Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a community case conference, where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines | \$492.20 |

| Item No. | Description | Max fee (excl GST) |
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| 03051 | Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to participate in a community case conference, (other than to organise and to coordinate the conference) where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines | \$128.20 |
| 03055 | Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to participate in a community case conference, (other than to organise and to coordinate the conference) where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines | \$232.10 |
| 03062 | Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to participate in a community case conference, (other than to organise and to coordinate the conference) where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines | \$366.30 |
| 03069 | Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a discharge case conference, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines | \$267.80 |
| 03074 | Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a discharge case conference, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines | \$401.90 |
| 03078 | Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a discharge case conference, where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines | \$535.60 |
| 03083 | Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to participate in a discharge case conference, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines | \$167.10 |
| 03088 | Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to participate in a discharge case conference, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines | \$268.40 |
| 03093 | Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to participate in a discharge case conference, where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines | \$366.30 |
| 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 person who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item or item 81000, 81005 or 81010 applies in relation to that pregnancy Note: For items 81000, 81005 and 81010, see the determination about allied health services under subsection 3C(1) of the Act. | \$132.20 |
| GROUP A22 - GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES | | |
| 05000 | Level 'a' professional attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management surgery consultation professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8 am or after 8pm on any other day. | \$61.00 |
| 05003 | Professional attendance by a general practitioner (not being an attendance at consulting rooms, a hospital or a residential aged care facility and not being a service to which any other item in this table applies) that requires a short patient history and, if necessary, limited examination and management - an attendance on 1 or more patients on 1 occasion - each patient | \$122.00 |
| 05010 | Consultation at a residential aged care facility professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12noon on a Saturday, or before 8am or after pm on any other day. | \$122.00 |
| 05020 | Level 'b' Professional attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, or a professional attendance of less than 20 minutes duration involving components of a service to which item 5040, 5043, 5046, 5049, 5060, 5063, 5064 or 5067 applies surgery consultation (Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) | \$122.00 |
| 05023 | Professional attendance by a general practitioner (not being an attendance at consulting rooms, a hospital or a residential aged care facility and not being a service to which any other item in this 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; | \$180.00 |

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| | for 1 or more health-related issues, with appropriate documentation - an attendance on 1 or more patients on 1 occasion - each patient | |
| 05028 | Professional attendance by a general practitioner (not being a service to which any other item in this 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 1 or more health-related issues, with appropriate documentation - an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion - each patient | \$180.00 |
| 05040 | Level 'c' Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, or a professional attendance of less than 40 minutes duration involving components of a service to which item 5060, 5063, 5064 or 5067 applies surgery consultation (Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) | \$220.00 |
| 05043 | Professional attendance by a general practitioner (not being an attendance at consulting rooms, a hospital or a residential aged care facility and not being a service to which any other item in this 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 1 or more health-related issues, with appropriate documentation - an attendance on 1 or more patients on 1 occasion - each patient | \$275.00 |
| 05049 | Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (not being a service to which any other item in this 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 1 or more health-related issues, with appropriate documentation - an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion - each patient | \$275.00 |
| 05060 | level 'd' Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, or a professional attendance of at least 40 minutes duration for implementation of a management plan surgery consultation (Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.) | \$340.00 |
| 05063 | Professional attendance by a general practitioner (not being an attendance at consulting rooms, a hospital or a residential aged care facility and not being a service to which any other item in this 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 1 or more health-related issues, with appropriate documentation - an attendance on 1 or more patients on 1 occasion - each patient | \$405.00 |
| 05067 | Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (not being a service to which any other item in this 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 1 or more health-related issues, with appropriate documentation - an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion - each patient | \$405.00 |
| GROUP A26 - NEUROSURGERY ATTENDANCES TO WHICH NO OTHER ITEM APPLIES | | |
| 06004 | Initial professional attendance of 10 minutes or less in duration on a patient by a specialist practising in his or her specialty of neurosurgery if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19 (2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment | \$163.10 |
| 06007 | Professional attendance at consulting rooms or hospital by a specialist practising in the specialty of neurosurgery, where the patient was referred to him or her by a medical practitioner. - Initial attendance in a single course of treatment. | \$254.50 |
| 06009 | Each minor attendance subsequent to the first in a single course of treatment. - An attendance of not more than 15 minutes duration. | \$85.30 |
| 06011 | Each attendance subsequent to the first in a single course of treatment being an attendance involving a detailed and comprehensive examination, arranging or evaluating any necessary investigations in relation to one or more complex problems. An attendance of more than 15 minutes duration but not more than 30 minutes duration. | \$169.10 |
| 06013 | Each attendance subsequent to the first in a single course of treatment being an attendance involving an extensive and comprehensive examination, arranging or evaluating any necessary investigations in relation to one or more complex problems. An attendance of more than 30 minutes duration but not more than 45 minutes duration. | \$233.10 |
| 06015 | Each attendance subsequent to the first in a single course of treatment being an attendance involving an exhaustive and comprehensive examination, arranging or evaluating any necessary investigations in relation to one or more complex problems - An attendance of more than 45 minutes duration. | \$281.10 |

| Item No. | Description | Max fee (excl GST) |
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| 06016 | Professional attendance on a patient by a specialist practising in his or her specialty of neurosurgery if: (a) the attendance is by video conference; and (b) item 6007, 6009, 6011, 6013 or 6015 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) outside an inner metropolitan area; and (b) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; (b) or an aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies. Derived Fee: 50% of the fee for the associated item. | DF |
| GROUP A31 - ADDICTION MEDICINE | | |
| Addiction Medicine Attendances | | |
| 06018 | Professional attendance by an addiction medicine specialist in the practice of his or her specialty following referral of the patient to him or her 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 | \$231.50 |
| 06019 | Professional attendance by an addiction medicine specialist in the practice of his or her specialty following referral of the patient to him or her 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 | \$117.70 |
| 06023 | Professional attendance by an addiction medicine specialist in the practice of his or her specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to him or her 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 | \$411.20 |
| 06024 | Professional attendance by an addiction medicine specialist in the practice of his or her 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 | \$205.90 |
| 06025 | Initial professional attendance of 10 minutes or less, on a patient by an addiction medicine specialist in the practice of his or her specialty, if:(a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance at least 15 km by road from the addiction medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment | \$176.40 |
| 06026 | Professional attendance on a patient by an addiction medicine specialist in the practice of his or her specialty, if:(a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 6018 or 6019 and lasting more than 10 minutes; or (ii) provided with item 6023 or 6024; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance at least 15 km by road from the addiction medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19 (2) of the act applies. Derived Fee: 50% of the fee for item 6018, 6019, 6023, or 6024 Benefit: 85% of the derived fee | DF |
| 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 his or her 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 | \$76.90 |
| GROUP A32 - SEXUAL HEALTH MEDICINE | | |
| Sexual Health Medicine Attendances | | |
| 06051 | Professional attendance by a sexual health medicine specialist in the practice of his or her specialty following referral of the patient to him or her 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 | \$235.20 |

| Item No. | Description | Max fee (excl GST) |
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| 06052 | Professional attendance by a sexual health medicine specialist in the practice of his or her specialty following referral of the patient to him or her 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 | \$117.70 |
| 06057 | Professional attendance by a sexual health medicine specialist in the practice of his or her specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to him or her 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 | \$411.20 |
| 06058 | Professional attendance by a sexual health medicine specialist in the practice of his or her 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 | \$205.90 |
| 06059 | Initial professional attendance of 10 minutes or less, on a patient by a sexual health medicine specialist in the practice of his or her specialty, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance at least 15 km by road from the sexual health medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment | \$176.40 |
| 06060 | Professional attendance on a patient by a sexual health medicine specialist in the practice of his or her specialty if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 6051 or 6052 and lasting more than 10 minutes; or (ii) provided with item 6057 or 6058; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance at least 15 km by road from the sexual health medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19 (2) of the act applies. Derived Fee: 50% of the fee for item 6051, 6052, 6057 or 6058 Benefit: 85% of the derived fee | DF |
| 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 his or her specialty following referral of the patient to him or her by a referring practitioner - initial attendance in a single course of treatment | \$285.40 |
| 06063 | Professional attendance at a place other than consulting rooms or a hospital by a sexual health medicine specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner - each attendance after the attendance under item 6062 in a single course of treatment | \$172.60 |
| 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 - 1 service in any period of 36 months - patients with myopia of 5.0 dioptres or greater (spherical equivalent) in 1 eye | \$214.10 |
| 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 - 1 service in any period of 36 months - patients with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in 1 eye | \$214.10 |
| 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 - 1 service in any period of 36 months - patients with astigmatism of 3.0 dioptres or greater in 1 eye | \$214.10 |
| 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 - 1 service in any period of 36 months - patients with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens | \$239.20 |
| 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 - 1 service in any period of 36 months - patients with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents) | \$214.10 |

| Item No. | Description | Max fee (excl GST) |
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| 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 - 1 service in any period of 36 months - patients with corrected visual acuity of 0.7 logMAR (6/30) or worse in both eyes, being patients for whom a contact lens is prescribed as part of a telescopic system | \$214.10 |
| 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 - 1 service in any period of 36 months - patients for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by pathological mydriasis, aniridia, coloboma of the iris, pupillary malformation or distortion, significant ocular deformity or corneal opacity - whether congenital, traumatic or surgical in origin | \$214.10 |
| 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 - 1 service in any period of 36 months - patients who, by reason of physical deformity, are unable to wear spectacles | \$214.10 |
| 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 - 1 service in any period of 36 months - patients who have a medical or optical condition (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10806, 10807 or 10808 applies) requiring the use of a contact lens for correction, where the condition is specified on the patient's account | \$214.10 |
| 10816 | Attendance for the refitting of contact lenses with keratometry and testing with trial lenses and the issue of a prescription, where the patient requires a change in contact lens material or basic lens parameters, other than simple power change, because of a structural or functional change in the eye or an allergic response within 36 months of the fitting of a contact lens to which Items 10801 to 10809 apply | \$214.10 |
| GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS | | |
| Neurology | | |
| 11000 | Electroencephalography, not being a service: (a) associated with a service to which item 11003, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices (Anaes.) | \$236.10 |
| 11003 | Electroencephalography, prolonged recording of at least 3 hours duration, not being a service: (a) associated with a service to which item 11000, 11004, 11005, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices | \$540.10 |
| 11004 | Electroencephalography, ambulatory or video, prolonged recording of at least 3 hours duration up to 24 hours duration, recording on the first day, not being a service: (a) associated with a service to which item 11000, 11003, 11005, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices | \$602.50 |
| 11005 | Electroencephalography, ambulatory or video, prolonged recording of at least 3 hours duration up to 24 hours duration, recording on each day subsequent to the first day, not being a service: (a) associated with a service to which item 11000, 11003, 11004, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices | \$576.70 |
| 11006 | Electroencephalography, temporosphenoidal, not being a service involving quantitative topographic mapping using neurometrics or similar devices | \$279.40 |
| 11009 | Electrocorticography | \$373.60 |
| 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) | \$198.40 |
| 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) | \$282.70 |
| 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) | \$413.40 |
| 11021 | Neuromuscular electrodiagnosis - repetitive stimulation for study of neuromuscular conduction or electromyography with quantitative computerised analysis or both of these examinations | \$279.70 |
| 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 involving multifocal multichannel objective perimetry - 1 or 2 studies | \$187.40 |
| 11027 | Central nervous system evoked responses, investigation of, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials or involving multifocal multichannel objective perimetry - 3 or more studies | \$276.80 |
| Ophthalmology | | |
| 11200 | Provocative test or tests for open angle glaucoma, including water drinking | \$66.40 |
| 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. | \$190.50 |
| 11205 | Electroretinography 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. | \$190.50 |
| 11210 | Pattern electroretinography of 1 or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards | \$190.50 |

| Item No. | Description | Max fee (excl GST) |
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| 11211 | Dark adaptometry of 1 or both eyes with a quantitative estimation of threshold in log lumens at 45 minutes of dark adaptations | \$190.50 |
| 11215 | Retinal angiography, multiple exposures of 1 eye with intravenous dye injection | \$235.70 |
| 11218 | Retinal angiography, multiple exposures of both eyes with intravenous dye injection | \$291.50 |
| 11219 | Optical Coherence Tomography for diagnosis of ocular conditions for which a medication is listed on the Pharmaceutical Benefits Scheme for intraocular administration Maximum of one service in a 12 month period | \$62.40 |
| 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. | \$62.40 |
| 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 | \$235.80 |
| 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, 1 eye, not being a service associated with a service to which an item in group II of the Diagnostic Imaging Services Table applies | \$156.90 |
| 11240 | Orbital contents, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of 1 eye prior to lens surgery on that eye, not being a service associated with a service to which an item in group II of the Diagnostic Imaging Services Table applies | \$156.90 |
| 11241 | Orbital contents, unidimensional ultrasonic echography or partial coherence interferometry of, for bilateral eye measurement prior to lens surgery on both eye s, not being a service associated with a service to which an item in group II of the Diagnostic Imaging Services Table applies | \$193.40 |
| 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 an item in group II of the Diagnostic Imaging Services Table applies | \$154.30 |
| 11243 | Orbital contents, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of a second eye if: (a) surgery for the first eye has resulted in more than 1 dioptre of error; or (b) more than 3 years have elapsed since the surgery for the first eye; not being a service associated with a service to which an item in group II of the Diagnostic Imaging Services Table applies | \$141.10 |
| 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 I of the diagnostic imaging services table applies. | \$132.20 |
| Otolaryngology | | |
| 11300 | Brain stem evoked response audiometry (Anaes.) | \$325.40 |
| 11303 | Electrocochleography, extratympanic method, 1 or both ears | \$325.40 |
| 11304 | Electrocochleography, transtympanic membrane insertion technique, 1 or both ear s | \$530.30 |
| 11306 | Non-determinate audiometry | \$36.60 |
| 11309 | Audiogram, air conduction | \$42.80 |
| 11312 | Audiogram, air and bone conduction or air conduction and speech discrimination | \$61.90 |
| 11315 | Audiogram, air and bone conduction and speech | \$80.90 |
| 11318 | Audiogram, air and bone conduction and speech, with other cochlear tests | \$113.10 |
| 11324 | Impedance audiogram involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, if the patient is referred by a medical practitioner - not being a service associated with a service to which item 11309, 11312, 11 315 or 11318 applies | \$61.90 |
| 11327 | Impedance audiogram involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, if the patient is referred by a medical practitioner - being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies | \$38.10 |
| 11330 | Impedance audiogram if the patient is not referred by a medical practitioner - 1 examination in any 4 week period | \$14.80 |
| 11332 | Oto-acoustic emission audiometry for the detection of permanent congenital hearing impairment, performed by or on behalf of a specialist or consultant physician, on an infant or child who is at risk due to 1 or more of the following factors: (a) admission to a neonatal intensive care unit; (b) family history of hearing impairment; (c) intra-uterine or perinatal infection (either suspected or confirmed); (d) birthweight less than 1.5 kg; (e) craniofacial deformity; (f) birth asphyxia; (g) chromosomal | \$103.20 |

| Item No. | Description | Max fee (excl GST) |
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| | abnormality, including Down's Syndrome; (h) exchange transfusion; if: (i) the patient is referred by another medical practitioner; and (j) middle ear pathology has been excluded by specialist opinion | |
| 11333 | Caloric test of labyrinth or labyrinths | \$80.50 |
| 11336 | Simultaneous bithermal caloric test of labyrinths | \$86.40 |
| 11339 | Electronystagmography | \$80.90 |
| 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 consultant respiratory physician who is responsible for staff training, supervision, quality assurance and the issuing of written reports on tests performed; and (c) using any of the following tests: (i) measurement of absolute lung volumes by any method; (ii) measurement of carbon monoxide diffusing capacity by any method; (iii) measurement of airway or pulmonary resistance by any method; (iv) inhalation provocation testing, including pre-provocation spirometry and the construction of a dose response curve, using a recognised direct or indirect bronchoprovocation agent and post-bronchodilator spirometry; (v) provocation testing involving sequential measurement of lung function at baseline and after exposure to specific sensitising agents, including drugs, or occupational asthma triggers; (vi) spirometry performed before and after simple exercise testing undertaken as a provocation test for the investigation of asthma, in premises equipped with resuscitation equipment and personnel trained in Advanced Life Support; (vii) measurement of the strength of inspiratory and expiratory muscles at multiple lung volumes; (viii) simulated altitude test involving exposure to hypoxic gas mixtures and oxygen saturation at rest and/or during exercise with or without an observation of the effect of supplemental oxygen; (ix) calculation of pulmonary or cardiac shunt by measurement of arterial oxygen partial pressure and haemoglobin concentration following the breathing of an inspired oxygen concentration of 100% for a duration of 15 minutes or greater; (x) if the measurement is for the purpose of determining eligibility for pulmonary arterial hypertension medications subsidised under the Pharmaceutical Benefits Scheme or eligibility for the provision of portable oxygen—functional exercise test by any method (including 6 minute walk test and shuttle walk test); each occasion at which one or more tests are performed 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 | \$246.40 |
| 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 | \$34.50 |
| 11512 | Measurement of spirometry: (a) that includes continuous measurement of the relationship between flow and volume during expiration or during expiration and inspiration, performed before and after inhalation of a bronchodilator; and (b) that is performed with a respiratory scientist in continuous attendance; and (c) that is performed in a respiratory laboratory equipped to perform complex lung function tests; and (d) that is performed under the supervision of a consultant physician practising respiratory medicine who is responsible for staff training, supervision, quality assurance and the issuing of written reports; and (e) for which a permanently recorded tracing and written report is provided; and (f) for which 3 or more spirometry recordings are performed; each occasion at which one or more such tests are performed Not applicable for a service associated with a service to which item 11503, 11507 or 22018 applies | \$101.30 |
| 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) | \$108.00 |
| 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 | \$95.40 |
| 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 | \$99.60 |
| 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 | \$96.90 |
| 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) brachialsystolic pressure indices and assessment of arterial waveforms for the evaluation of lower extremity arterial disease - examination, hard copy trace and report | \$95.40 |
| 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 wave forms for the evaluation of upper extremity arterial disease - examination, hardcopy trace and report | \$95.40 |

| Item No. | Description | Max fee (excl GST) |
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| 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 | \$149.70 |
| 11614 | Transcranial doppler, examination of the intracranial arterial circulation using CW Doppler or pulsed doppler with hard copy recording of waveforms, examination and report, not being a service associated with a service to which item 5528 0 of the Diagnostic Imaging Services Table applies | \$99.60 |
| 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 | \$140.20 |
| 11627 | Pulmonary artery pressure monitoring during open heart surgery, in a person under 12 years of age | \$402.90 |
| Cardiovascular | | |
| 11700 | Twelve-lead electrocardiography, tracing and report | \$56.40 |
| 11701 | Twelve-lead electrocardiography, report only where the tracing has been forwarded to another medical practitioner, not in association with a consultation on the same occasion | \$28.00 |
| 11702 | Twelve-lead electrocardiography, tracing only | \$28.00 |
| 11708 | Continuous ECG recording of ambulatory patient for 12 or more hours (including resting ECG and the recording of parameters), not in association with ambulatory blood pressure monitoring, involving microprocessor based analysis equipment, interpretation and report of recordings by a specialist physician or consultant physician. Not being a service to which item 11709 applies. The changing of a tape or batteries does not constitute a separate service. Where a recording is analysed and reported on and a decision is made to undertake a further period of monitoring, the second episode is regarded as a separate service. | \$226.30 |
| 11709 | Continuous ECG recording (Holter) of ambulatory patient for 12 or more hours (including resting ECG and the recording of parameters), not in association with ambulatory blood pressure monitoring, utilising a system capable of superimposition and full disclosure printout of at least 12 hours of recorded ECG data, microprocessor based scanning analysis, with interpretation and report by a specialist physician or consultant physician. The changing of a tape or batteries does not constitute a separate service. Where a recording is analysed and reported on and a decision is made to undertake a further period of monitoring, the second episode is regarded as a separate service. | \$303.90 |
| 11710 | Ambulatory ECG monitoring, patient activated, single or multiple event recording, utilising a looping memory recording device which is connected continuously to the patient for 12 hours or more and is capable of recording for at least 20 seconds prior to each activation and for 15 seconds after each activation, including transmission, analysis, interpretation and report - payable once in any 4 week period | \$100.50 |
| 11711 | Ambulatory ECG monitoring for 12 hours or more, patient activated, single or multiple event recording, utilising a memory recording device which is capable of recording for at least 30 seconds after each activation, including transmission, analysis, interpretation and report - payable once in any 4 week period | \$54.30 |
| 11712 | Multi channel ECG monitoring and recording during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts) or pharmacological stress, involving the continuous attendance of a medical practitioner for not less than 20 minutes, with resting ECG, and with or without continuous blood pressure monitoring and the recording of other parameters, on premises equipped with mechanical respirator and defibrillator | \$282.70 |
| 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 | \$134.10 |
| 11715 | Blood dye - dilution indicator test | \$214.20 |
| 11718 | Implanted pacemaker testing involving electrocardiography, measurement of rate, width and amplitude of stimulus, including reprogramming when required, not being a service associated with a service to which item 11700, 11719, 11720, 11721, 11725 or 11726 applies | \$64.50 |
| 11719 | Implanted pacemaker (including cardiac resynchronisation pacemaker) remote monitoring involving reviews (without patient attendance) or arrhythmias, lead and device parameters, if at least one remote review is provided in a 12 month period. Payable only once in any 12 month period | \$106.30 |
| 11720 | Implanted pacemaker testing, with patient attendance, following detection of abnormality by remote monitoring involving electrocardiography, measurement of rate, width and amplitude of stimulus including reprogramming when required, not being a service associated with a service to which item 11718 or 11721 applies. | \$106.30 |
| 11721 | Implanted pacemaker testing of atrioventricular (AV) sequential, rate responsive, or antitachycardia pacemakers, including reprogramming when required, not being a service associated with a service to which item 11700, 11718 11719, 11720, 11725 or 11726 applies | \$127.50 |
| 11722 | Implanted ECG loop recording for the investigation of recurrent unexplained syncope if: (a) a diagnosis has not been achieved through all other available cardiac investigations; and (b) a neurogenic cause is not suspected; and (c) the patient to whom the service is provided does not have a structural heart defect associated with a high risk of sudden cardiac death; including reprogramming when required, retrieval of stored data, analysis, interpretation and report, not being a service to which item 38285 applies | \$64.60 |
| 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 | \$327.90 |

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| | physician - on premises equipped with a mechanical respirator and defibrillator | |
| 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 | \$301.50 |
| 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. | \$150.70 |
| 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 11700, 11718, 11719, 11720, 11721, 11725 or 11726 applies | \$169.70 |
| Gastroenterology and colorectal | | |
| 11800 | Oesophageal motility test, manometric | \$338.00 |
| 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 catheter-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.) | \$418.40 |
| 11810 | Clinical assessment of gastro- oesophageal reflux disease involving 24-hour pH monitoring, including analysis, interpretation and report and including any associated consultation | \$304.70 |
| 11820 | Capsule endoscopy to investigate an episode of obscure gastrointestinal bleeding, using a capsule endoscopy device (including administration of the capsule, associated endoscopy procedure if required for placement, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if: (a) the service is provided to a patient who: (i) has overt gastrointestinal bleeding; or (ii) has gastrointestinal bleeding that is recurrent or persistent, and iron deficiency anaemia that is not due to coeliac disease, and, if the patient also has menorrhagia, has had the menorrhagia considered and managed; and (b) an upper gastrointestinal endoscopy and a colonoscopy have been performed on the patient and have not identified the cause of the bleeding; and (c) the service has not been provided to the same patient on more than 2 occasions in the preceding 12 months; and (d) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and (e) the service is not associated with a service to which item 30680, 30682, 30684 or 30686 applies | \$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 | \$251.20 |
| 11833 | Diagnosis of abnormalities of the pelvic floor and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency | \$429.20 |
| Gentio/urinary physiological investigations | | |
| 11900 | Urine flow study including peak urine flow measurement, not being a service associated with a service to which item 11919 applies | \$50.80 |
| 11903 | Cystometrography, not being a service associated with a service to which any of items 11012 to 11027, 11912, 11915, 11919, 11921 and 36800 or an item in group I3 of the Diagnostic Imaging Services Table applies | \$213.60 |
| 11906 | Urethral pressure profilometry, not being a service associated with a service to which any of items 11012 to 11027, 11909, 11919, 11921 and 36800 or an item in group I3 of the Diagnostic Imaging Services Table applies | \$200.10 |
| 11909 | Urethral pressure profilometry with simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which item 11906, 11915, 11919, 36800 or an item in group I3 of the Diagnostic Imaging Services Table applies | \$292.30 |
| 11912 | Cystometrography with simultaneous measurement of rectal pressure, not being a service associated with a service to which any of items 11012 to 11027, 11903, 11915, 11919, 11921 and 36800 or an item in group I3 of the Diagnostic Imaging Services Table applies (Anaes.) | \$298.80 |
| 11915 | Cystometrography with simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which any of items 110 12 to 11027, 11903, 11909, 11912, 11919, 11921 and 36800 or an item in group I3 of the Diagnostic Imaging Services Table applies (Anaes.) | \$298.80 |
| 11917 | Cystometrography in conjunction with ultrasound of 1 or more components of the urinary tract, with measurement of any 1 or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography; including all imaging associated with cystometrography, not being a | \$772.80 |

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| | service associated with a service to which any of items 11012 to 11027, 11900 to 11915, 11919, 11921 and 36800 applies (Anaes.) | |
| 11919 | Cystometrography in conjunction with contrast micturating cystourethrography, with measurement of any 1 or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography; including all imaging associated with cystometrography, not being a service associated with a service to which any of items 11012 to 11027, 11900 to 11917, 11921 and 36800 applies (Anaes.) | \$772.80 |
| 11921 | Bladder washout test for localisation of urinary infection - not including bacterial counts for organisms in specimens | \$144.50 |
| 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 | \$74.60 |
| 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 | \$114.70 |
| 12012 | Epicutaneous patch testing in the investigation of allergic dermatitis using not more than 25 allergens | \$40.20 |
| 12017 | Epicutaneous patch testing in the investigation of allergic dermatitis using more than 25 allergens but not more than 50 allergens | \$109.60 |
| 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 | \$225.80 |
| 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 | \$211.50 |
| 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 | \$240.80 |
| Other diagnostic procedures and investigations | | |
| 12200 | Collection of specimen of sweat by iontophoresis | \$72.20 |
| 12201 | Administration, by a specialist or consultant physician in the practice of his or her 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 | \$3067.60 |
| 12203 | Overnight diagnostic assessment of sleep, for a period of at least 8 hours duration, for a patient aged 18 years or more, to confirm diagnosis of a sleep disorder, if: (a) either: (i) the patient has been referred by a medical practitioner to a qualified sleep medicine practitioner or a consultant respiratory physician who has determined that the patient has a high probability for symptomatic, moderate to severe obstructive sleep apnoea based on a STOP-Bang score of 4 or more, an OSA50 score of 5 or more or a high risk score on the Berlin Questionnaire, and an Epworth Sleepiness Scale score of 8 or more; or (ii) following professional attendance on the patient (either face-to-face or by video conference) by a qualified sleep medicine practitioner or a consultant respiratory physician, the qualified sleep medicine practitioner or consultant respiratory physician determines that assessment is necessary to confirm the diagnosis of a sleep disorder; and (b) the overnight diagnostic assessment is performed to investigate: (i) suspected obstructive sleep apnoea syndrome where the patient is assessed as not suitable for an unattended sleep study; or (ii) suspected central sleep apnoea syndrome; or (iii) suspected sleep hypoventilation syndrome; or (iv) suspected sleep-related breathing disorders in association with non-respiratory co-morbid conditions including heart failure, significant cardiac arrhythmias, neurological disease, acromegaly or hypothyroidism; or (v) unexplained hypersomnolence which is not attributed to inadequate sleep hygiene or environmental factors; or (vi) suspected parasomnia or seizure disorder where clinical diagnosis cannot be established on clinical features alone (including associated atypical features, vigilance behaviours or failure to respond to conventional therapy); or (vii) suspected sleep related movement disorder, where the diagnosis of restless legs syndrome is not evident on clinical assessment; and (c) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (d) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of report; and (f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the overnight diagnostic assessment is not provided to the patient on the same occasion that a service mentioned in any of items 11000 to 11005, 11503, 11700 to 11709, 11713 or 12250 is provided to the patient Applicable only once in any 12 month period | \$945.80 |

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| 12207 | Overnight investigation, for a patient aged 18 years or more, for a sleep-related breathing disorder, following professional attendance by a qualified sleep medicine practitioner or a consultant respiratory physician (either face-to-face or by video conference), if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (c) there is continuous monitoring and recording, in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen) (ix) position; and (d) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of report; and (f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the investigation is not provided to the patient on the same occasion that a service mentioned in any of items 11000 to 11005, 11503, 11700 to 11709, 11713 or 12250 is provided to the patient; and (h) previous studies have demonstrated failure of continuous positive airway pressure or oxygen; and (i) if the patient has severe cardio-respiratory failure—a further investigation is indicated in the same 12 month period to which items 12204 and 12205 apply to a service for the patient, for the adjustment or testing, or both, of the effectiveness of a positive pressure ventilatory support device (other than continuous positive airway pressure) in sleep Applicable only once in the same 12 month period to which item 12204 or 12205 applies | \$945.80 |
| 12210 | Overnight paediatric investigation, for a period of at least 8 hours in duration, for a patient less than 12 years of age, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of report; and (f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient For each particular patient—applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period | \$1236.20 |
| 12213 | Overnight paediatric investigation, for a period of at least 8 hours in duration, for a patient aged at least 12 years but less than 18 years, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of report; and (f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient For each particular patient—applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period | \$1113.80 |
| 12215 | Overnight paediatric investigation, for a period of at least 8 hours in duration, for a patient less than 12 years of age, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of report; and (f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and (g) a further investigation is indicated in the same 12 month period to which item 12210 applies to a service for the patient, for a patient using Continuous Positive Airway Pressure (CPAP) or non-invasive or invasive ventilation, or supplemental oxygen, in either or both of the following circumstances: (i) there is ongoing hypoxia or | \$1236.20 |

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| | 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 Applicable only once in the same 12 month period to which item 12210 applies | |
| 12217 | Overnight paediatric investigation for a period of at least 8 hours in duration for a patient aged at least 12 years but less than 18 years, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of report; and (f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and (g) a further investigation is indicated in the same 12 month period to which item 12213 applies to a service for the patient, for a patient using Continuous Positive Airway Pressure (CPAP) or non-invasive or invasive ventilation, or supplemental oxygen, in either or both of the following circumstances: (i) there is ongoing hypoxia or hypoventilation on the third study to which item 12213 applied for the patient, and further titration is needed to optimise therapy; (ii) there is clear and significant change in clinical status (for example lung function or functional status) or an intervening treatment that may affect ventilation in the period since the third study to which item 12213 applied for the patient, and repeat study is therefore required to determine the need for or the adequacy of respiratory support Applicable only once in the same 12 month period to which item 12213 applies | \$1113.80 |
| 12250 | Overnight investigation of sleep for a period of at least 8 hours of a patient aged 18 years or more to confirm diagnosis of obstructive sleep apnoea, if: (a) either: (i) the patient has been referred by a medical practitioner to a qualified sleep medicine practitioner or a consultant respiratory physician who has determined that the patient has a high probability for symptomatic, moderate to severe obstructive sleep apnoea based on a STOP-Bang score of 4 or more, an OSA50 score of 5 or more or a high risk score on the Berlin Questionnaire, and an Epworth Sleepiness Scale score of 8 or more; or (ii) following professional attendance on the patient (either face-to-face or by video conference) by a qualified sleep medicine practitioner or a consultant respiratory physician, the qualified sleep medicine practitioner or consultant respiratory physician determines that investigation is necessary to confirm the diagnosis of obstructive sleep apnoea; and (b) during a period of sleep, there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) continuous ECG; (iv) continuous EEG; (v) EOG; (vi) oxygen saturation; (vii) respiratory effort; and (c) the investigation is performed under the supervision of a qualified sleep medicine practitioner; and (d) either: (i) the equipment is applied to the patient by a sleep technician; or (ii) if this is not possible—the reason it is not possible for the sleep technician to apply the equipment to the patient is documented and the patient is given instructions on how to apply the equipment by a sleep technician supported by written instructions; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events and cardiac abnormalities) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of report; and (f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the investigation is not provided to the patient on the same occasion that a service mentioned in any of items 11000 to 11005, 11503, 11700 to 11709, 11713 and 12203 is provided to the patient Applicable only once in any 12 month period | \$593.60 |
| 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 | \$191.10 |
| 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 | \$191.10 |
| 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 | \$191.10 |
| 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 | \$157.10 |

| Item No. | Description | Max fee (excl GST) |
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| | 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 | |
| 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 | \$191.10 |
| 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 | \$157.10 |
| 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 | \$77.90 |
| 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 | \$77.90 |
| GROUP D2 - NUCLEAR MEDICINE (NON-IMAGING) | | |
| 12500 | Blood volume estimation | \$357.50 |
| 12503 | Erythrocyte radioactive uptake survival time test or iron kinetic test | \$659.50 |
| 12506 | Gastrointestinal blood loss estimation involving examination of stool specimens | \$476.70 |
| 12509 | Gastrointestinal protein loss | \$357.50 |
| 12512 | Radioactive B12 absorption test - 1 isotope | \$198.90 |
| 12515 | Radioactive B12 absorption test - 2 isotopes | \$373.60 |
| 12518 | Thyroid uptake (using probe) | \$186.10 |
| 12521 | Perchlorate discharge study | \$224.20 |
| 12524 | Renal function test (without imaging procedure) | \$280.20 |
| 12527 | Renal function test (with imaging and at least 2 blood samples) | \$150.30 |
| 12530 | Whole body count - not being a service associated with a service to which another item applies | \$224.20 |
| 12533 | Carbon-labelled urea breath test using oral C-13 or C-14 urea, performed by a specialist or consultant physician, including the measurement of exhaled $^{13}\text{CO}_2$ or $^{14}\text{CO}_2$, 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 | \$149.70 |
| 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. | \$448.70 |
| 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 | \$458.70 |
| 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) | \$222.00 |
| 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) | \$289.20 |

| Item No. | Description | Max fee (excl GST) |
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| Dialysis | | |
| 13100 | Supervision in hospital by a medical specialist of - haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in 1 day | \$256.90 |
| 13103 | Supervision in hospital by a medical specialist of - haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist does not exceed 45 minutes in 1 day | \$137.30 |
| 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 | \$262.10 |
| 13106 | Declotting of an arteriovenous shunt | \$194.00 |
| 13109 | Indwelling peritoneal catheter (Tenckhoff or similar) for dialysis insertion and fixation of (Anaes.) | \$436.40 |
| 13110 | Indwelling Peritoneal Catheter (Tenckhoff or similar) for dialysis, removal of (including catheter cuffs) (Anaes.) | \$402.50 |
| Assisted reproductive services | | |
| 13200 | Assisted reproductive services (such as in vitro fertilisation, gamete intrafallopian transfer or similar procedures) involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13203, 13206 or 13218 applies - being services rendered during 1 treatment cycle, if the duration of the treatment cycle is at least 9 days | \$5264.40 |
| 13201 | Assisted reproductive technologies superovulated treatment cycle proceeding to oocyte retrieval, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13200, 13202, 13203, 13206, 13218 applies - being services rendered during 1 treatment cycle - each cycle subsequent to the first in a single calendar year | \$4921.10 |
| 13202 | Assisted reproductive technologies superovulated treatment cycle that is cancelled before oocyte retrieval, involving the use of drugs to induce superovulation and including quantitative estimation of hormones, semen preparation, ultrasound examinations, but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13200, 13201, 13203, 13206, 13218, applies being services rendered during 1 treatment cycle | \$789.70 |
| 13203 | Ovulation monitoring services, for superovulated treatment cycles of less than 9 days duration and artificial insemination including quantitative estimation of hormones and ultrasound examinations, being services rendered during 1 treatment cycle but excluding a service to which item 13200, 13206, 13212, 13215 or 13218 applies | \$945.40 |
| 13206 | Assisted reproductive services (such as in vitro fertilisation, gamete intrafallopian transfer or similar procedures), using unstimulated ovulation or ovulation stimulated only by clomiphene citrate, and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, frozen embryo transfer or donated embryos or ova or treatment involving the use of drugs to induce superovulation being services rendered during 1 treatment cycle but only if rendered in conjunction with a service to which item 13212 applies | \$1251.10 |
| 13209 | Planning and management of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies including in vitro fertilisation, gamete intrafallopian transfer and similar procedures, or for artificial insemination payable once only during 1 treatment cycle | \$192.00 |
| 13210 | Professional attendance on a patient by a specialist practising in his or her specialty if: (a) the attendance is by video conference; and (b) item 13209 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an Aboriginal Medical Service; (b) or an Aboriginal Community Controlled Health service for which a direction made under subsection 19 (2) of the act applies Derived Fee: 50% of the fee for the associated item. | DF |
| 13212 | Oocyte retrieval for the purpose of assisted reproductive technologies - only if rendered in connection with a service to which item 13200, 13201 or 13206 applies (Anaes.) | \$641.60 |
| 13215 | Transfer of embryos or both ova and sperm to the uterus or fallopian tubes, excluding artificial insemination - only if rendered in connection with a service to which item 13200, 13201, 13206 or 13218 applies, being services rendered in one treatment cycle (Anaes.) | \$213.50 |
| 13218 | Preparation of frozen or donated embryos or donated oocytes for transfer to the uterus or fallopian tubes, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in 1 treatment cycle and excluding a service to which item 13200, 13201, 13202, 13203, 13206, 13212 applies (Anaes.) | \$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 |
| 13251 | Intracytoplasmic sperm injection for the purposes of assisted reproductive technologies, for male factor infertility, excluding a service to which item 13218 applies. | \$760.80 |
| 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 | \$359.70 |

| Item No. | Description | Max fee (excl GST) |
|--|--|--------------------|
| 13292 | Semen, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required, under general anaesthetic, in a hospital (Anaes.) | \$720.10 |
| Paediatric and neonatal | | |
| 13300 | Umbilical or scalp vein catheterisation in a neonate with or without infusion; or cannulation of a vein | \$100.30 |
| 13303 | Umbilical artery catheterisation with or without infusion | \$148.80 |
| 13306 | Blood transfusion with venesection and complete replacement of blood, including collection from donor | \$588.30 |
| 13309 | Blood transfusion with venesection and complete replacement of blood, using blood already collected | \$501.70 |
| 13312 | Blood for pathology test, collection of, by femoral or external jugular vein puncture in infants | \$50.10 |
| 13318 | Central vein catheterisation (via jugular or subclavian vein) - by open exposure, in a person under 12 years of age (Anaes.) | \$400.60 |
| 13319 | Central vein catheterisation in a neonate via peripheral vein (Anaes.) | \$400.60 |
| Cardiovascular | | |
| 13400 | Restoration of cardiac rhythm by electrical stimulation (cardioversion), other than in the course of cardiac surgery (Anaes.) | \$168.20 |
| Gastroenterology | | |
| 13506 | Gastro-oesophageal balloon intubation, for control of bleeding from gastric oesophageal varices | \$325.40 |
| Haematology | | |
| 13700 | Harvesting of homologous (including allogeneic) or autologous bone marrow for the purpose of transplantation (Anaes.) | \$548.60 |
| 13703 | Transfusion of blood, including collection from donor | \$200.10 |
| 13706 | Transfusion of blood or bone marrow already collected | \$136.70 |
| 13709 | Collection of blood for autologous transfusion or when homologous blood is required for immediate transfusion in emergency situation | \$80.90 |
| 13750 | Therapeutic haemapheresis for the removal of plasma or cellular (or both) elements of blood, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies, if performed; continuous monitoring of vital signs, fluid balance, blood volume and other parameters with continuous registered nurse attendance under the supervision of a consultant physician, not being a service associated with a service to which item 1375 5 applies - each day | \$223.70 |
| 13755 | Donor haemapheresis for the collection of blood products for transfusion, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies; continuous monitoring of vital signs, fluid balance, blood volume and other parameters; with continuous registered nurse attendance under the supervision of a consultant physician; not being a service associated with a service to which item 13750 applies - each day | \$223.70 |
| 13757 | Therapeutic venesection for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda | \$108.20 |
| 13760 | In vitro processing (and cryopreservation) of bone marrow or peripheral blood or autologous stem cell transplantation as an adjunct to high dose chemotherapy for: .chemosensitive intermediate or high grade non-Hodgkin's lymphoma at high risk of relapse following first line chemotherapy; or . Hodgkin's disease which has relapsed following, or is refractory to, chemotherapy; or . Acute myelogenous leukaemia in first remission, where suitable genotypically matched sibling donor is not available for allogeneic bone marrow transplant; or multiple myeloma in remission (complete or partial) following standard dose chemotherapy; or small round cell sarcomas; or primitive neuroectodermal tumour; or germ cell tumours which have relapsed following, or are refractory to, chemotherapy ; or . germ cell tumours which have had an incomplete response to first line therapy. - performed under the supervision of a consultant physician - each day. | \$1260.40 |
| Procedures associated with intensive care and cardiopulmonary support | | |
| 13815 | Central vein catheterisation (via jugular, subclavian or femoral vein) by percutaneous or open exposure not being a service to which item 13318 applies (Anaes.) | \$142.90 |
| 13818 | Right heart balloon catheter, insertion of, including pulmonary wedge pressure and cardiac output measurement (Anaes.) | \$220.80 |
| 13830 | Intracranial pressure, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician - each day | \$124.60 |
| 13839 | Arterial puncture and collection of blood for diagnostic purposes | \$40.70 |
| 13842 | Intra-arterial cannulation for the purpose of taking multiple arterial blood samples for blood gas analysis | \$113.00 |
| 13847 | Counterpulsation by intraaortic balloon management on the first day including initial and subsequent consultations and monitoring of parameters (Anaes.) | \$300.60 |
| 13848 | Counterpulsation by intraaortic balloon management on each day subsequent to the first, including associated consultations and monitoring of parameters | \$229.20 |
| 13851 | Circulatory support device, management of, on first day | \$890.30 |
| 13854 | Circulatory support device, management of, on each day subsequent to the first | \$206.30 |
| 13857 | Airway access, establishment of and initiation of mechanical ventilation (other than in the context an | \$255.10 |

| Item No. | Description | Max fee (excl GST) |
|---|--|--------------------|
| | anaesthetic for surgery), outside of an Intensive Care Unit, for the purpose of subsequent ventilatory support in an Intensive Care Unit | |
| Management and procedures undertaken in an intensive care unit | | |
| 13870 | Management of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on the first day (H) | \$556.40 |
| 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) | \$407.80 |
| 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) | \$114.40 |
| 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) | \$281.90 |
| 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) | \$222.00 |
| 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) | \$295.70 |
| 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) | \$149.00 |
| Chemotherapeutic procedures | | |
| 13915 | Cytotoxic chemotherapy, administration of, either by intravenous push technique (directly into a vein, or a butterfly needle, or the side-arm of an infusion) or by intravenous infusion of not more than 1 hours duration - payable once only on the same day, not being a service associated with photodynamic therapy with verteporfin or for the administration of drugs used immediately prior to, or with microwave (uhf radiowave) cancer therapy alone | \$117.80 |
| 13918 | Cytotoxic chemotherapy, administration of, by intravenous infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day | \$162.10 |
| 13921 | Cytotoxic chemotherapy, administration of, by intravenous infusion of more than 6 hours duration - for the first day of treatment | \$184.10 |
| 13924 | Cytotoxic chemotherapy, administration of, by intravenous infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode | \$107.70 |
| 13927 | Cytotoxic chemotherapy, administration of, either by intra-arterial push technique (directly into an artery, a butterfly needle or the side-arm of an infusion) or by intra-arterial infusion of not more than 1 hours duration - payable once only on the same day | \$141.30 |
| 13930 | Cytotoxic chemotherapy, administration of, by intra-arterial infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day | \$197.10 |
| 13933 | Cytotoxic chemotherapy, administration of, by intra-arterial infusion of more than 6 hours duration - for the first day of treatment | \$216.30 |
| 13936 | Cytotoxic chemotherapy, administration of, by intra-arterial infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode | \$141.30 |
| 13939 | Implanted pump or reservoir, loading of, with a cytotoxic agent or agents, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies | \$162.10 |
| 13942 | Ambulatory drug delivery device, loading of, with a cytotoxic agent or agents for the infusion of the agent or agents via the intravenous, intra- arterial or spinal routes, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies | \$107.70 |
| 13945 | Long-term implanted drug delivery device for cytotoxic chemotherapy, accessing of | \$87.00 |
| 13948 | Cytotoxic agent, instillation of, into a body cavity | \$107.70 |
| 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 | \$93.50 |
| 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, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), if the abnormality is visible from 3 metres, including any associated consultation, up to a maximum of | \$405.40 |

| Item No. | Description | Max fee (excl GST) |
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| | 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12 month period—area of treatment less than 150 cm ² (Anaes.) | |
| 14115 | Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12 month period—area of treatment 150 cm ² to 300 cm ² (Anaes.) | \$596.00 |
| 14118 | Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14115 apply) in any 12 month period—area of treatment more than 300 cm ² (Anaes.) | \$835.20 |
| 14124 | Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, if: (a) a seventh or subsequent session (including any sessions to which this item or any of items 14100 to 14118 apply) is indicated in a 12 month period commencing on the day of the first session; and (b) photographic evidence demonstrating the need for this service is documented in the patient notes (Anaes.) | \$322.00 |
| Other therapeutic procedures | | |
| 14200 | Gastric lavage in the treatment of ingested poison | \$113.50 |
| 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 | \$412.50 |
| 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 | \$208.60 |
| 14203 | Hormone or living tissue implantation, by direct implantation involving incision and suture (Anaes.) | \$87.00 |
| 14206 | Hormone or living tissue implantation by cannula | \$55.80 |
| 14209 | Intraarterial infusion or retrograde intravenous perfusion of a sympatholytic agent | \$152.80 |
| 14212 | Intussusception, management of fluid or gas reduction for (Anaes.) | \$328.20 |
| 14218 | Implanted infusion pump 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 | \$168.20 |
| 14221 | Long-term implanted device for delivery of therapeutic agents, accessing of, not being a service associated with a service to which item 13945 applies | \$94.80 |
| 14224 | Electroconvulsive therapy, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.) | \$120.90 |
| 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 | \$172.50 |
| 14230 | Intrathecal or epidural spinal catheter insertion or replacement of, for connection to a subcutaneous implanted infusion pump, for the management of severe chronic spasticity with baclofen (Assist.) (Anaes.) | \$525.00 |
| 14233 | Infusion pump, subcutaneous implantation or replacement of, and connection to intrathecal or epidural catheter, and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Assist.) (Anaes.) | \$637.40 |
| 14236 | Infusion pump, subcutaneous implantation of, and intrathecal or epidural spinal catheter insertion, and connection of pump to catheter and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Assist.) (Anaes.) | \$1162.40 |
| 14239 | Removal of subcutaneously implanted infusion pump, or removal or repositioning of intrathecal or epidural spinal catheter, for the management of severe chronic spasticity (Anaes.) | \$281.00 |
| 14242 | Subcutaneous reservoir and spinal catheter, insertion of, for the management of severe chronic spasticity (Anaes.) | \$834.20 |
| 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 | \$172.50 |

GROUP T2 - RADIATION ONCOLOGY**Superficial**

| | | |
|-------|---|----------|
| 15000 | Radiotherapy, superficial (including treatment with xrays, radium rays or other radioactive substances), not being a service to which another item in this Group applies each attendance at which fractionated treatment is given 1 field | \$75.50 |
| 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 Derived fee: The fee for item 15000 (\$75.50) plus for each field in excess of 1, an amount of \$43.30 | DF |
| 15006 | Radiotherapy, superficial attendance at which a single dose technique is applied - 1 field | \$189.80 |
| 15009 | Radiotherapy, superficial attendance at which a single dose technique is applied - 2 or more fields up | DF |

| Item No. | Description | Max fee (excl GST) |
|---------------------|---|--------------------|
| | to a maximum of 5 additional fields Derived fee: The fee for item 15006 (\$189.80) plus each field in excess of 1, an amount of \$45.70. | |
| 15012 | Radiotherapy, superficial each attendance at which treatment is given to an eye | \$102.60 |
| Orthovoltage | | |
| 15100 | Radiotherapy, deep or orthovoltage each attendance at which fractionated treatment is given at 3 or more treatments per week - 1 field | \$84.50 |
| 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) Derived fee: The fee for item 15100 (\$84.50) plus for each field in excess of 1, and amount of \$47.40. | DF |
| 15106 | Radiotherapy, deep or orthovoltage each attendance at which fractionated treatment is given at 2 treatments per week or less frequently - 1 field | \$99.80 |
| 15109 | Radiotherapy, deep or orthovoltage each attendance at which fractionated treatment is given at 2 treatments per week or less frequently - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) Derived fee: The fee for item 15106 (\$99.80) plus for each field in excess of 1, an amount of \$57.40. | DF |
| 15112 | Radiotherapy, deep or orthovoltage attendance at which a single dose technique is applied - 1 field | \$212.90 |
| 15115 | Radiotherapy, deep or orthovoltage attendance at which a single dose technique is applied - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) Derived fee: The fee for item 15112 (\$212.90) plus for each field in excess of 1, an amount of \$119.30. | DF |
| Megavoltage | | |
| 15211 | Radiation oncology treatment, using cobalt unit or caesium teletherapy unit each attendance at which treatment is given 1 field | \$94.00 |
| 15214 | Radiation oncology treatment, using cobalt unit or caesium teletherapy unit - each attendance at which treatment is given 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) Derived fee: The fee for item 15211 (\$94.00) plus for each field in excess of 1, an amount of \$58.40. | DF |
| 15215 | Radiation oncology treatment, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given n - 1 field - treatment delivered to primary site (lung) | \$105.50 |
| 15218 | Radiation oncology treatment, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given n - 1 field - treatment delivered to primary site (prostate) | \$105.50 |
| 15221 | Radiation oncology treatment, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given n - 1 field - treatment delivered to primary site (breast) | \$105.50 |
| 15224 | Radiation oncology treatment, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given n - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15215, 15218 and 15221 | \$107.70 |
| 15227 | Radiation oncology treatment, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given n - 1 field - treatment delivered to secondary site | \$107.70 |
| 15230 | Radiation oncology treatment, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (lung) Derived fee: The fee for item 15215 (\$105.50) plus for each field in excess of 1, an amount of \$70.00. | DF |
| 15233 | Radiation oncology treatment, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate) Derived fee: The fee for item 15218 (\$105.50) plus for each field in excess of 1, an amount of \$70.00. | DF |
| 15236 | Radiation oncology treatment, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast) Derived fee: The fee for item 15221 (\$105.50) plus for each field in excess of 1, an amount of \$70.00. | DF |
| 15239 | Radiation oncology treatment, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15230, 15233 or 15236 Derived fee: The fee for item 15224 (\$107.70) plus for each field in excess of 1, an amount of \$70.00. | DF |
| 15242 | Radiation oncology treatment, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to secondary site Derived fee: The fee for item 15227 (\$107.70) plus for each field in excess of 1, an amount of \$70.00. | DF |
| 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) cology 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 - 1 field - treatment delivered to primary site (lung) | \$107.70 |
| 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)nt, using a dual photon | \$105.50 |

| Item No. | Description | Max fee (excl GST) |
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| | energy linear accelerator with a minimum higher energy of 10mv photons or greater, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (prostate) | |
| 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) | \$107.70 |
| 15254 | Radiation oncology treatment, using a radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10m v 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 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 - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15245, 1524 8 or 15251 | \$107.70 |
| 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 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 - 1 field - treatment delivered to secondary site | \$107.70 |
| 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) Derived fee: The fee for item 15245 (\$107.70) plus for each field in excess of 1, an amount of \$70.00. | DF |
| 15263 | Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10mv photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate) Derived fee: The fee for item 15248 (\$105.50) plus for each field in excess of 1, an amount of \$70.00. | DF |
| 15266 | Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10mv photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast) Derived fee: The fee for item 15251 (\$107.70) plus for each field in excess of 1, an amount of \$70.00. | DF |
| 15269 | Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10mv photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15260, 15263 or 15266 Derived fee: The fee for item 15254 (\$107.70) plus for each field in excess of 1, an amount of \$70.00. | DF |
| 15272 | Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10mv photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to secondary site Derived fee: The fee for item 15257 (\$107.70) plus for each field in excess of 1, an amount of \$70.00. | DF |
| 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. | \$291.10 |
| Brachytherapy | | |
| 15303 | Intrauterine treatment alone using radioactive sealed sources having a half-life greater than 115 days using manual after loading techniques (Anaes.) | \$632.00 |
| 15304 | Intrauterine treatment alone using radioactive sealed sources having a half-life greater than 115 days using automatic after loading techniques (Anaes.) | \$632.00 |
| 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.) | \$1198.30 |
| 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.) | \$1198.30 |
| 15311 | Intravaginal treatment alone using radioactive sealed sources having a half-life greater than 115 days using manual after loading techniques (Anaes.) | \$590.00 |
| 15312 | Intravaginal treatment alone using radioactive sealed sources having a half-life greater than 115 days using automatic after loading techniques (Anaes.) | \$585.60 |
| 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.) | \$1158.30 |
| 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.) | \$1169.80 |

| Item No. | Description | Max fee (excl GST) |
|------------------------------|---|--------------------|
| 15319 | Combined intrauterine and intravaginal treatment using radioactive sealed sources having a half-life greater than 115 days using manual after loading techniques (Anaes.) | \$718.80 |
| 15320 | Combined intrauterine and intravaginal treatment using radioactive sealed sources having a half-life greater than 115 days using automatic after loading techniques (Anaes.) | \$718.80 |
| 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.) | \$1278.20 |
| 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.) | \$1303.30 |
| 15327 | Implantation of a sealed radioactive source (having a half-life of less than 11 5 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.) | \$1390.60 |
| 15328 | Implantation of a sealed radioactive source (having a half-life of less than 11 5 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 11 5 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.) | \$1320.30 |
| 15332 | Implantation of a sealed radioactive source (having a half-life of less than 11 5 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.) | \$1459.60 |
| 15335 | Implantation of a sealed radioactive source (having a half-life of less than 11 5 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.) | \$1198.30 |
| 15336 | Implantation of a sealed radioactive source (having a half-life of less than 11 5 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.) | \$1198.30 |
| 15338 | Prostate, radioactive seed implantation of, radiation oncology component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages t1 (clinically inapparent tumour not palpable or visible by imaging) or t2 (tumour confined within prostate), with a gleason score of less than or equal to 7 and a prostate specific antigen (psa) of less than or equal to 10ng/ml at the time of diagnosis. The procedure must be performed at an approved site in association with an urologist. | \$1797.00 |
| 15339 | Removal of a sealed radioactive source under general anaesthesia, or under epidural or spinal nerve block (Anaes.) | \$150.00 |
| 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 | \$336.90 |
| 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 | \$913.80 |
| 15348 | Subsequent applications of radioactive mould referred to in item 15342 or 15345 each attendance | \$104.70 |
| 15351 | Construction with or without first application of a radioactive mould not exceeding 5 cm in diameter to an external surface | \$231.80 |
| 15354 | Construction and first application of a radioactive mould more than 5 cm in diameter to an external surface | \$250.40 |
| 15357 | Attendance upon a patient to apply a radioactive mould constructed for application to an external surface of the patient other than an attendance which is the first attendance to apply the mould each attendance | \$79.50 |
| Computerised planning | | |
| 15500 | Radiation field setting using a simulator or isocentric xray or megavoltage machine or CT of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15509 applies) | \$389.60 |
| 15503 | Radiation field setting using a simulator or isocentric xray or megavoltage machine or CT of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15512 applies) | \$532.50 |
| 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 off axis fields or several joined fields (not being a service associated with a service to which item 15515 applies) | \$834.50 |
| 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) | \$370.90 |
| 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) | \$347.70 |
| 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 | \$587.10 |

| Item No. | Description | Max fee (excl GST) |
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| 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 off axis fields or several joined fields (not being a service associated with a service to which item 15506 applies) | \$641.00 |
| 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 | \$148.90 |
| 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 | \$650.80 |
| 15524 | Radiation Dosimetry by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields or tangential fields or irregularly shaped fields using multiple blocks, or off axis fields, or several joined fields | \$1224.20 |
| 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 | \$140.10 |
| 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 | \$548.60 |
| 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 bloc, or offaxis fields, or several joined fields | \$1080.30 |
| 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 p reparations 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 | \$890.70 |
| 15553 | Simulation for three dimensional conformal radiotherapy pre and post intravenous s 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 | \$910.80 |
| 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. | \$1130.50 |
| 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 | \$875.50 |
| 15559 | Dosimetry for three dimensional conformal radiotherapy of level 2 complexity where: (a) dosimetry for a two phase three dimensional conformal treatment plan u sing 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 prescript ion; 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 | \$1169.50 |
| 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 | \$1619.40 |

| Item No. | Description | Max fee (excl GST) |
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| | 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 | |
| 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. | \$5272.40 |
| 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) - each non-contiguous treatment site verified. | \$85.60 |
| 15705 | Radiation oncology treatment verification - multiple projection or volumetric acquisition - each non-contiguous treatment site verified to a maximum of 3 sites per attendance. | \$142.80 |
| 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 (i.e. maximum one per attendance). (see para t2.5 of explanatory notes to this category) | \$143.40 |
| 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. | \$121.90 |
| Brachytherapy planning and verification | | |
| 15800 | Brachytherapy treatment verification - maximum of one only for each attendance. | \$188.20 |
| 15850 | Radiation source localisation using a simulator, x-ray machine, ct or ultrasound of a single area, where views in more than one plane are required, for brachy therapy treatment planning, not being a service to which item 15513 applies. | \$440.00 |
| GROUP T3 - THERAPEUTIC NUCLEAR MEDICINE | | |
| 16003 | Intracavity administration of a therapeutic dose of yttrium 90 not including preliminary paracentesis, not being a service associated with selective internal radiation therapy or to which item 35404, 35406 or 35408 applies (Anaes.) | \$1191.90 |
| 16006 | Administration of a therapeutic dose of Iodine 131 for thyroid cancer by single dose technique | \$913.80 |
| 16009 | Administration of a therapeutic dose of Iodine 131 for thyrotoxicosis by single dose technique | \$603.90 |
| 16012 | Intravenous administration of a therapeutic dose of Phosphorous 32 | \$522.60 |
| 16015 | Administration of Strontium 89 for painful bony metastases from carcinoma of the prostate where hormone therapy has failed and either: (i) the disease is poorly controlled by conventional radiotherapy; or (ii) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain | \$6372.20 |

| Item No. | Description | Max fee (excl GST) |
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| 16018 | Administration of 153 Sm-lexidronam for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan) where hormonal therapy and/or chemotherapy have failed and either the disease is poorly controlled by conventional radiotherapy or conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain | \$3396.70 |
| GROUP T2 - TARGETED INTRAOPERATIVE RADIOTHERAPY | | |
| Intraoperative radiotherapy | | |
| 15900 | Breast, malignant tumour, targeted intraoperative radiotherapy, using an intrabeam device, delivered at the time of breast-conserving surgery (partial mastectomy or lumpectomy) for a patient who: a) is 45 years of age or more; and b) has a t1 or small t2 (less than or equal to 3cm in diameter) primary tumour; and c) has an histologic grade 1 or 2 tumour; and d) has an oestrogen-receptor positive tumour; and e) has a node negative malignancy; and f) is suitable for wide local excision of a primary invasive ductal carcinoma that was diagnosed as unifocal on conventional examination and imaging; and g) has no contra-indications to breast irradiation | \$397.80 |
| GROUP T4 - OBSTETRICS | | |
| 16399 | Professional attendance on a patient by a specialist practising in his or her specialty of obstetrics if: (a) the attendance is by video conference; and (b) item 16401, 16404, 16406, 16500, 16590 or 16591 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an Aboriginal Medical Service; (b) or an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the act applies Derived Fee: 50% of the fee for the associated item. | DF |
| 16400 | Antenatal service provided by a midwife, nurse or a registered Aboriginal Health Worker if: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; (b) the service is provided at, or from, a practice location in a regional, rural or remote area rrrma 3-7; (c) the service is not performed in conjunction with another antenatal attendance item (same patient, same practitioner on the same day); (d) the service is not provided for a n admitted patient of a hospital; and to a maximum of 10 service per pregnancy | \$43.80 |
| 16401 | Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics, after referral of the patient to him or her - each attendance, other than a second or subsequent attendance in a single course of treatment. | \$187.10 |
| 16404 | Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics after referral of the patient to him or her - each attendance subsequent to the first attendance in a single course of treatment | \$82.40 |
| 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. Payable only once for a pregnancy. | \$233.10 |
| 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 | \$110.00 |
| 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 | \$81.90 |
| 16500 | Antenatal attendance | \$91.50 |
| 16501 | External cephalic version for breech presentation, after 36 weeks where no contraindication exists, in a Unit with facilities for Caesarean Section, including pre- and post version ctg, with or without tocolysis, not being a service to which items 55718 to 55728 and 55768 to 55774 apply - chargeable whether or not the version is successful and limited to a maximum of 2 ecv's per pregnancy | \$247.50 |
| 16502 | Polyhydramnios, unstable lie, multiple pregnancy, pregnancy complicated by diabetes or anaemia, threatened premature labour treated by bed rest only or oral medication, requiring admission to hospital each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day | \$82.00 |
| 16505 | Threatened abortion, threatened miscarriage or hyperemesis gravidarum, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance | \$87.90 |
| 16508 | Pregnancy complicated by acute intercurrent infection, foetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital - each professional attendance (other than a service to which item 16533 applies) that is not a routine antenatal attendance, to a maximum of one visit per day | \$81.90 |
| 16509 | Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of - each professional attendance (other than a service to which item 16534 applies) that is not a routine antenatal attendance. | \$90.40 |
| 16511 | Cervix, purse string ligation of (Anaes.) | \$422.70 |
| 16512 | Cervix, removal of purse string ligature of (Anaes.) | \$121.80 |
| 16514 | Antenatal cardiotocography in the management of high risk pregnancy (not during the course of the confinement) | \$64.70 |
| 16515 | Management of vaginal birth as an independent procedure, if the patient's care has been transferred by | \$1191.10 |

| Item No. | Description | Max fee (excl GST) |
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| | 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.) | |
| 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) foetal 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 foetal compromise evidenced by: (i) scalp pH less than 7.15; or (ii) scalp lactate greater than 4.0; (j) acute foetal compromise evidenced by at least one of the following significant cardiotocograph abnormalities: (i) prolonged bradycardia (less than 100 bpm for more than 2 minutes); (ii) absent baseline variability (less than 3 bpm); (iii) sinusoidal pattern; (iv) complicated variable decelerations with reduced (3 to 5 bpm) or absent baseline variability; (v) late decelerations; (k) pregnancy induced hypertension of at least 140/90 mm Hg associated with: (i) at least 2+ proteinuria on urinalysis; or (ii) protein-creatinine ratio greater than 30 mg/mmol; or (iii) platelet count less than 150 x 10 ⁹ /L; or (iv) uric acid greater than 0.36 mmol/L; (l) gestational diabetes mellitus requiring at least daily blood glucose monitoring; (m) mental health disorder (whether arising prior to pregnancy, during pregnancy or postpartum) that is demonstrated by: (i) the patient requiring hospitalisation; or (ii) the patient receiving ongoing care by a psychologist or psychiatrist to treat the symptoms of a mental health disorder; or (iii) the patient having a GP mental health treatment plan; or (iv) the patient having a management plan prepared in accordance with item 291; (n) disclosure or evidence of domestic violence; (o) any of the following conditions either diagnosed pre-pregnancy or evident at the first antenatal visit before 20 weeks gestation: (i) pre-existing hypertension requiring antihypertensive medication prior to pregnancy; (ii) cardiac disease (co-managed with a specialist physician and with echocardiographic evidence of myocardial dysfunction); (iii) previous renal or liver transplant; (iv) renal dialysis; (v) chronic liver disease with documented oesophageal varices; (vi) renal insufficiency in early pregnancy (serum creatinine greater than 110 mmol/L); (vii) neurological disorder that confines the patient to a wheelchair throughout pregnancy; (viii) maternal height of less than 148 cm; (ix) a body mass index greater than or equal to 40; (x) pre-existing diabetes mellitus on medication prior to pregnancy; (xi) thyrotoxicosis requiring medication; (xii) previous thrombosis or thromboembolism requiring anticoagulant therapy through pregnancy and the early puerperium; (xiii) thrombocytopenia with platelet count of less than 100,000 prior to 20 weeks gestation; (xiv) HIV, hepatitis B or hepatitis C carrier status positive; (xv) red cell or platelet iso-immunisation; (xvi) cancer with metastatic disease; (xvii) illicit drug misuse during pregnancy (Anaes.) | \$2761.40 |
| 16527 | Management of vaginal birth, if the patient's care has been transferred by a participating midwife for management of the birth, including all attendances related to the birth. Payable once only for a pregnancy. (Anaes.) | \$784.50 |
| 16528 | Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by a participating midwife for management of the birth. Payable once only for a pregnancy. (Anaes.) | \$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.) | \$589.50 |
| 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.) | \$1179.00 |
| 16533 | Pregnancy complicated by acute intercurrent infection, foetal 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 | \$161.90 |
| 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 | \$161.90 |
| 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.) | \$417.50 |
| 16567 | Management of postpartum haemorrhage by special measures such as packing of uterus, as an independent procedure (Anaes.) | \$613.90 |
| 16570 | Acute inversion of the uterus, vaginal correction of, as an independent procedure (Anaes.) | \$758.70 |
| 16571 | Cervix, repair of extensive laceration or lacerations (Anaes.) | \$611.90 |
| 16573 | Third degree tear, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.) | \$495.00 |
| 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 | \$377.70 |

| Item No. | Description | Max fee (excl GST) |
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| 16591 | hospital or birth centre; and (e) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (f) a service to which item 16591 applies is not provided in relation to the same pregnancy Payable once only for a pregnancy. Planning and management, by a practitioner, of a pregnancy if: (a) the pregnancy has progressed beyond 28 weeks gestation; and (b) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (c) a service to which item 16590 applies is not provided in relation to the same pregnancy Payable once only for a pregnancy. | \$200.00 |
| 16600 | Amniocentesis, diagnostic | \$153.00 |
| 16603 | Chorionic villus sampling, by any route | \$233.30 |
| 16606 | Foetal blood sampling, using interventional techniques from umbilical cord or foetus, including foetal neuromuscular blockade and amniocentesis (Anaes.) | \$428.50 |
| 16609 | Foetal intravascular blood transfusion, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling (Anaes.) | \$873.70 |
| 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.) | \$687.30 |
| 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.) | \$366.30 |
| 16618 | Amniocentesis, therapeutic, when indicated because of polyhydramnios with at least 500ml being aspirated | \$371.30 |
| 16621 | Amnioinfusion, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios | \$366.30 |
| 16624 | Foetal fluid filled cavity, drainage of | \$526.90 |
| 16627 | Feto-amniotic shunt, insertion of, into foetal fluid filled cavity, including neuromuscular blockade and amniocentesis | \$1072.50 |

GROUP T6 - ANAESTHETICS**Anaesthesia consultations**

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| 17609 | Professional attendance on a patient by a specialist practising in his or her specialty of anaesthesia if: (a) the attendance is by video conference; and (b) item 17610, 17615, 17620, 17625, 17640, 17645, 17650, or 17655 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies . Derived Fee: 50% of the fee for the associated item. | DF |
| 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 duration, not being a service associated with a service to which items 2801 - 3000 apply | \$84.30 |
| 17615 | 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 | \$167.70 |
| 17620 | 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 | \$235.00 |
| 17625 | 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 | \$295.00 |
| 17640 | Anaesthetist, 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 | \$85.20 |
| 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. | \$158.80 |
| 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 | \$222.10 |
| 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 | \$297.20 |

| Item No. | Description | Max fee (excl GST) |
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| 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. | \$169.20 |
| 17690 | - Where a pre-anaesthesia consultation covered by an item in the range 17615-1 7625 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 provide | \$70.00 |
| GROUP T7 - REGIONAL OR FIELD NERVE BLOCKS | | |
| 18213 | Intravenous regional anaesthesia of limb by retrograde perfusion | \$158.20 |
| 18216 | Intrathecal or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner (Anaes.) | \$373.90 |
| 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.) Derived fee: The fee for item 18216 (\$373.90) plus \$38.80 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner. | DF |
| 18222 | Infusion of a therapeutic substance to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is 15 minutes or less | \$91.10 |
| 18225 | Infusion of a therapeutic substance to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is more than 15 minutes | \$127.50 |
| 18226 | Intrathecal or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner, 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. | \$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. Derived fee: The fee for item 18226 (\$574.50) plus \$48.40 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner. | DF |
| 18228 | Interpleural block, initial injection or commencement of infusion of a therapeutic substance | \$155.20 |
| 18230 | Intrathecal or epidural injection of neurolytic substance (Anaes.) | \$458.10 |
| 18232 | Intrathecal or epidural injection of substance other than anaesthetic, contrast or neurolytic solutions, not being a service to which another item in this Group applies (Anaes.) | \$353.30 |
| 18233 | Epidural injection of blood for blood patch (Anaes.) | \$367.20 |
| 18234 | Trigeminal nerve, primary division of, injection of an anaesthetic agent (Anaes.) | \$229.30 |
| 18236 | Trigeminal nerve, peripheral branch of, injection of an anaesthetic agent (Anaes.) | \$119.80 |
| 18238 | Facial nerve, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies | \$66.90 |
| 18240 | Retrolbulbar or peribulbar injection of an anaesthetic agent | \$183.30 |
| 18242 | Greater occipital nerve, injection of an anaesthetic agent (Anaes.) | \$72.90 |
| 18244 | Vagus nerve, injection of an anaesthetic agent | \$241.40 |
| 18248 | Phrenic nerve, injection of an anaesthetic agent | \$173.30 |
| 18250 | Spinal accessory nerve, injection of an anaesthetic agent | \$162.40 |
| 18252 | Cervical plexus, injection of an anaesthetic agent | \$193.60 |
| 18254 | Brachial plexus, injection of an anaesthetic agent | \$248.50 |
| 18256 | Suprascapular nerve, injection of an anaesthetic agent | \$130.10 |
| 18258 | Intercostal nerve (single), injection of an anaesthetic agent | \$120.50 |
| 18260 | Intercostal nerves (multiple), injection of an anaesthetic agent | \$185.70 |
| 18262 | Ilio-inguinal, iliohypogastric or genitofemoral nerves, 1 or more of, injection of an anaesthetic agent (Anaes.) | \$163.10 |
| 18264 | Pudendal nerve and or dorsal nerve, injection of an anaesthetic agent | \$203.00 |
| 18266 | Ulnar, radial or median nerve, main trunk of, 1 or more of, injection of an anaesthetic agent, not being associated with a brachial plexus block | \$144.70 |
| 18268 | Obturator nerve, injection of an anaesthetic agent | \$176.90 |
| 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 |
| 18274 | Paravertebral, cervical, thoracic, lumbar, sacral or coccygeal nerves, injection of an anaesthetic agent, (single vertebral level) | \$180.10 |
| 18276 | Paravertebral nerves, injection of an anaesthetic agent, (multiple levels) | \$249.40 |
| 18278 | Sciatic nerve, injection of an anaesthetic agent | \$192.30 |
| 18280 | Sphenopalatine ganglion, injection of an anaesthetic agent (Anaes.) | \$258.10 |

| Item No. | Description | Max fee (excl GST) |
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| 18282 | Carotid sinus, injection of an anaesthetic agent, as an independent percutaneous procedure | \$292.90 |
| 18284 | Stellate ganglion, injection of an anaesthetic agent, (cervical sympathetic block) (Anaes.) | \$292.90 |
| 18286 | Lumbar or thoracic nerves, injection of an anaesthetic agent, (paravertebral sympathetic block) (Anaes.) | \$292.90 |
| 18288 | Coeliac plexus or splanchnic nerves, injection of an anaesthetic agent (Anaes.) | \$288.00 |
| 18290 | Cranial nerve other than trigeminal, destruction by a neurolytic agent, not being a service associated with the injection of botulinum toxin (Anaes.) | \$442.30 |
| 18292 | Nerve branch, destruction by a neurolytic agent, not being a service to which any other item in this Group applies or a service associated with the injection of botulinum toxin except those services to which item 18354 applies (Anaes.) | \$269.40 |
| 18294 | Coeliac plexus or splanchnic nerves, destruction by a neurolytic agent (Anaes.) | \$338.30 |
| 18296 | Lumbar sympathetic chain, destruction by a neurolytic agent (Anaes.) | \$318.00 |
| 18298 | Cervical or thoracic sympathetic chain, destruction by a neurolytic agent (Anaes.) | \$311.50 |
| 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 | \$222.50 |
| 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 | \$240.60 |
| 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 | \$442.30 |
| 18354 | Botulinum Toxin Type A Purified Neurotoxin 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.) | \$240.00 |
| 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 | \$221.10 |
| 18361 | Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of moderate to severe upper limb spasticity due to cerebral palsy if: (a) the patient is at least 2 years of age, and (b) for a patient who is at least 18 years of age - before the patient turned 18, the patient had commenced treatment for the spasticity with botulinum toxin supplied under the pharmaceutical benefits scheme; and (c) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set (Anaes.) | \$217.30 |
| 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.) | \$496.00 |
| 18365 | Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of moderate to severe spasticity of the upper limb following a stroke, if: (a) the patient is at least 18 years of age; and (b) treatment is provided as: (i) second line therapy when standard treatment for the condition has failed; or (ii) an adjunct to physical therapy; and (c) the patient does not have established severe contracture in the limb that is to be treated; and (d) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set; and (e) for a patient who has received treatment on 2 previous separate occasions - the patient has responded to the treatment | \$222.00 |
| 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.) | \$303.50 |
| 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 | \$472.80 |
| 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 |

| Item No. | Description | Max fee (excl GST) |
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| 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.) | \$83.90 |
| 18372 | Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of bilateral blepharospasm, in a patient who is at least 12 years of age; including all such injections on any one day) (Anaes.) | \$219.90 |
| 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.) | \$219.90 |
| 18375 | Botulinum toxin type A (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.) | \$385.70 |
| 18377 | Botulinum toxin type a (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) | \$209.40 |
| 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.) | \$374.10 |

GROUP T10 - RELATIVE VALUE GUIDE FOR ANAESTHESIA - WORKCOVER BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

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| 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 (00 5) (basic units) | \$264.50 |
| 20102 | Initiation of management of anaesthesia for plastic repair of cleft lip (006) (basic units) | \$317.40 |
| 20104 | Initiation of management of anaesthesia for electroconvulsive therapy (004) (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 (005) (basic units) | \$264.50 |
| 20124 | Initiation of management of anaesthesia for otoscopy (004) (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 (005) (basic units) | \$264.50 |
| 20142 | Initiation of management of anaesthesia for lens surgery (006) (basic units) | \$317.40 |
| 20143 | Initiation of management of anaesthesia for retinal surgery (006) (basic units) | \$317.40 |
| 20144 | Initiation of management of anaesthesia for corneal transplant (008) (basic units) | \$423.20 |
| 20145 | Initiation of management of anaesthesia for vitrectomy (008) (basic units) | \$423.20 |
| 20146 | Initiation of management of anaesthesia for biopsy of conjunctiva (005) (basic units) | \$264.50 |
| 20147 | Initiation of management of anaesthesia for squint repair (006) (basic units) | \$317.40 |
| 20148 | Initiation of management of anaesthesia for ophthalmoscopy (004) (basic units) | \$211.60 |
| 20160 | Initiation of management of anaesthesia for procedures on nose or accessory sinuses, not being a service to which another item in this subgroup applies (006) (basic units) | \$317.40 |
| 20162 | Initiation of management of anaesthesia for radical surgery on the nose and accessory sinuses (007) (basic units) | \$370.30 |
| 20164 | Initiation of management of anaesthesia for biopsy of soft tissue of the nose and accessory sinuses (004) (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 (006) (basic units) | \$317.40 |

| Item No. | Description | Max fee (excl GST) |
|---------------|---|--------------------|
| 20172 | Initiation of management of anaesthesia for repair of cleft palate (007) (basic units) | \$370.30 |
| 20174 | Initiation of management of anaesthesia for excision of retropharyngeal tumour (009) (basic units) | \$476.10 |
| 20176 | Initiation of management of anaesthesia for radical intraoral surgery (010) (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 (005) (basic units) | \$264.50 |
| 20192 | Initiation of management of anaesthesia for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction) (010) (basic un its) | \$529.00 |
| 20210 | Initiation of management of anaesthesia for intracranial procedures, not being a service to which another item in this subgroup applies (015) (basic units) | \$793.50 |
| 20212 | Initiation of management of anaesthesia for subdural taps (005) (basic units) | \$264.50 |
| 20214 | Initiation of management of anaesthesia for burr holes of the cranium (009) (basic units) | \$476.10 |
| 20216 | Initiation of management of anaesthesia for intracranial vascular procedures including those for aneurysms or arterio-venous abnormalities (020) (basic units) | \$1058.00 |
| 20220 | Initiation of management of anaesthesia for spinal fluid shunt procedures (010) (basic units) | \$529.00 |
| 20222 | Initiation of management of anaesthesia for ablation of an intracranial nerve (006) (basic units) | \$317.40 |
| 20225 | Initiation of management of anaesthesia for all cranial bone procedures (012) (basic units) | \$634.80 |
| 20230 | Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the head or face (012) (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 (005) (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 (015) (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 (006) (basic units) | \$317.40 |
| 20321 | Initiation of management of anaesthesia for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy (010) (basic units) | \$529.00 |
| 20330 | Initiation of management of anaesthesia for laser surgery to the airway (excluding nose and mouth) (008) (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 (010) (basic units) | \$529.00 |
| 20352 | Initiation of management of anaesthesia for simple ligation of major vessels of neck (005) (basic units) | \$264.50 |
| 20355 | Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the neck (012) (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 (003) (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 (004) (basic units) | \$211.60 |
| 20402 | Initiation of management of anaesthesia for reconstructive procedures on breast (005) (basic units) | \$264.50 |
| 20403 | Initiation of management of anaesthesia for removal of breast lump or for breast segmentectomy where axillary node dissection is performed (005) (basic units) | \$264.50 |
| 20404 | Initiation of management of anaesthesia for mastectomy (006) (basic units) | \$317.40 |
| 20405 | Initiation of management of anaesthesia for reconstructive procedures on the breast using myocutaneous flaps (008) (basic units) | \$423.20 |
| 20406 | Initiation of management of anaesthesia for radical or modified radical procedures on breast with internal mammary node dissection (013) (basic units) | \$687.70 |
| 20410 | Initiation of management of anaesthesia for electrical conversion of arrhythmia s (005) (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 (005) (basic units) | \$264.50 |
| 20440 | Initiation of management of anaesthesia for percutaneous bone marrow biopsy of the sternum (004) (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 (00 5) (basic units) | \$264.50 |
| 20452 | Initiation of management of anaesthesia for radical surgery on clavicle, scapula or sternum (006) (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 (006) (basic units) | \$317.40 |
| 20472 | Initiation of management of anaesthesia for thoracoplasty (010) (basic units) | \$529.00 |
| 20474 | Initiation of management of anaesthesia for radical procedures on chest wall (0 13) (basic units) | \$687.70 |

| Item No. | Description | Max fee (excl GST) |
|------------------------------|--|--------------------|
| 20475 | Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior thorax (010) (basic units) | \$529.00 |
| Intrathoracic | | |
| 20500 | Initiation of management of anaesthesia for open procedures on the oesophagus (015) (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 (006) (basic units) | \$317.40 |
| 20522 | Initiation of management of anaesthesia for needle biopsy of pleura (004) (basic units) | \$211.60 |
| 20524 | Initiation of management of anaesthesia for pneumocentesis (004) (basic units) | \$211.60 |
| 20526 | Initiation of management of anaesthesia for thoracoscopy (010) (basic units) | \$529.00 |
| 20528 | Initiation of management of anaesthesia for mediastinoscopy (008) (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 (013) (basic units) | \$687.70 |
| 20542 | Initiation of management of anaesthesia for pulmonary decortication (015) (basic units) | \$793.50 |
| 20546 | Initiation of management of anaesthesia for pulmonary resection with thoracoplasty (015) (basic units) | \$793.50 |
| 20548 | Initiation of management of anaesthesia for intrathoracic repair of trauma to trachea and bronchi (015) (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) (010) (basic units) | \$529.00 |
| 20604 | Initiation of management of anaesthesia for posterior cervical laminectomy with the patient in the sitting position (013) (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 (010) (basic units) | \$529.00 |
| 20622 | Initiation of management of anaesthesia for thoracolumbar sympathectomy (013) (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 (008) (basic units) | \$423.20 |
| 20632 | Initiation of management of anaesthesia for lumbar sympathectomy (007) (basic u nits) | \$370.30 |
| 20634 | Initiation of management of anaesthesia for chemonucleolysis (010) (basic units) | \$529.00 |
| 20670 | Initiation of management of anaesthesia for extensive spine and/or spinal cord procedures (013) (basic units) | \$687.70 |
| 20680 | Initiation of management of anaesthesia for manipulation of spine when performed in the operating theatre of a hospital (003) (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 (005) (basic un its) | \$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 (003) (basic units) | \$158.70 |
| 20702 | Initiation of management of anaesthesia for percutaneous liver biopsy (004) (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 (004) (basic units) | \$211.60 |
| 20704 | Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior upper abdomen (010) (basic units) | \$529.00 |
| 20705 | Initiation of management of anaesthesia for diagnostic laparoscopy procedures (006) (basic units) | \$317.40 |
| 20706 | Initiation of management of anaesthesia for laparoscopic procedures in the upper abdomen, not being a service to which another item in this subgroup applies (007) (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 (005) (basic units) | \$264.50 |
| 20740 | Initiation of management of anaesthesia for upper gastrointestinal endoscopic procedures (005) (basic units) | \$264.50 |
| 20745 | Initiation of management of anaesthesia for upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage (006) (basic u nits) | \$317.40 |
| 20750 | Initiation of management of anaesthesia for hernia repairs in upper abdomen, not being a service to which another item in this subgroup applies (004) (basic u nits) | \$211.60 |
| 20752 | Initiation of management of anaesthesia for repair of incisional hernia and/or wound dehiscence (006) (basic units) | \$317.40 |

| Item No. | Description | Max fee (excl GST) |
|----------------------|---|--------------------|
| 20754 | Initiation of management of anaesthesia for procedures on an omphalocele (007) (basic units) | \$370.30 |
| 20756 | Initiation of management of anaesthesia for transabdominal repair of diaphragmatic hernia (009) (basic units) | \$476.10 |
| 20770 | Initiation of management of anaesthesia for procedures on major upper abdominal blood vessels (015) (basic units) | \$793.50 |
| 20790 | Initiation of management of anaesthesia for procedures within the peritoneal cavity in upper abdomen including cholecystectomy, gastrectomy, laparoscopic nephrectomy or bowel shunts (008) (basic units) | \$423.20 |
| 20791 | Initiation of the management of anaesthesia for bariatric surgery in a patient with clinically severe obesity (010) (basic units) | \$529.00 |
| 20792 | Initiation of management of anaesthesia for partial hepatectomy (excluding liver biopsy) (013) (basic units) | \$687.70 |
| 20793 | Initiation of management of anaesthesia for extended or trisegmental hepatectomy (015) (basic units) | \$793.50 |
| 20794 | Initiation of management of anaesthesia for pancreatectomy, partial or total (012) (basic units) | \$634.80 |
| 20798 | Initiation of management of anaesthesia for neuro endocrine tumour removal in the upper abdomen (010) (basic units) | \$529.00 |
| 20799 | Initiation of management of anaesthesia for percutaneous procedures on an intra -abdominal organ in the upper abdomen (006) (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 (003) (basic units) | \$158.70 |
| 20802 | Initiation of management of anaesthesia for lipectomy of the lower abdomen (005) (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 (004) (basic units) | \$211.60 |
| 20804 | Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen (010) (basic units) | \$529.00 |
| 20805 | Initiation of management of anaesthesia for diagnostic laparoscopic procedures (006) (basic units) | \$317.40 |
| 20806 | Initiation of management of anaesthesia for laparoscopic procedures in the lower abdomen (007) (basic units) | \$370.30 |
| 20810 | Initiation of management of anaesthesia for lower intestinal endoscopic procedures (004) (basic units) | \$211.60 |
| 20815 | Initiation of management of anaesthesia for extracorporeal shock wave lithotripsy to urinary tract (006) (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 (005) (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 (004) (basic units) | \$211.60 |
| 20832 | Initiation of management of anaesthesia for repair of incisional hernia and/or wound dehiscence of the lower abdomen (006) (basic units) | \$317.40 |
| 20840 | Initiation of management of anaesthesia for all procedures within the peritoneal cavity in lower abdomen including appendectomy, not being a service to which another item in this subgroup applies (006) (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 (008) (basic units) | \$423.20 |
| 20842 | Initiation of management of anaesthesia for amniocentesis (004) (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 (010) (basic units) | \$529.00 |
| 20845 | Initiation of management of anaesthesia for radical prostatectomy (010) (basic units) | \$529.00 |
| 20846 | Initiation of management of anaesthesia for radical hysterectomy (010) (basic units) | \$529.00 |
| 20847 | Initiation of management of anaesthesia for ovarian malignancy (010) (basic units) | \$529.00 |
| 20848 | Initiation of management of anaesthesia for pelvic exenteration (010) (basic units) | \$529.00 |
| 20850 | Initiation of management of anaesthesia for caesarean section (012) (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 (006) (basic units) | \$317.40 |
| 20862 | initiation of management of anaesthesia for renal procedures, including upper 1 /3 of ureter (007) (basic units) | \$370.30 |
| 20863 | Initiation of management of anaesthesia for nephrectomy (010) (basic units) | \$529.00 |
| 20864 | Initiation of management of anaesthesia for total cystectomy (010) (basic units) | \$529.00 |
| 20866 | Initiation of management of anaesthesia for adrenalectomy (010) (basic units) | \$529.00 |

| Item No. | Description | Max fee (excl GST) |
|-----------------|---|--------------------|
| 20867 | Initiation of management of anaesthesia for neuro endocrine tumour removal in the lower abdomen (010) (basic units) | \$529.00 |
| 20868 | Initiation of management of anaesthesia for renal transplantation (donor or recipient) (010) (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 (0 15) (basic units) | \$793.50 |
| 20882 | Initiation of management of anaesthesia for inferior vena cava ligation (010) (basic units) | \$529.00 |
| 20884 | Initiation of management of anaesthesia for percutaneous umbrella insertion (00 5) (basic units) | \$264.50 |
| 20886 | Initiation of management of anaesthesia for percutaneous procedures on an intra -abdominal organ in the lower abdomen (006) (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 (003) (basic units) | \$158.70 |
| 20902 | Initiation of management of anaesthesia for anorectal procedures (including endoscopy and/or biopsy) (004) (basic units) | \$211.60 |
| 20904 | Initiation of management of anaesthesia for radical perineal procedures including radical perineal prostatectomy or radical vulvectomy (007) (basic units) | \$370.30 |
| 20905 | Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the perineum (010) (basic units) | \$529.00 |
| 20906 | Initiation of management of anaesthesia for vulvectomy (004) (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 (004) (basic units) | \$211.60 |
| 20911 | Initiation of management of anaesthesia for endoscopic ureteroscopic surgery including laser procedures (005) (basic units) | \$264.50 |
| 20912 | Initiation of management of anaesthesia for transurethral resection of bladder tumour(s) (005) (basic units) | \$264.50 |
| 20914 | Initiation of management of anaesthesia for transurethral resection of prostate (007) (basic units) | \$370.30 |
| 20916 | Initiation of management of anaesthesia for bleeding post- transurethral resect ion (007) (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. (004) (basic units) | \$211.60 |
| 20924 | Initiation of management of anaesthesia for procedures on undescended testis, unilateral or bilateral (004) (basic units) | \$211.60 |
| 20926 | Initiation of management of anaesthesia for radical orchidectomy, inguinal approach (004) (basic units) | \$211.60 |
| 20928 | Initiation of management of anaesthesia for radical orchidectomy, abdominal app roach (006) (basic units) | \$317.40 |
| 20930 | Initiation of management of anaesthesia for orchiopexy, unilateral or bilateral (004) (basic units) | \$211.60 |
| 20932 | Initiation of management of anaesthesia for complete amputation of penis (004) (basic units) | \$211.60 |
| 20934 | Initiation of management of anaesthesia for complete amputation of penis with bilateral inguinal lymphadenectomy (006) (basic units) | \$317.40 |
| 20936 | Initiation of management of anaesthesia for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy (008) (basic units) | \$423.20 |
| 20938 | Initiation of management of anaesthesia for insertion of penile prosthesis (004) (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 (004) (basic units) | \$211.60 |
| 20942 | Initiation of management of anaesthesia for vaginal procedures including repair operations and urinary incontinence procedures (perineal) (005) (basic units) | \$264.50 |
| 20943 | Initiation of management of anaesthesia for transvaginal assisted reproductive services (004) (basic units) | \$211.60 |
| 20944 | Initiation of management of anaesthesia for vaginal hysterectomy (006) (basic u nits) | \$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, or removal of purse string ligature (004) (basic units) | \$211.60 |
| 20950 | Initiation of management of anaesthesia for culdoscopy (005) (basic units) | \$264.50 |
| 20952 | Initiation of management of anaesthesia for hysteroscopy (004) (basic units) | \$211.60 |
| 20953 | Initiation of management of anaesthesia for endometrial ablation or resection i n association with hysteroscopy (005) (basic units) | \$264.50 |
| 20954 | Initiation of management of anaesthesia for correction of inverted uterus (010) (basic units) | \$529.00 |
| 20956 | Initiation of management of anaesthesia for evacuation of retained products of conception, as a complication of confinement (004) (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 |

| Item No. | Description | Max fee (excl GST) |
|--------------------------------|--|--------------------|
| 20960 | Initiation of management of anaesthesia for vaginal procedures in the management of post partum haemorrhage (blood loss > 500mls) (007) (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 (003) (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 (005) (basic units) | \$264.50 |
| 21112 | Initiation of management of anaesthesia for percutaneous bone marrow biopsy of the anterior iliac crest (004) (basic units) | \$211.60 |
| 21114 | Initiation of management of anaesthesia for percutaneous bone marrow biopsy of the posterior iliac crest (005) (basic units) | \$264.50 |
| 21116 | Initiation of management of anaesthesia for percutaneous bone marrow harvesting from the pelvis (006) (basic units) | \$317.40 |
| 21120 | Initiation of management of anaesthesia for procedures on the bony pelvis (006) (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 (003) (basic units) | \$158.70 |
| 21140 | Initiation of management of anaesthesia for interpelviabdominal (hind-quarter) amputation (015) (basic units) | \$793.50 |
| 21150 | Initiation of management of anaesthesia for radical procedures for tumour of the pelvis, except hind-quarter amputation (010) (basic units) | \$529.00 |
| 21155 | Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior pelvis (010) (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 (004) (basic units) | \$211.60 |
| 21170 | Initiation of management of anaesthesia for open procedures involving symphysis pubis or sacroiliac joint (008) (basic units) | \$423.20 |
| Upper leg (except knee) | | |
| 21195 | Initiation of management of anaesthesia for procedures on the skins or subcutaneous tissue of the upper leg (003) (basic units) | \$158.70 |
| 21199 | Initiation of management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg (004) (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 (004) (basic units) | \$211.60 |
| 21202 | Initiation of management of anaesthesia for arthroscopic procedures of the hip joint (004) (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 (006) (basic units) | \$317.40 |
| 21212 | Initiation of management of anaesthesia for hip disarticulation (010) (basic units) | \$529.00 |
| 21214 | Initiation of management of anaesthesia for total hip replacement or revision (010) (basic units) | \$529.00 |
| 21216 | Initiation of management of anaesthesia for bilateral total hip replacement (014) (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 (004) (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 (006) (basic units) | \$317.40 |
| 21232 | Initiation of management of anaesthesia for above knee amputation (005) (basic units) | \$264.50 |
| 21234 | Initiation of management of anaesthesia for radical resection of the upper 2/3 of femur (008) (basic units) | \$423.20 |
| 21260 | Initiation of management of anaesthesia for procedures involving veins of upper leg, including exploration (004) (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 (008) (basic units) | \$423.20 |
| 21272 | Initiation of management of anaesthesia for femoral artery ligation (004) (basic units) | \$211.60 |
| 21274 | Initiation of management of anaesthesia for femoral artery embolectomy (006) (basic units) | \$317.40 |
| 21275 | Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the upper leg (010) (basic units) | \$529.00 |
| 21280 | Initiation of management of anaesthesia for microsurgical reimplantation of upper leg (015) (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 (003) (basic units) | \$158.70 |

| Item No. | Description | Max fee (excl GST) |
|-------------------------------|--|--------------------|
| 21321 | Initiation of management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of knee and/or popliteal area (004) (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 (004) (basic units) | \$211.60 |
| 21360 | Initiation of management of anaesthesia for open procedures on lower 1/3 of femur (005) (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 (003) (basic units) | \$158.70 |
| 21382 | Initiation of management of anaesthesia for arthroscopic procedures of knee joint (004) (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 (003) (basic units) | \$158.70 |
| 21392 | Initiation of management of anaesthesia for open procedures on upper ends of tibia, fibula, and/or patella (004) (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 (004) (basic units) | \$211.60 |
| 21402 | Initiation of management of anaesthesia for knee replacement (007) (basic units) | \$370.30 |
| 21403 | Initiation of management of anaesthesia for bilateral knee replacement (010) (basic units) | \$529.00 |
| 21404 | Initiation of management of anaesthesia for disarticulation of knee (005) (basic units) | \$264.50 |
| 21420 | Initiation of management of anaesthesia for cast application, removal, or repair involving knee joint, undertaken in a hospital (003) (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 (004) (basic units) | \$211.60 |
| 21432 | Initiation of management of anaesthesia for repair of arteriovenous fistula of knee or popliteal area (005) (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 (008) (basic units) | \$423.20 |
| 21445 | Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the knee and/or popliteal area (010) (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 (003) (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 (004) (basic units) | \$211.60 |
| 21462 | Initiation of management of anaesthesia for all closed procedures on lower leg, ankle, or foot (003) (basic units) | \$158.70 |
| 21464 | Initiation of management of anaesthesia for arthroscopic procedure of ankle joint (004) (basic units) | \$211.60 |
| 21472 | Initiation of management of anaesthesia for repair of achilles tendon (005) (basic units) | \$264.50 |
| 21474 | Initiation of management of anaesthesia for gastrocnemius recession (005) (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 (004) (basic units) | \$211.60 |
| 21482 | Initiation of management of anaesthesia for radical resection of bone involving lower leg, ankle or foot (005) (basic units) | \$264.50 |
| 21484 | Initiation of management of anaesthesia for osteotomy or osteoplasty of tibia or fibula (005) (basic units) | \$264.50 |
| 21486 | Initiation of management of anaesthesia for total ankle replacement (007) (basic units) | \$370.30 |
| 21490 | Initiation of management of anaesthesia for lower leg cast application, removal or repair, undertaken in a hospital (003) (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 sub group applies (008) (basic units) | \$423.20 |
| 21502 | Initiation of management of anaesthesia for embolectomy of the lower leg (006) (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 (004) (basic units) | \$211.60 |
| 21522 | Initiation of management of anaesthesia for venous thrombectomy of the lower leg (005) (basic units) | \$264.50 |
| 21530 | Initiation of management of anaesthesia for microsurgical reimplantation of lower leg, ankle or foot (015) (basic units) | \$793.50 |
| 21532 | Initiation of management of anaesthesia for microsurgical reimplantation of toe (008) (basic units) | \$423.20 |
| 21535 | Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the lower leg (010) (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 (003) (basic units) | \$158.70 |

| Item No. | Description | Max fee (excl GST) |
|-------------------------------|---|--------------------|
| 21610 | Initiation of management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla including axillary dissection (005) (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 (004) (basic units) | \$211.60 |
| 21622 | Initiation of management of anaesthesia for arthroscopic procedures of shoulder joint (005) (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 (005) (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 (006) (basic units) | \$317.40 |
| 21634 | Initiation of management of anaesthesia for shoulder disarticulation (009) (basic units) | \$476.10 |
| 21636 | Initiation of management of anaesthesia for interthoracoscapular (forequarter) amputation (015) (basic units) | \$793.50 |
| 21638 | Initiation of management of anaesthesia for total shoulder replacement (010) (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 (008) (basic units) | \$423.20 |
| 21652 | Initiation of management of anaesthesia for procedures for axillary-brachial aneurysm (010) (basic units) | \$529.00 |
| 21654 | Initiation of management of anaesthesia for bypass graft of arteries of shoulder or axilla (008) (basic units) | \$423.20 |
| 21656 | Initiation of management of anaesthesia for axillary-femoral bypass graft (010) (basic units) | \$529.00 |
| 21670 | Initiation of management of anaesthesia for procedures on veins of shoulder or axilla (004) (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 (003) (basic units) | \$158.70 |
| 21682 | Initiation of management of anaesthesia for shoulder spica application when undertaken in a hospital (004) (basic units) | \$211.60 |
| 21685 | Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the shoulder or the axilla (010) (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 (003) (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 (004) (basic units) | \$211.60 |
| 21712 | Initiation of management of anaesthesia for open tenotomy of the upper arm or elbow (005) (basic units) | \$264.50 |
| 21714 | Initiation of management of anaesthesia for tenoplasty of the upper arm or elbow (005) (basic units) | \$264.50 |
| 21716 | Initiation of management of anaesthesia for tenodesis for rupture of long tendon of biceps (005) (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 (003) (basic units) | \$158.70 |
| 21732 | Initiation of management of anaesthesia for arthroscopic procedures of elbow joint (004) (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 (005) (basic units) | \$264.50 |
| 21756 | Initiation of management of anaesthesia for radical procedures on the upper arm or elbow (006) (basic units) | \$317.40 |
| 21760 | Initiation of management of anaesthesia for total elbow replacement (007) (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 (008) (basic units) | \$423.20 |
| 21772 | Initiation of management of anaesthesia for embolectomy of arteries of the upper arm (006) (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 (004) (basic units) | \$211.60 |
| 21785 | Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the upper arm or elbow (010) (basic units) | \$529.00 |
| 21790 | Initiation of management of anaesthesia for microsurgical reimplantation of upper arm (015) (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 (003) (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 (004) (basic units) | \$211.60 |

| Item No. | Description | Max fee (excl GST) |
|---|---|--------------------|
| 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 (003) (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 (004) (basic units) | \$211.60 |
| 21832 | Initiation of management of anaesthesia for total wrist replacement (007) (basic units) | \$370.30 |
| 21834 | Initiation of management of anaesthesia for arthroscopic procedures of the wrist joint (004) (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 (008) (basic units) | \$423.20 |
| 21842 | Initiation of management of anaesthesia for embolectomy of artery of forearm, wrist or hand (006) (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 (004) (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 (003) (basic units) | \$158.70 |
| 21865 | Initiation of management of anaesthesia for microvascular free tissue flap surgery involving the forearm, wrist or hand (010) (basic units) | \$529.00 |
| 21870 | Initiation of management of anaesthesia for microsurgical reimplantation of forearm, wrist or hand (015) (basic units) | \$793.50 |
| 21872 | Initiation of management of anaesthesia for microsurgical reimplantation of a finger (008) (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 (003) (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 (005) (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 (007) (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 (009) (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 (011) (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 (013) (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 (015) (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 (017) (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 (019) (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 (021) (basic units) | \$1110.90 |
| Anaesthesia for radiological or other diagnostic or therapeutic procedures | | |
| 21900 | Initiation of management of anaesthesia for injection procedure for hysterosalpingography (003) (basic units) | \$158.70 |
| 21906 | Initiation of management of anaesthesia for injection procedure for myelography : lumbar or thoracic (005) (basic units) | \$264.50 |
| 21908 | Initiation of management of anaesthesia for injection procedure for myelography : cervical (006) (basic units) | \$317.40 |
| 21910 | Initiation of management of anaesthesia for injection procedure for myelography : posterior fossa (009) (basic units) | \$476.10 |
| 21912 | Initiation of management of anaesthesia for injection procedure for discography : lumbar or thoracic (005) (basic units) | \$264.50 |
| 21914 | Initiation of management of anaesthesia for injection procedure for discography cervical (006) (basic units) | \$317.40 |
| 21915 | Initiation of management of anaesthesia for peripheral arteriogram (005) (basic units) | \$264.50 |
| 21916 | Initiation of management of anaesthesia for arteriograms: cerebral, carotid or vertebral (005) (basic units) | \$264.50 |

| Item No. | Description | Max fee (excl GST) |
|--|---|--------------------|
| 21918 | Initiation of management of anaesthesia for retrograde arteriogram: brachial or femoral (005) (basic units) | \$264.50 |
| 21922 | Initiation of management of anaesthesia for computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning (007) (basic units) | \$370.30 |
| 21925 | Initiation of management of anaesthesia for retrograde cystography, retrograde urethrography or retrograde cystourethrography (004) (basic units) | \$211.60 |
| 21926 | Initiation of management of anaesthesia for fluoroscopy (005) (basic units) | \$264.50 |
| 21927 | Initiation of management of anaesthesia for barium enema or other opaque study of the small bowel (005) (basic units) | \$264.50 |
| 21930 | Initiation of management of anaesthesia for bronchography (006) (basic units) | \$317.40 |
| 21935 | Initiation of management of anaesthesia for phlebography (005) (basic units) | \$264.50 |
| 21936 | Initiation of management of anaesthesia for heart, 2 dimensional real time transoesophageal examination (006) (basic units) | \$317.40 |
| 21939 | Initiation of management of anaesthesia for peripheral venous cannulation (003) (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 (007) (basic units) | \$370.30 |
| 21942 | Initiation of management of anaesthesia for cardiac electrophysiological procedures including radio frequency ablation (010) (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 (005) (basic units) | \$264.50 |
| 21945 | Initiation of management of anaesthesia for lumbar puncture, cisternal puncture , or epidural injection (005) (basic units) | \$264.50 |
| 21949 | Initiation of management of anaesthesia for harvesting of bone marrow for the p purpose of transplantation (005) (basic units) | \$264.50 |
| 21952 | Initiation of management of anaesthesia for muscle biopsy for malignant hyperpyrexia (010) (basic units) | \$529.00 |
| 21955 | Initiation of management of anaesthesia for electroencephalography (005) (basic units) | \$264.50 |
| 21959 | Initiation of management of anaesthesia for brain stem evoked response audiometry (005) (basic units) | \$264.50 |
| 21962 | Initiation of management of anaesthesia for electrocochleography by extratympanic method or transtympanic membrane insertion method (005) (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) (008) (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) (015) (basic units) | \$793.50 |
| 21973 | Initiation of management of anaesthesia for brachytherapy using radioactive sealed sources (005) (basic units) | \$264.50 |
| 21976 | Initiation of management of anaesthesia for therapeutic nuclear medicine (005) (basic units) | \$264.50 |
| 21980 | Initiation of management of anaesthesia for radiotherapy (005) (basic units) | \$264.50 |
| Miscellaneous | | |
| 21990 | Initiation of management of anaesthesia when no procedure ensues (003) (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 (004) (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 | | |
| 22001 | Collection of blood for autologous transfusion or when homologous blood is required for immediate transfusion in an emergency situation, when performed in association with the administration of anaesthesia (003) (basic units) | \$158.70 |
| 22002 | Administration of blood or bone marrow already collected when performed in association with the administration of anaesthesia (004) (basic units) | \$211.60 |
| 22007 | Endotracheal intubation with flexible fibre optic scope associated with difficult airway when performed in association with the administration of anaesthesia (004) (basic units) | \$211.60 |
| 22008 | Double lumen endobronchial tube or bronchial blocker, insertion of when performed in association with the administration of anaesthesia (004) (basic units) | \$211.60 |
| 22012 | 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) when performed in association with the administration of anaesthesia (003) (basic units) | \$158.70 |

| Item No. | Description | Max fee (excl GST) |
|--|--|--------------------|
| 22014 | 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) when performed in association with the administration of anaesthesia relating to another discrete operation on the same day (0 03) (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 (006) (basic units) | \$317.40 |
| 22018 | Measurement of the mechanical or gas exchange function of the respiratory system, using measurements of parameters, including pressures, volumes, flow, gas concentrations in inspired or expired air, alveolar gas or blood and incorporating serial arterial blood gas analysis and a written record of the results, when performed in association with the administration of anaesthesia, not being a service associated with a service to which item 11503 applies (007) (basic units) | \$370.30 |
| 22020 | Central vein catheterisation (via jugular, subclavian or femoral vein) by percutaneous or open exposure, not being a service to which item 13318 applies, when performed in association with the administration of anaesthesia (004) (basic units) | \$211.60 |
| 22025 | Intraarterial cannulation when performed in association with the administration of anaesthesia (004) (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 postoperative pain management, not being a service associated with a service to which 22036 applies (005) (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 (003) (basic units) | \$158.70 |
| 22040 | Introduction of a regional or field nerve block peri-operatively performed in the induction room theatre or recovery room for the control of post-operative pain via the femoral or sciatic nerves, in conjunction with hip, knee, ankle or foot surgery (002) (basic units) | \$105.80 |
| 22045 | Introduction of a regional or field nerve block peri-operatively performed in the induction room, theatre or recovery room for the control of post-operative pain via the femoral and sciatic nerves, in conjunction with hip, knee, ankle or foot surgery (003) (basic units) | \$158.70 |
| 22050 | Introduction of a regional or field nerve block peri-operatively performed in the induction room, theatre or recovery room for the control of post-operative pain via the brachial plexus in conjunction with shoulder surgery (002) (basic units) | \$105.80 |
| 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) (009) (basic units) | \$476.10 |
| 22055 | Perfusion of limb or organ using heart-lung machine or equivalent, not being a service associated with a service to which an item in subgroup 21 applies (012) (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. (20 basic units) | \$1058.00 |
| 22065 | Induced controlled hypothermia total body, not being a service associated with a service to which an item in subgroup 21 applies (005) (basic units) | \$264.50 |
| 22070 | Cardioplegia, blood or crystalloid, administration by any route, not being a service associated with a service to which an item in subgroup 21 applies (010) (basic units) | \$529.00 |
| 22075 | Deep hypothermic circulatory arrest, with core temperature less than 22c, including management of retrograde cerebral perfusion if performed, not being a service associated with a service to which an item in subgroup 21 applies (015) (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 (006) (basic units) | \$317.40 |
| 22905 | Initiation of management of anaesthesia for restorative dental work (006) (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 229 00 to 22905; or (b) perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 2520 5 For a period of: (fifteen minutes or less) (001) (basic units) | \$52.90 |
| 23021 | 16 minutes to 20 minutes (002) (basic units) | \$105.80 |
| 23022 | 21 minutes to 25 minutes (002) (basic units) | \$105.80 |
| 23023 | 26 minutes to 30 minutes (002) (basic units) | \$105.80 |
| 23031 | 31 minutes to 35 minutes (003) (basic units) | \$158.70 |
| 23032 | 36 minutes to 40 minutes (003) (basic units) | \$158.70 |
| 23033 | 41 minutes to 45 minutes (003) (basic units) | \$158.70 |
| 23041 | 46 minutes to 50 minutes (004) (basic units) | \$211.60 |
| 23042 | 51 minutes to 55 minutes (004) (basic units) | \$211.60 |
| 23043 | 56 minutes to 1:00 hour (004) (basic units) | \$211.60 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 23051 | 1:01 hours to 1:05 hours (005) (basic units) | \$264.50 |
| 23052 | 1:06 hours to 1:10 hours (005) (basic units) | \$264.50 |
| 23053 | 1:11 hours to 1:15 hours (005) (basic units) | \$264.50 |
| 23061 | 1:16 hours to 1:20 hours (006) (basic units) | \$317.40 |
| 23062 | 1:21 hours to 1:25 hours (006) (basic units) | \$317.40 |
| 23063 | 1:26 hours to 1:30 hours (006) (basic units) | \$317.40 |
| 23071 | 1:31 hours to 1:35 hours (007) (basic units) | \$370.30 |
| 23072 | 1:36 hours to 1:40 hours (007) (basic units) | \$370.30 |
| 23073 | 1:41 hours to 1:45 hours (007) (basic units) | \$370.30 |
| 23081 | 1:46 hours to 1:50 hours (008) (basic units) | \$423.20 |
| 23082 | 1:51 hours to 1:55 hours (008) (basic units) | \$423.20 |
| 23083 | 1:56 hours to 2:00 hours (008) (basic units) | \$423.20 |
| 23091 | 2:01 hours to 2:10 hours (009) (basic units) | \$476.10 |
| 23101 | 2:11 hours to 2:20 hours (010) (basic units) | \$529.00 |
| 23111 | 2:21 hours to 2:30 hours (011) (basic units) | \$581.90 |
| 23112 | 2:31 hours to 2:40 hours (012) (basic units) | \$634.80 |
| 23113 | 2:41 hours to 2:50 hours (013) (basic units) | \$687.70 |
| 23114 | 2:51 hours to 3:00 hours (014) (basic units) | \$740.60 |
| 23115 | 3:01 hours to 3:10 hours (015) (basic units) | \$793.50 |
| 23116 | 3:11 hours to 3:20 hours (016) (basic units) | \$846.40 |
| 23117 | 3:21 hours to 3:30 hours (017) (basic units) | \$899.30 |
| 23118 | 3:31 hours to 3:40 hours (018) (basic units) | \$952.20 |
| 23119 | 3:41 hours to 3:50 hours (019) (basic units) | \$1005.10 |
| 23121 | 3:51 hours to 4:00 hours (020) (basic units) | \$1058.00 |
| 23170 | 4:01 hours to 4:10 hours (021) (basic units) | \$1110.90 |
| 23180 | 4:11 hours to 4:20 hours (022) (basic units) | \$1163.80 |
| 23190 | 4:21 hours to 4:30 hours (023) (basic units) | \$1216.70 |
| 23200 | 4:31 hours to 4:40 hours (024) (basic units) | \$1269.60 |
| 23210 | 4:41 hours to 4:50 hours (025) (basic units) | \$1322.50 |
| 23220 | 4:51 hours to 5:00 hours (026) (basic units) | \$1375.40 |
| 23230 | 5:01 hours to 5:10 hours (027) (basic units) | \$1428.30 |
| 23240 | 5:11 hours to 5:20 hours (028) (basic units) | \$1481.20 |
| 23250 | 5:21 hours to 5:30 hours (029) (basic units) | \$1534.10 |
| 23260 | 5:31 hours to 5:40 hours (030) (basic units) | \$1587.00 |
| 23270 | 5:41 hours to 5:50 hours (031) (basic units) | \$1639.90 |
| 23280 | 5:51 hours to 6:00 hours (032) (basic units) | \$1692.80 |
| 23290 | 6:01 hours to 6:10 hours (033) (basic units) | \$1745.70 |
| 23300 | 6:11 hours to 6:20 hours (034) (basic units) | \$1798.60 |
| 23310 | 6:21 hours to 6:30 hours (035) (basic units) | \$1851.50 |
| 23320 | 6:31 hours to 6:40 hours (036) (basic units) | \$1904.40 |
| 23330 | 6:41 hours to 6:50 hours (037) (basic units) | \$1957.30 |
| 23340 | 6:51 hours to 7:00 hours (038) (basic units) | \$2010.20 |
| 23350 | 7:01 hours to 7:10 hours (039) (basic units) | \$2063.10 |
| 23360 | 7:11 hours to 7:20 hours (040) (basic units) | \$2116.00 |
| 23370 | 7:21 hours to 7:30 hours (041) (basic units) | \$2168.90 |
| 23380 | 7:31 hours to 7:40 hours (042) (basic units) | \$2221.80 |
| 23390 | 7:41 hours to 7:50 hours (043) (basic units) | \$2274.70 |
| 23400 | 7:51 hours to 8:00 hours (044) (basic units) | \$2327.60 |
| 23410 | 8:01 hours to 8:10 hours (045) (basic units) | \$2380.50 |
| 23420 | 8:11 hours to 8:20 hours (046) (basic units) | \$2433.40 |
| 23430 | 8:21 hours to 8:30 hours (047) (basic units) | \$2486.30 |
| 23440 | 8:31 hours to 8:40 hours (048) (basic units) | \$2539.20 |
| 23450 | 8:41 hours to 8:50 hours (049) (basic units) | \$2592.10 |
| 23460 | 8:51 hours to 9:00 hours (050) (basic units) | \$2645.00 |
| 23470 | 9:01 hours to 9:10 hours (051) (basic units) | \$2697.90 |

| Item No. | Description | Max fee (excl GST) |
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| 23480 | 9:11 hours to 9:20 hours (052) (basic units) | \$2750.80 |
| 23490 | 9:21 hours to 9:30 hours (053) (basic units) | \$2803.70 |
| 23500 | 9:31 hours to 9:40 hours (054) (basic units) | \$2856.60 |
| 23510 | 9:41 hours to 9:50 hours (055) (basic units) | \$2909.50 |
| 23520 | 9:51 hours to 10:00 hours (056) (basic units) | \$2962.40 |
| 23530 | 10:01 hours to 10:10 hours (057) (basic units) | \$3015.30 |
| 23540 | 10:11 hours to 10:20 hours (058) (basic units) | \$3068.20 |
| 23550 | 10:21 hours to 10:30 hours (059) (basic units) | \$3121.10 |
| 23560 | 10:31 hours to 10:40 hours (060) (basic units) | \$3174.00 |
| 23570 | 10:41 hours to 10:50 hours (061) (basic units) | \$3226.90 |
| 23580 | 10:51 hours to 11:00 hours (062) (basic units) | \$3279.80 |
| 23590 | 11:01 hours to 11:10 hours (063) (basic units) | \$3332.70 |
| 23600 | 11:11 hours to 11:20 hours (064) (basic units) | \$3385.60 |
| 23610 | 11:21 hours to 11:30 hours (065) (basic units) | \$3438.50 |
| 23620 | 11:31 hours to 11:40 hours (066) (basic units) | \$3491.40 |
| 23630 | 11:41 hours to 11:50 hours (067) (basic units) | \$3544.30 |
| 23640 | 11:51 hours to 12:00 hours (068) (basic units) | \$3597.20 |
| 23650 | 12:01 hours to 12:10 hours (069) (basic units) | \$3650.10 |
| 23660 | 12:11 hours to 12:20 hours (070) (basic units) | \$3703.00 |
| 23670 | 12:21 hours to 12:30 hours (071) (basic units) | \$3755.90 |
| 23680 | 12:31 hours to 12:40 hours (072) (basic units) | \$3808.80 |
| 23690 | 12:41 hours to 12:50 hours (073) (basic units) | \$3861.70 |
| 23700 | 12:51 hours to 13:00 hours (074) (basic units) | \$3914.60 |
| 23710 | 13:01 hours to 13:10 hours (075) (basic units) | \$3967.50 |
| 23720 | 13:11 hours to 13:20 hours (076) (basic units) | \$4020.40 |
| 23730 | 13:21 hours to 13:30 hours (077) (basic units) | \$4073.30 |
| 23740 | 13:31 hours to 13:40 hours (078) (basic units) | \$4126.20 |
| 23750 | 13:41 hours to 13:50 hours (079) (basic units) | \$4179.10 |
| 23760 | 13:51 hours to 14:00 hours (080) (basic units) | \$4232.00 |
| 23770 | 14:01 hours to 14:10 hours (081) (basic units) | \$4284.90 |
| 23780 | 14:11 hours to 14:20 hours (082) (basic units) | \$4337.80 |
| 23790 | 14:21 hours to 14:30 hours (083) (basic units) | \$4390.70 |
| 23800 | 14:31 hours to 14:40 hours (084) (basic units) | \$4443.60 |
| 23810 | 14:41 hours to 14:50 hours (085) (basic units) | \$4496.50 |
| 23820 | 14:51 hours to 15:00 hours (086) (basic units) | \$4549.40 |
| 23830 | 15:01 hours to 15:10 hours (087) (basic units) | \$4602.30 |
| 23840 | 15:11 hours to 15:20 hours (088) (basic units) | \$4655.20 |
| 23850 | 15:21 hours to 15:30 hours (089) (basic units) | \$4708.10 |
| 23860 | 15:31 hours to 15:40 hours (090) (basic units) | \$4761.00 |
| 23870 | 15:41 hours to 15:50 hours (091) (basic units) | \$4813.90 |
| 23880 | 15:51 hours to 16:00 hours (092) (basic units) | \$4866.80 |
| 23890 | 16:01 hours to 16:10 hours (093) (basic units) | \$4919.70 |
| 23900 | 16:11 hours to 16:20 hours (094) (basic units) | \$4972.60 |
| 23910 | 16:21 hours to 16:30 hours (095) (basic units) | \$5025.50 |
| 23920 | 16:31 hours to 16:40 hours (096) (basic units) | \$5078.40 |
| 23930 | 16:41 hours to 16:50 hours (097) (basic units) | \$5131.30 |
| 23940 | 16:51 hours to 17:00 hours (098) (basic units) | \$5184.20 |
| 23950 | 17:01 hours to 17:10 hours (099) (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 |

| Item No. | Description | Max fee (excl GST) |
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| 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 (001) (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 (002) (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 (003) (basic units) | \$158.70 |
| Anaesthesia/perfusion modifying units - other | | |
| 25015 | Anaesthesia, perfusion or assistance at anaesthesia - where the patient is less than 12 months of age or 70 years or greater (001) (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 (002) (basic units) | \$105.80 |
| Anaesthesia after hours emergency modifier | | |
| 25025 | Emergency anaesthesia performed in the after hours period where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for the emergency anaesthesia service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25030 or 25050 applies (000) (basic units) Derived fee: An additional amount of 50% of the fee for the anaesthetic service. That is: (a) an anaesthesia item/s in the range 20100 - 21997 or 22900 plus, (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000 - 25015, (d) where performed, any associated therapeutic or diagnostic service/s in the range 22 001 - 22050 | DF |

| Item No. | Description | Max fee (excl GST) |
|---|---|--------------------|
| 25030 | Assistance at after hours emergency anaesthesia where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for which the assistant is in professional attendance on the patient is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25025 or 25050 applies (000) (basic units) Derived fee: An additional amount of 50% of the fee for the anaesthetic service. That is: (a) an anaesthesia item in the range 25200 - 25205 plus, (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000 - 25015 plus, (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22050 | DF |
| Perfusion after hours emergency modifier | | |
| 25050 | After hours emergency perfusion where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the perfusion service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25025 or 25030 applies (000) (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 in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000 - 25015 plus, (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22050 and 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 | 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. | DF |
| GROUP T8 - SURGICAL OPERATIONS | | |
| General | | |
| 30001 | Operative procedure, not being a service to which any other item in this Group applies, being a service to which an item in this Group would have applied had the procedure not been discontinued on medical grounds Derived fee : 50% of the fee which would have applied had the procedure not been discontinued. | DF |
| 30003 | Localised burns, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation | \$55.50 |
| 30006 | Extensive burns, dressing of, without anaesthesia (not involving grafting) each attendance at which the procedure is performed, including any associated consultation | \$82.40 |
| 30010 | Localised burns, dressing of, under general anaesthesia (not involving grafting) (Anaes.) | \$142.10 |
| 30014 | Extensive burns, dressing of, under general anaesthesia (not involving grafting) (Anaes.) | \$298.20 |
| 30017 | Burns, excision of, under general anaesthesia, involving not more than 10 per cent of body surface, where grafting is not carried out during the same operation (Assist.) (Anaes.) | \$577.10 |
| 30020 | Burns, excision of, under general anaesthesia, involving more than 10 per cent of body surface, where grafting is not carried out during the same operation (Assist.) (Anaes.) | \$1220.80 |
| 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 (Assist.) (Anaes.) | \$630.80 |
| 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 (Assist.) (Anaes.) | \$627.80 |
| 30026 | Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, small (not more than 7cm long), superficial, not being a service to which another item in Group T4 applies (Anaes.) | \$92.50 |
| 30029 | Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, small (not more than 7cm in length), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.) | \$159.30 |
| 30032 | Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, small (not more than 7cm long), superficial (Anaes.) | \$145.90 |
| 30035 | Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, small (not more than 7cm long), involving deeper tissue (Anaes.) | \$208.20 |
| 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 7cm long), superficial, not being a service to which another item in Group T4 applies (Anaes.) | \$159.30 |
| 30042 | Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, other than on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue, other than a service to which another item in Group T4 applies (Anaes.) | \$359.10 |
| 30045 | Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, large (more than 7cm long), superficial (Anaes.) | \$208.20 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 30049 | Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, large (more than 7cm long), involving deeper tissue (Anaes.) | \$355.70 |
| 30052 | Full thickness laceration of ear, eyelid, nose or lip, repair of, with accurate apposition of each layer of tissue (Assist.) (Anaes.) | \$471.90 |
| 30055 | Wounds, dressing of, under general anaesthesia, with or without removal of sutures, not being a service associated with a service to which another item in this Group applies (Anaes.) | \$142.10 |
| 30058 | Postoperative haemorrhage, control of, under general anaesthesia, as an independent procedure (Anaes.) | \$280.20 |
| 30061 | Superficial foreign body, removal of, (including from cornea or sclera) as an independent procedure (Anaes.) | \$42.80 |
| 30062 | Etonogestrel subcutaneous implant, removal of, as an independent procedure (Anaes.) | \$107.10 |
| 30064 | Subcutaneous foreign body, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.) | \$194.70 |
| 30068 | Foreign body in muscle, tendon or other deep tissue, removal of, as an independent procedure (Assist.) (Anaes.) | \$531.10 |
| 30071 | Diagnostic biopsy of skin, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.) | \$100.40 |
| 30072 | Diagnostic biopsy of mucous membrane, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.) | \$81.40 |
| 30075 | Diagnostic biopsy of lymph gland, muscle or other deep tissue or organ, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.) | \$290.30 |
| 30078 | Diagnostic drill biopsy of lymph gland, deep tissue or organ, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.) | \$91.30 |
| 30081 | Diagnostic biopsy of bone marrow by trephine using open approach, where the biopsy specimen is sent for pathological examination (Anaes.) | \$195.50 |
| 30084 | Diagnostic biopsy of bone marrow by trephine using percutaneous approach where the biopsy is sent for pathological examination (Anaes.) | \$112.90 |
| 30087 | Diagnostic biopsy of bone marrow by aspiration or punch biopsy of synovial membrane, where the biopsy is sent for pathological examination (Anaes.) | \$56.70 |
| 30090 | Diagnostic biopsy of pleura, percutaneous 1 or more biopsies on any 1 occasion, where the biopsy is sent for pathological examination (Anaes.) | \$246.70 |
| 30093 | Diagnostic needle biopsy of vertebra, where the biopsy is sent for pathological examination (Anaes.) | \$301.60 |
| 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.) | \$363.20 |
| 30096 | Diagnostic scalene node biopsy, by open procedure, where the specimen excised is sent for pathological examination (Anaes.) | \$325.40 |
| 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. | \$186.50 |
| 30099 | Sinus, excision of, involving superficial tissue only (Anaes.) | \$170.00 |
| 30103 | Sinus, excision of, involving muscle and deep tissue (Anaes.) | \$352.10 |
| 30104 | Pre-auricular sinus, on a person 10 years of age or over. Excision of, (Anaes.) | \$245.20 |
| 30105 | Pre-auricular sinus, on a person under 10 years of age. Excision of (Anaes.) | \$262.40 |
| 30107 | Ganglion or small bursa, excision of, other than a service associated with a service to which another item in this Group applies (Anaes.) | \$426.00 |
| 30111 | Bursa (large), including olecranon, calcaneum or patella, excision of (Assist.) (Anaes.) | \$711.60 |
| 30114 | Bursa, semimembranosus (Baker's cyst), excision of (Assist.) (Anaes.) | \$711.90 |
| 30165 | Lipectomy, wedge excision of abdominal apron that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30168, 30171, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and (b) the abdominal apron interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (H) (Anaes.) (Assist.) | \$930.00 |
| 30168 | Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30171, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy; and (d) the procedure involves 1 excision only (H) (Anaes.) (Assist.) | \$907.30 |
| 30171 | Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30168, | \$1395.00 |

| Item No. | Description | Max fee (excl GST) |
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| | 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy; and (d) the procedure involves 2 excisions only (H) (Anaes.) (Assist.) | |
| 30172 | Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30168, 30171, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy; and (d) the procedure involves 3 or more excisions (H) (Anaes.) (Assist.) | \$1100.60 |
| 30176 | Lipectomy, radical abdominoplasty (Pitanguy type or similar), with excision of skin and subcutaneous tissue, repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30177, 30179, 45530, 45564 or 45565 applies, if the patient has previously had a massive intra-abdominal or pelvic tumour surgically removed (Anaes.) (Assist.) | \$1568.40 |
| 30177 | Lipectomy, excision of skin and subcutaneous tissue associated with redundant abdominal skin and fat that is a direct consequence of significant weight loss, in conjunction with a radical abdominoplasty (pitanguy type or similar), with or without repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (H) (Anaes.) (Assist.) | \$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 (pitanguy type or similar), not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 45530, 45564 or 45565 applies, if: (a) the circumferential excess of redundant skin and fat is complicated by intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and (b) the circumferential excess of redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (H) (Anaes.) (Assist.) | \$1930.10 |
| 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.) | \$382.40 |
| 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.) | \$290.00 |
| 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.) | \$763.00 |
| 30192 | Premalignant skin lesions (including solar keratoses), treatment of, by ablative technique (10 or more lesions) (Anaes.) | \$70.60 |
| 30196 | Malignant neoplasm of skin or mucous membrane proven that has been: (a) proven by histopathology; or (b) confirmed by the opinion of a specialist in the specialty of dermatology where a specimen has been submitted for histologic confirmation; removal of, by serial curettage, or carbon dioxide laser or erbium laser excision-ablation, including any associated cryotherapy or diathermy (Anaes.) | \$222.60 |
| 30202 | Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by the opinion of a specialist in the specialty of dermatology—removal of, by liquid nitrogen cryotherapy using repeat freeze thaw cycles | \$85.00 |
| 30207 | Skin lesions, multiple injections with glucocorticoid preparations (Anaes.) | \$85.60 |
| 30210 | Keloid and other skin lesions, extensive, multiple injections of glucocorticoid preparations, if undertaken in the operating theatre of a hospital on a patient less than 16 years of age (Anaes.) | \$312.60 |
| 30216 | Haematoma, aspiration of (Anaes.) | \$47.10 |
| 30219 | Haematoma, furuncle, small abscess or similar lesion not requiring admission to a hospital - incision with drainage of (excluding aftercare) | \$47.10 |
| 30223 | Large haematoma, large abscess, carbuncle, cellulitis or similar lesion, requiring admission to a hospital, incision with drainage of (excluding aftercare) (Anaes.) | \$313.00 |
| 30224 | Percutaneous drainage of deep abscess using interventional imaging techniques - but not including imaging (Anaes.) | \$459.10 |
| 30225 | Abscess drainage tube, exchange of using interventional imaging techniques - but not including imaging (Anaes.) | \$513.00 |
| 30226 | Muscle, excision of (limited) or fasciotomy (Anaes.) | \$287.40 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 30229 | Muscle, excision of (extensive) (Assist.) (Anaes.) | \$524.70 |
| 30232 | Muscle, ruptured, repair of (limited), not associated with external wound (Anaes.) | \$429.10 |
| 30235 | Muscle, ruptured, repair of (extensive), not associated with external wound (Assist.) (Anaes.) | \$568.60 |
| 30238 | Fascia, deep, repair of, for herniated muscle (Anaes.) | \$287.30 |
| 30241 | Bone tumour, innocent, excision of, not being a service to which another item in this Group applies (Assist.) (Anaes.) | \$690.60 |
| 30244 | Styloid process of temporal bone, removal of (Assist.) (Anaes.) | \$730.00 |
| 30246 | Parotid duct, repair of, using micro- surgical techniques (Assist.) (Anaes.) | \$1326.40 |
| 30247 | Parotid gland, total extirpation of (Assist.) (Anaes.) | \$1389.60 |
| 30250 | Parotid gland, total extirpation of with preservation of facial nerve (Assist.) (Anaes.) | \$2562.20 |
| 30251 | Recurrent parotid tumour, excision of, with preservation of facial nerve (Assist.) (Anaes.) | \$3690.30 |
| 30253 | Parotid gland, superficial lobectomy of, with exposure of facial nerve (Assist.) (Anaes.) | \$1784.60 |
| 30255 | Submandibular ducts, relocation of, for surgical control of drooling (Assist.) (Anaes.) | \$2495.00 |
| 30256 | Submandibular gland, extirpation of (Assist.) (Anaes.) | \$864.40 |
| 30259 | Sublingual gland, extirpation of (Anaes.) | \$412.50 |
| 30262 | Salivary gland, dilatation or diathermy of duct (Anaes.) | \$113.20 |
| 30266 | Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, 1 or more such procedures (Anaes.) | \$290.20 |
| 30269 | Salivary gland, repair of cutaneous fistula of (Anaes.) | \$345.00 |
| 30272 | Tongue, partial excision of (Assist.) (Anaes.) | \$573.50 |
| 30275 | Radical excision of intraoral tumour involving resection of mandible and lymph glands of neck (commando type operation) (Assist.) (Anaes.) | \$3417.20 |
| 30278 | Tongue tie, repair of, not being a service to which another item in this Group applies (Anaes.) | \$86.60 |
| 30281 | Tongue tie, mandibular frenulum or maxillary frenulum, repair of, in a person aged 2 years and over, under general anaesthesia (Anaes.) | \$265.00 |
| 30283 | Ranula or mucous cyst of mouth, removal of (Anaes.) | \$372.10 |
| 30286 | Branchial cyst, on a person 10 years of age or over. Removal of, (Anaes.) (Assist.) | \$851.80 |
| 30287 | Branchial cyst, on a person under 10 years of age. Removal of, (Anaes.) (Assist.) | \$822.90 |
| 30289 | Branchial fistula, on a person 10 years of age or over. Removal of, (Anaes.) (Assist.) | \$1011.00 |
| 30293 | Cervical oesophagostomy; or closure of cervical oesophagostomy with or without plastic repair (Assist.) (Anaes.) | \$855.00 |
| 30294 | Cervical oesophagectomy with tracheostomy and oesophagostomy, with or without plastic reconstruction; or laryngopharyngectomy with tracheostomy and plastic reconstruction (Assist.) (Anaes.) | \$3104.80 |
| 30296 | Thyroidectomy, total (Assist.) (Anaes.) | \$2101.60 |
| 30297 | Thyroidectomy following previous thyroid surgery (Assist.) (Anaes.) | \$1984.10 |
| 30299 | Sentinel lymph node biopsy or biopsies for breast cancer, involving dissection in a level I axilla (as defined at t8.16), using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30300, 30302 or 30303 applies (Assist.) (Anaes.) | \$1225.50 |
| 30300 | Sentinel lymph node biopsy or biopsies for breast cancer, involving dissection in a level ii/iii axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30299, 30302 or 30303 applies (Assist.) (Anaes.) | \$1467.80 |
| 30302 | Sentinel lymph node biopsy or biopsies for breast cancer, involving dissection in a level i axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30303 applies (Assist.) (Anaes.) | \$979.20 |
| 30303 | Sentinel lymph node biopsy or biopsies for breast cancer, involving dissection in a level ii/iii axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30302 applies (Assist.) (Anaes.) | \$1147.20 |
| 30306 | Total hemithyroidectomy (Assist.) (Anaes.) | \$1575.70 |
| 30310 | Partial or subtotal thyroidectomy (Anaes.) (Assist.) | \$878.90 |
| 30314 | Thyroglossal cyst or fistula or both, on a person 10 years of age or over. Radical removal of, including thyroglossal duct and portion of hyoid bone (Anaes.) (Assist.) | \$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.) | \$2210.80 |
| 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.) | \$2618.80 |
| 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. | \$1738.60 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| | 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.) | |
| 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.) | \$2618.80 |
| 30323 | Excision of phaeochromocytoma or extraadrenal paraganglioma via endoscopic or open approach. (Anaes.) (Assist.) | \$2618.80 |
| 30324 | Excision of an adrenocortical tumour or hyperplasia via endoscopic or open approach. (Anaes.) (Assist.) | \$2624.80 |
| 30326 | Thyroglossal cyst or fistula or both, radical removal of, including thyroglossal duct and portion of hyoid bone, on a person under 10 years of age (Anaes.) (Assist.) | \$946.00 |
| 30329 | Lymph glands of groin, limited excision of (Anaes.) | \$482.90 |
| 30330 | Lymph glands of groin, radical excision of (Assist.) (Anaes.) | \$1380.60 |
| 30332 | Lymph nodes of axilla, limited excision of (sampling) (Assist.) (Anaes.) | \$677.90 |
| 30335 | Lymph nodes of axilla, complete excision of, to level I (Assist.) (Anaes.) | \$1606.00 |
| 30336 | Lymph nodes of axilla, complete excision of, to level II or level III (Assist.) (Anaes.) | \$2019.70 |
| 30373 | Laparotomy (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Assist.) (Anaes.) | \$925.90 |
| 30375 | Caecostomy, enterostomy, colostomy, enterotomy, colotomy, cholecystostomy, gastrostomy, gastrotomy, on a person 10 years of age or over. reduction of intussusception, removal of meckel's diverticulum, suture of perforated peptic ulcer, simple repair of ruptured viscus, reduction of volvulus, pyloroplasty (adult) or drainage of pancreas (Anaes.) (Assist.) | \$999.20 |
| 30376 | Laparotomy involving division of peritoneal adhesions (where no other intraabdominal procedure is performed) on a person 10 years of age or over (Anaes.) (Assist.) | \$999.20 |
| 30378 | Laparotomy involving division of adhesions in conjunction with another intraabdominal procedure where the time taken to divide the adhesions is between 45 minutes and 2 hours, on a person 10 years of age or over (Anaes.) (Assist.) | \$1004.20 |
| 30379 | Laparotomy with division of extensive adhesions (duration greater than 2 hours) with or without insertion of long intestinal tube (Assist.) (Anaes.) | \$1779.00 |
| 30382 | Enterocutaneous fistula, radical repair of, involving extensive dissection and resection of bowel (Assist.) (Anaes.) | \$2508.80 |
| 30384 | Laparotomy for grading of lymphoma, including splenectomy, liver biopsies, lymph node biopsies and oophoropexy (Assist.) (Anaes.) | \$2104.80 |
| 30385 | Laparotomy for control of postoperative haemorrhage, where no other procedure is performed (Assist.) (Anaes.) | \$1081.60 |
| 30387 | Laparotomy involving operation on abdominal viscera (including pelvic viscera), not being a service to which another item in this Group applies (Assist.) (Anaes.) | \$1275.10 |
| 30388 | Laparotomy for trauma involving 3 or more organs (Assist.) (Anaes.) | \$3065.10 |
| 30390 | Laparoscopy, diagnostic, not being a service associated with any other laparoscopic procedure, on a person 10 years of age or over (Anaes.) | \$422.70 |
| 30391 | Laparoscopy, with biopsy (Assist.) (Anaes.) | \$557.60 |
| 30392 | Radical or debulking operation for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (Assist.) | \$1213.40 |
| 30393 | Laparoscopic division of adhesions in association with another intra- abdominal procedure where the time taken to divide the adhesions exceeds 45 minutes (Assist.) (Anaes.) | \$1006.60 |
| 30394 | Laparotomy for drainage of subphrenic abscess, pelvic abscess, appendiceal abscess, ruptured appendix or for peritonitis from any cause, with or without appendicectomy (Assist.) (Anaes.) | \$943.90 |
| 30396 | Laparotomy for gross intra peritoneal sepsis requiring debridement of fibrin, with or without removal of foreign material or enteric contents, with lavage of the entire peritoneal cavity via a major abdominal incision with or without closure of abdomen and with or without mesh or zipper insertion (Assist.) (Anaes.) | \$1952.50 |
| 30397 | Laparostomy, via wound previously made and left open or closed with zipper, involving change of dressings or packs, and with or without drainage of loculated collections (Anaes.) | \$446.20 |
| 30399 | Laparostomy, final closure of wound made at previous operation, after removal of dressings or packs and removal of mesh or zipper if previously inserted (Assist.) (Anaes.) | \$612.10 |
| 30400 | Laparotomy with insertion of portacath for administration of cytotoxic therapy including placement of reservoir (Assist.) (Anaes.) | \$1215.20 |
| 30402 | Retroperitoneal abscess, drainage of, not involving laparotomy (Assist.) (Anaes.) | \$889.50 |
| 30403 | Ventral, incisional, or recurrent hernia or burst abdomen, repair of with or without mesh (Assist.) (Anaes.) | \$998.60 |
| 30405 | Ventral or incisional hernia, (excluding recurrent inguinal or femoral hernia), repair of, requiring muscle transposition, mesh hernioplasty or resection of strangulated bowel (Assist.) (Anaes.) | \$1756.40 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 30406 | Paracentesis abdominis (Anaes.) | \$100.10 |
| 30408 | Peritoneovenous shunt, insertion of (Assist.) (Anaes.) | \$752.40 |
| 30409 | Liver biopsy, percutaneous (Anaes.) | \$337.20 |
| 30411 | Liver biopsy by wedge excision when performed in association with another intra-abdominal procedure (Anaes.) | \$200.00 |
| 30412 | Liver biopsy by core needle, when performed in conjunction with another intra-abdominal procedure (Anaes.) | \$100.30 |
| 30414 | Liver, subsegmental resection of, (local excision), other than for trauma (Assist.) (Anaes.) | \$1325.10 |
| 30415 | Liver, segmental resection of, other than for trauma (Assist.) (Anaes.) | \$2641.50 |
| 30416 | Liver cyst, laparoscopic marsupialisation of, where the size of the cyst is greater than 5cm in diameter (Assist.) | \$1435.50 |
| 30417 | Liver cysts, laparoscopic marsupialisation of 5 or more, including any cyst greater than 5cm in diameter (Assist.) | \$2152.90 |
| 30418 | Liver, lobectomy of, other than for trauma (Assist.) (Anaes.) | \$3065.10 |
| 30419 | Liver tumours, destruction of, by hepatic cryotherapy, not being a service associated with a service to which item 50950 or 50952 apply (Assist.) | \$1598.00 |
| 30421 | Liver, tri-segmental resection (extended lobectomy) of, other than for trauma (Assist.) (Anaes.) | \$3826.30 |
| 30422 | Liver, repair of superficial laceration of, for trauma (Assist.) (Anaes.) | \$1293.50 |
| 30425 | Liver, repair of deep multiple lacerations of, or debridement of, for trauma (Assist.) (Anaes.) | \$2508.80 |
| 30427 | Liver, segmental resection of, for trauma (Assist.) (Anaes.) | \$2763.50 |
| 30428 | Liver, lobectomy of, for trauma (Assist.) (Anaes.) | \$2956.60 |
| 30430 | Liver, extended lobectomy (tri- segmental resection) of, for trauma (Assist.) (Anaes.) | \$4453.60 |
| 30431 | Liver abscess, open abdominal drainage of (Assist.) (Anaes.) | \$998.60 |
| 30433 | Liver abscess (multiple), open abdominal drainage of (Assist.) (Anaes.) | \$1419.20 |
| 30434 | Hydatid cyst of liver, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles (Assist.) (Anaes.) | \$1129.20 |
| 30436 | Hydatid cyst of liver, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles, with omentoplasty or myeloplasty (Assist.) (Anaes.) | \$1156.80 |
| 30437 | Hydatid cyst of liver, total excision of, by cysto-pericystectomy (membrane plus fibrous wall) (Assist.) (Anaes.) | \$1528.20 |
| 30438 | Hydatid cyst of liver, excision of, with drainage and excision of liver tissue (Assist.) | \$2208.70 |
| 30439 | Operative cholangiography or operative pancreatography or intra operative ultra sound of the biliary tract (including 1 or more examinations performed during the 1 operation) (Assist.) (Anaes.) | \$356.70 |
| 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 (Assist.) (Anaes.) | \$1011.50 |
| 30441 | Intra operative ultrasound for staging of intra abdominal tumours | \$261.40 |
| 30442 | Choledochoscopy in conjunction with another procedure (Anaes.) | \$359.10 |
| 30443 | Cholecystectomy (Assist.) (Anaes.) | \$1418.80 |
| 30445 | Laparoscopic cholecystectomy (Assist.) (Anaes.) | \$1433.00 |
| 30446 | Laparoscopic cholecystectomy when procedure is completed by laparotomy (Assist.) (Anaes.) | \$1428.90 |
| 30448 | Laparoscopic cholecystectomy, involving removal of common duct calculi via the cystic duct (Assist.) (Anaes.) | \$1866.50 |
| 30449 | Laparoscopic cholecystectomy with removal of common duct calculi via laparoscopic choledochotomy (Assist.) (Anaes.) | \$2077.50 |
| 30450 | Calculus of biliary or renal tract, extraction of, using interventional imaging techniques - not being a service associated with a service to which items 36627, 36630, 36645 or 36648 applies (Assist.) | \$1005.60 |
| 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 (Assist.) (Anaes.) | \$500.30 |
| 30452 | Choledochoscopy with balloon dilatation of a stricture or passage of stent or extraction of calculi (Assist.) (Anaes.) | \$732.10 |
| 30454 | Choledochotomy (with or without cholecystectomy), with or without removal of calculi (Assist.) (Anaes.) | \$1672.50 |
| 30455 | Choledochotomy (with or without cholecystectomy), with removal of calculi including biliary intestinal anastomosis (Assist.) (Anaes.) | \$1942.60 |
| 30457 | Choledochotomy, intrahepatic, involving removal of intrahepatic bile duct calculi (Assist.) (Anaes.) | \$2650.50 |
| 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 (Assist.) (Anaes.) | \$1949.70 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 30460 | Cholecystoduodenostomy, cholecystoenterostomy, choledochojejunostomy or Roux-en -Y as a bypass procedure when no prior biliary surgery performed (Assist.) (Anaes.) | \$1654.00 |
| 30461 | Radical resection of porta hepatis with biliary-enteric anastomoses, not being a service associated with a service to which item 30443, 30454, 30455, 30458 or 30460 applies (Assist.) (Anaes.) | \$2866.00 |
| 30463 | Radical resection of common hepatic duct and right and left hepatic ducts, with 2 duct anastomoses (Assist.) (Anaes.) | \$3641.60 |
| 30464 | Radical resection of common hepatic duct and right and left hepatic ducts, involving more than 2 anastomoses or resection of segment or major portion of segment of liver (Assist.) (Anaes.) | \$4179.40 |
| 30466 | Intrahepatic biliary bypass of left hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Assist.) (Anaes.) | \$2406.30 |
| 30467 | Intraheptic bypass of right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Assist.) (Anaes.) | \$3036.60 |
| 30469 | Biliary stricture, repair of, after 1 or more operations on the biliary tree (Assist.) (Anaes.) | \$3300.20 |
| 30472 | Hepatic or common bile duct, repair of, as the primary procedure subsequent to partial or total transection of bile duct or ducts (Assist.) (Anaes.) | \$1791.50 |
| 30473 | Oesophagoscopy (not being a service to which item 41816 or 41822 applies), gastroscopy, duodenoscopy or panendoscopy (1 or more such procedures), with or without biopsy, not being a service associated with a service to which item 30478 or 30479 applies. (Anaes.) | \$339.40 |
| 30475 | Endoscopic dilatation of stricture of upper gastrointestinal tract (including the use of imaging intensification where clinically indicated) (Anaes.) | \$627.40 |
| 30478 | Oesophagoscopy (other than a service to which item 41816, 41822 or 41825 applies), gastroscopy, duodenoscopy, panendoscopy or push enteroscopy, one or more such procedures, if: (a) the procedures are performed using one or more of the following endoscopic procedures: (i) polypectomy; (ii) sclerosing or adrenalin injections; (iii) banding; (iv) endoscopic clips; (v) haemostatic powders; (vi) diathermy; (vii) argon plasma coagulation; and (b) the procedures are for the treatment of one or more of the following: (i) upper gastrointestinal tract bleeding; (ii) polyps; (iii) removal of foreign body; (iv) oesophageal or gastric varices; (v) peptic ulcers; (vi) neoplasia; (vii) benign vascular lesions; (viii) strictures of the gastrointestinal tract; (ix) tumorous overgrowth through or over oesophageal stents; other than a service associated with a service to which item 30473 or 30479 applies (Anaes.) | \$472.70 |
| 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.) | \$914.00 |
| 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.) | \$692.40 |
| 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.) | \$496.50 |
| 30483 | Gastrostomy Button, Caecostomy Antegrade enema device (chait etc.) or stomal indwelling device: (a) non-endoscopic insertion of; or (b) non-endoscopic replacement of; on a person 10 years of age or over, excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.) | \$343.10 |
| 30484 | Endoscopic retrograde cholangiopancreatography (Anaes.) | \$713.80 |
| 30485 | Endoscopic sphincterotomy with or without extraction of stones from common bile duct (Anaes.) | \$1081.60 |
| 30488 | Small bowel intubation as an independent procedure (Anaes.) | \$174.50 |
| 30490 | Oesophageal prosthesis, insertion of, including endoscopy and dilatation (Anaes.) | \$1020.30 |
| 30491 | Bile duct, endoscopic stenting of (including endoscopy and dilatation) (Anaes.) | \$1075.40 |
| 30492 | Bile duct, percutaneous stenting of (including dilatation when performed), using interventional imaging techniques - but not including imaging | \$1486.50 |
| 30494 | Endoscopic biliary dilatation (Anaes.) | \$808.10 |
| 30495 | Percutaneous biliary dilatation for biliary stricture, using interventional imaging techniques - but not including imaging | \$1486.50 |
| 30496 | Vagotomy, truncal or selective, with or without pyloroplasty or gastroenterostomy (Assist.) (Anaes.) | \$1041.30 |
| 30497 | Vagotomy and antrectomy (Assist.) (Anaes.) | \$1241.50 |
| 30499 | Vagotomy, highly selective (Assist.) (Anaes.) | \$1602.10 |
| 30500 | Vagotomy, highly selective with duodenoplasty for peptic stricture (Assist.) (Anaes.) | \$1709.60 |
| 30502 | Vagotomy, highly selective, with dilatation of pylorus (Assist.) (Anaes.) | \$1745.20 |
| 30503 | Vagotomy or antrectomy, or both, for peptic ulcer following previous operation for peptic ulcer (Assist.) (Anaes.) | \$1954.00 |
| 30505 | Bleeding peptic ulcer, control of, involving suture of bleeding point or wedge excision (Assist.) (Anaes.) | \$1095.50 |
| 30506 | Bleeding peptic ulcer, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy (Assist.) (Anaes.) | \$1709.60 |
| 30508 | Bleeding peptic ulcer, control of, involving suture of bleeding point or wedge excision, and highly selective vagotomy (Assist.) (Anaes.) | \$1952.50 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 30509 | Bleeding peptic ulcer, control of, involving gastric resection (other than wedge resection) (Assist.) (Anaes.) | \$1952.50 |
| 30515 | Gastroenterostomy (including gastroduodenostomy) or enterocolostomy or enteroenterostomy not being a service to which any of items 31569 to 31581 apply (Assist.) (Anaes.) | \$1354.50 |
| 30517 | Gastroenterostomy, pyloroplasty or gastroduodenostomy, reconstruction of (Assist.) (Anaes.) | \$1780.30 |
| 30518 | Partial gastrectomy, not being a service associated with a service to which any of items 31569 to 31581 apply (Assist.) (Anaes.) | \$2240.00 |
| 30520 | Gastric tumour, removal of, by local excision, not being a service to which item 30518 applies (Assist.) (Anaes.) | \$1293.50 |
| 30521 | Gastrectomy, total, for benign disease (Assist.) (Anaes.) | \$2549.20 |
| 30523 | Gastrectomy, subtotal radical, for carcinoma, (including splenectomy when performed) (Assist.) (Anaes.) | \$2781.00 |
| 30524 | Gastrectomy, total radical, for carcinoma (including extended node dissection and distal pancreatectomy and splenectomy when performed) (Assist.) (Anaes.) | \$3218.90 |
| 30526 | Gastrectomy, total, and including lower oesophagus, performed by left thoraco- abdominal incision or opening of diaphragmatic hiatus, (including splenectomy when performed) (Assist.) (Anaes.) | \$4131.00 |
| 30527 | Antireflux operation by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus not being a service to which item 30601 applies (Assist.) (Anaes.) | \$1679.80 |
| 30529 | Antireflux operation by fundoplasty, with oesophagoplasty for stricture or short oesophagus (Assist.) (Anaes.) | \$2508.80 |
| 30530 | Antireflux operation by cardiopexy, with or without fundoplasty (Assist.) (Anaes.) | \$1502.20 |
| 30532 | Oesophagogastric myotomy (Heller's operation) via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus by laparoscopy or open operation (Assist.) (Anaes.) | \$1726.80 |
| 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 (Assist.) (Anaes.) | \$2053.80 |
| 30535 | Oesophagectomy with gastric reconstruction by abdominal mobilisation and thoracotomy (Assist.) (Anaes.) | \$3260.90 |
| 30536 | Oesophagectomy involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - 1 surgeon (Assist.) (Anaes.) | \$3300.20 |
| 30538 | Oesophagectomy involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest- conjoint surgery, principal surgeon (including aftercare) (Assist.) (Anaes.) | \$2288.60 |
| 30539 | Oesophagectomy involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - conjoint surgery, co-surgeon (Assist.) | \$1669.60 |
| 30541 | Oesophagectomy, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - 1 surgeon (Assist.) (Anaes.) | \$2908.10 |
| 30542 | Oesophagectomy, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, principal surgeon (including aftercare) (Assist.) (Anaes.) | \$1975.10 |
| 30544 | Oesophagectomy, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, co- surgeon (Assist.) | \$1617.60 |
| 30545 | Oesophagectomy with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - 1 surgeon (Assist.) (Anaes.) | \$3520.40 |
| 30547 | Oesophagectomy with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, principal surgeon (including aftercare) (Assist.) (Anaes.) | \$2236.70 |
| 30548 | Oesophagectomy with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, co-surgeon (Assist.) | \$1810.60 |
| 30550 | Oesophagectomy with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - 1 surgeon (Assist.) (Anaes.) | \$3951.60 |
| 30551 | Oesophagectomy with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, principal surgeon (including aftercare) (Assist.) (Anaes.) | \$2728.90 |
| 30553 | Oesophagectomy with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, co-surgeon (Assist.) | \$1863.60 |
| 30554 | Oesophagectomy with reconstruction by free jejunal graft - 1 surgeon (Assist.) (Anaes.) | \$4062.00 |
| 30556 | Oesophagectomy with reconstruction by free jejunal graft - conjoint surgery, principal surgeon (including aftercare) (Assist.) (Anaes.) | \$2863.30 |
| 30557 | Oesophagectomy with reconstruction by free jejunal graft - conjoint surgery, co -surgeon (Assist.) | \$2069.40 |
| 30559 | Oesophagus, local excision for tumour of (Assist.) (Anaes.) | \$1631.10 |
| 30560 | Oesophageal perforation, repair of, by thoracotomy (Assist.) (Anaes.) | \$1810.60 |
| 30562 | Enterostomy or colostomy, closure of (not involving resection of bowel), on a person 10 years of age or over (Anaes.) (Assist.) | \$1144.20 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 30563 | Colostomy or ileostomy, refashioning of, on a person 10 years of age or over (Anaes.) (Assist.) | \$1144.20 |
| 30564 | Small bowel stricturoplasty for chronic inflammatory bowel disease (Assist.) | \$1481.20 |
| 30565 | Small intestine, resection of, without anastomosis (including formation of stoma) (Assist.) (Anaes.) | \$1670.60 |
| 30566 | Small intestine, resection of, with anastomosis, on a person 10 years of age or over (Anaes.) (Assist.) | \$1879.40 |
| 30568 | Intraoperative enterotomy for visualisation of the small intestine by endoscopy (Assist.) (Anaes.) | \$1396.10 |
| 30569 | Endoscopic examination of small bowel with flexible endoscope passed at laparotomy, with or without biopsies (Assist.) (Anaes.) | \$709.50 |
| 30571 | Appendicectomy, not being a service to which item 30574 applies on a person 10 years of age or over (Anaes.) (Assist.) | \$862.60 |
| 30572 | Laparoscopic appendicectomy, on a person 10 years of age or over (Anaes.) (Assist.) | \$864.10 |
| 30574 | Appendicectomy, when performed in conjunction with any other intraabdominal procedure through the same incision (Anaes.) | \$264.20 |
| 30575 | Pancreatic abscess, laparotomy and external drainage of, not requiring retro-pancreatic dissection (Assist.) (Anaes.) | \$984.00 |
| 30577 | Pancreatic necrosectomy for pancreatic necrosis or abscess formation requiring major pancreatic or retro-pancreatic dissection, excluding aftercare (Assist.) (Anaes.) | \$2084.90 |
| 30578 | Endocrine tumour, exploration of pancreas or duodenum, followed by local excision of pancreatic tumour (Assist.) (Anaes.) | \$2202.60 |
| 30580 | Endocrine tumour, exploration of pancreas or duodenum, followed by local excision of duodenal tumour (Assist.) (Anaes.) | \$2006.90 |
| 30581 | Endocrine tumour, exploration of pancreas or duodenum for, but no tumour found (Assist.) (Anaes.) | \$1349.70 |
| 30583 | Distal pancreatectomy (Assist.) (Anaes.) | \$2317.60 |
| 30584 | Pancreatico-duodenectomy, Whipple's operation, with or without preservation of pylorus (Assist.) (Anaes.) | \$3386.20 |
| 30586 | Pancreatic cyst anastomosis to stomach or duodenum - by open or endoscopic means (Assist.) (Anaes.) | \$1347.90 |
| 30587 | Pancreatic cyst, anastomosis to Roux loop of jejunum (Assist.) (Anaes.) | \$1396.10 |
| 30589 | Pancreatico-jejunostomy for pancreatitis or trauma (Assist.) (Anaes.) | \$2398.60 |
| 30590 | Pancreatico-jejunostomy following previous pancreatic surgery (Assist.) (Anaes.) | \$2641.50 |
| 30593 | Pancreatectomy, near total or total (including duodenum), with or without splenectomy (Assist.) (Anaes.) | \$3621.30 |
| 30594 | Pancreatectomy for pancreatitis following previously attempted drainage procedure or partial resection (Assist.) (Anaes.) | \$4179.40 |
| 30596 | Splenorrhaphy or partial splenectomy (Assist.) (Anaes.) | \$1724.80 |
| 30597 | Splenectomy (Assist.) (Anaes.) | \$1379.50 |
| 30599 | Splenectomy, for massive spleen (weighing more than 1500gms) or involving thoraco-abdominal incision (Assist.) (Anaes.) | \$2508.80 |
| 30600 | Diaphragmatic hernia, traumatic, repair of (Assist.) (Anaes.) | \$1492.80 |
| 30601 | Diaphragmatic hernia, congenital repair of, by thoracic or abdominal approach, not being a service to which any of items 31569 to 31581 apply, on a person 10 years of age or over (Anaes.) (Assist.) | \$1841.00 |
| 30602 | Portal hypertension, porto-caval shunt for (Assist.) (Anaes.) | \$2974.90 |
| 30603 | Portal hypertension, meso-caval shunt for (Assist.) (Anaes.) | \$2905.20 |
| 30605 | Portal hypertension, selective spleno-renal shunt for (Assist.) (Anaes.) | \$3574.80 |
| 30606 | Portal hypertension, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (Assist.) (Anaes.) | \$2131.70 |
| 30608 | Small intestine, resection of, with anastomosis, on a person under 10 years of age (Anaes.) (Assist.) | \$2001.70 |
| 30609 | Femoral or inguinal hernia, laparoscopic repair of, not being a service associated with a service to which item 30614 applies (Anaes.) (Assist.) | \$889.50 |
| 30611 | Benign tumour of soft tissue, excluding tumours of skin, cartilage, and bone, simple lipomas covered by item 31345 and lipomata - removal of by surgical excision, where the specimen excised is sent for histological confirmation of diagnosis, on a person under 10 years of age, not being a service to which another item in this group applies (Anaes.) (Assist.) | \$896.20 |
| 30614 | Femoral or inguinal hernia or infantile hydrocele, repair of, not being a service to which item 30403 or 30615 applies, on a person 10 years of age or over (Anaes.) (Assist.) | \$899.60 |
| 30615 | Strangulated, incarcerated or obstructed hernia, repair of, without bowel resection, on a person 10 years of age or over (Anaes.) (Assist.) | \$998.60 |
| 30618 | Lymph nodes of neck, selective dissection of 1 or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck, on a person under 10 years of age (Anaes.) (Assist.) | \$831.00 |
| 30619 | Laparoscopic splenectomy, on a person under 10 years of age (Anaes.) (Assist.) | \$1489.60 |
| 30621 | Repair of symptomatic umbilical, epigastric or linea alba hernia requiring mesh or other fromal repair | \$782.20 |

| Item No. | Description | Max fee (excl GST) |
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| | of, in a person 10 years of age or over, other than a service to which item 30403 or 30405 applies (Anaes.) (Assist.) | |
| 30622 | Caecostomy, enterostomy, colostomy, enterotomy, colotomy, cholecystostomy, gastrostomy, gastrotomy, reduction of intussusception, removal of meckel's diverticulum, suture of perforated peptic ulcer, simple repair of ruptured viscus, reduction of volvulus, pyloroplasty or drainage of pancreas on a person under 10 years of age (Anaes.) (Assist.) | \$1078.10 |
| 30623 | Laparotomy involving division of peritoneal adhesions (where no other intraabdominal procedure is performed) on a person under 10 years of age (Anaes.) (Assist.) | \$1078.10 |
| 30626 | Laparotomy involving division of adhesions in conjunction with another intraabdominal procedure where the time taken to divide the adhesions is between 45 minutes and 2 hours, on a person under 10 years of age (Anaes.) (Assist.) | \$1083.10 |
| 30627 | Laparoscopy, diagnostic, not being a service associated with any other laparoscopic procedure, on a person under 10 years of age (Anaes.) | \$454.90 |
| 30628 | Hydrocele, tapping of | \$65.50 |
| 30631 | Hydrocele, removal of, other than a service associated with a service to which item 30641, 30642 or 30644 applies (Anaes.) | \$464.10 |
| 30635 | Varicocele, surgical correction of, other than a service associated with a service to which item 30641, 30642 or 30644 applies one procedure (Anaes.) (Assist.) | \$605.10 |
| 30636 | Gastrostomy button, caecostomy antegrade enema device (chait etc.) and/or stomal indwelling device, non-endoscopic insertion of, or non-endoscopic replacement of, on a person under 10 years of age (Anaes.) | \$370.90 |
| 30637 | Enterostomy or colostomy, closure of not involving resection of bowel, on a person under 10 years of age (Anaes.) (Assist.) | \$1230.80 |
| 30639 | Colostomy or ileostomy, refashioning of, on a person under 10 years of age (Anaes.) (Assist.) | \$1230.80 |
| 30640 | Repair of large and irreducible scrotal hernia, where duration of surgery exceeds 2 hours, in a person 10 years of age or over, other than a service to which item 30403, 30405, 30614, 30615 or 30621 applies (Anaes.) (Assist.) | \$1425.80 |
| 30641 | Orchidectomy, simple or subcapsular, unilateral with or without insertion of testicular prosthesis (Assist.) (Anaes.) | \$789.10 |
| 30642 | Orchidectomy, radical, unilateral, with or without insertion of testicular prosthesis, other than a service associated with a service to which item 30631, 30635, 30641, 30643 or 30644 applies (Anaes.) (Assist.) | \$799.50 |
| 30643 | Exploration of spermatic cord, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis on a person under 10 years of age (Anaes.) (Assist.) | \$1078.10 |
| 30644 | Exploration of spermatic cord, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis on a person 10 years of age or over (Anaes.) (Assist.) | \$1019.70 |
| 30645 | Appendicectomy, not being a service to which item 30574 applies, on a person under 10 years of age (Anaes.) (Assist.) | \$921.20 |
| 30646 | Laparoscopic appendicectomy, on a person under 10 years of age (Anaes.) (Assist.) | \$921.20 |
| 30649 | Haemorrhage, arrest of, following circumcision requiring general anaesthesia on a person under 10 years of age (Anaes.) | \$298.60 |
| 30654 | Circumcision of the penis (other than a service to which item 30658 applies) | \$72.50 |
| 30658 | Circumcision of the penis, when performed in conjunction with a service to which an item in group t7 or group t10 applies (Anaes.) | \$217.80 |
| 30663 | Haemorrhage, arrest of, following circumcision requiring general anaesthesia on a person 10 years of age or over (Anaes.) | \$254.10 |
| 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.) | \$91.20 |
| 30672 | Coccyx, excision of (Assist.) (Anaes.) | \$860.70 |
| 30676 | Pilonidal sinus or cyst, or sacral sinus or cyst, excision of (Anaes.) | \$728.00 |
| 30679 | Pilonidal sinus, injection of sclerosant fluid under anaesthesia (Anaes.) | \$182.70 |
| 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.) | \$2086.80 |
| 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.) | \$2086.80 |

| Item No. | Description | Max fee (excl GST) |
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| 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.) | \$2568.30 |
| 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.) | \$2568.30 |
| 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.) | \$817.30 |
| 30688 | Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.) | \$650.80 |
| 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.) | \$1004.80 |
| 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.) | \$650.80 |
| 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.) | \$1004.80 |
| 30696 | Endoscopic ultrasound guided fine needle aspiration biopsy(s) (endoscopy with ultrasound imaging) to obtain one or more specimens from either: (a) mediastinal mass(es) or (b) locoregional nodes to stage non-small cell lung carcinoma not being a service associated with another item in this subgroup or to which items 30710 and 55054 apply (Anaes.) | \$974.50 |
| 30710 | Endobronchial ultrasound guided biopsy(s) (bronchoscopy with ultrasound imaging, with or without associated fluoroscopic imaging) to obtain one or more specimens by either: (a) transbronchial biopsy(s) of peripheral lung lesions; or (b) fine needle aspiration(s) of a mediastinal mass(es); or (c) fine needle aspiration(s) of locoregional nodes to stage non-small cell lung carcinoma not being a service associated with another item in this subgroup or to which items 30696, 41892, 41898, and 60500 to 60509 apply (Anaes.) | \$974.50 |
| 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.) | \$1113.70 |
| 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.) | \$1387.50 |
| 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.) | \$1648.60 |
| 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.) | \$148.80 |
| 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.) | \$191.90 |
| 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.) | \$223.60 |

| Item No. | Description | Max fee (excl GST) |
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| 31220 | Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of 4 to 10 lesions and suture, if: (a) the size of each lesion is not more than 10 mm in diameter; and (b) each removal is from cutaneous or subcutaneous tissue by surgical excision (other than by shave excision); and (c) all of the specimens excised are sent for histological examination (Anaes.) | \$389.30 |
| 31221 | Tumours, cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of 4 to 10 lesions, if: (a) the size of each lesion is not more than 10 mm in diameter; and (b) each removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) each site of excision is closed by suture; and (d) all of the specimens excised are sent for histological examination (Anaes.) | \$334.30 |
| 31225 | Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of more than 10 lesions, if: (a) the size of each lesion is not more than 10 mm in diameter; and (b) each removal is from cutaneous or subcutaneous tissue or mucous membrane by surgical excision (other than by shave excision); and (c) each site of excision is closed by suture; and (d) all of the specimens excised are sent for histological examination (Anaes.) | \$695.30 |
| 31245 | Skin and subcutaneous tissue, extensive excision of, in the treatment of suppurative hydradenitis (excision from axilla, groin or natal cleft) or sycosis barbae or nuchae (excision from face or neck) (Anaes.) | \$713.50 |
| 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.) | \$698.50 |
| 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, where lesion is subcutaneous and 50mm or more in diameter, or is sub-fascial, where the specimen is sent for histological confirmation of diagnosis (Anaes.) | \$406.90 |
| 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.) | \$373.40 |
| 31350 | Benign tumour of soft tissue, excluding tumours of skin, cartilage, and bone, simple lipomas covered by item 31345 and lipomata, removal of by surgical excision, where the specimen excised is sent for histological confirmation of diagnosis, on a person 10 years of age or over, not being a service to which another item in this Group applies (Anaes.) (Assist.) | \$839.40 |
| 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 (Assist.) (Anaes.) | \$1394.80 |
| 31356 | Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is less than 6 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) | \$344.90 |
| 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.) | \$171.00 |
| 31358 | Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is 6 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) | \$422.10 |
| 31359 | Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision), if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia (the applicable site); and (b) the necessary excision area is at least one third of the surface area of the applicable site; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy(H) (Anaes.) | \$514.40 |
| 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.) | \$261.90 |
| 31361 | Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is less than 14 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) | \$291.00 |

| Item No. | Description | Max fee (excl GST) |
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| 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.) | \$208.70 |
| 31363 | Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is 14 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) | \$380.80 |
| 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.) | \$261.90 |
| 31365 | Malignant skin lesion (other than a malignant skin lesion covered by item 31369, 31370, 31371, 31372 or 31373), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is less than 15 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) | \$246.70 |
| 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.) | \$148.80 |
| 31367 | Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) | \$332.80 |
| 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.) | \$195.60 |
| 31369 | Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) | \$383.20 |
| 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.) | \$223.60 |
| 31371 | Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (a) the tumour is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is 6 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) | \$556.30 |
| 31372 | Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is less than 14 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) | \$481.10 |
| 31373 | Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is 14 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) | \$556.00 |

| Item No. | Description | Max fee (excl GST) |
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| 31374 | Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and (b) the necessary excision diameter is less than 15 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) | \$439.40 |
| 31375 | Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and (b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) | \$472.80 |
| 31376 | Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and (b) the necessary excision diameter is more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) | \$547.90 |
| 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 (Assist.) (Anaes.) | \$564.50 |
| 31403 | Malignant upper aerodigestive tract tumour more than and including 20mm and up to 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$1020.00 |
| 31409 | Parapharyngeal tumour, excision of, by cervical approach (Assist.) (Anaes.) | \$3255.40 |
| 31412 | Recurrent or persistent parapharyngeal tumour, excision of, by cervical approach (Assist.) (Anaes.) | \$3686.30 |
| 31420 | Lymph node of neck, biopsy of (Anaes.) | \$323.90 |
| 31423 | Lymph nodes of neck, selective dissection of 1 or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck, on a person 10 years of age or over (Anaes.) (Assist.) | \$769.20 |
| 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 (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$2404.10 |
| 31432 | Lymph nodes of neck, bilateral selective dissection of levels I, II and III (bi lateral supraomohyoid dissections) (Assist.) (Anaes.) | \$3120.00 |
| 31435 | Lymph nodes of neck, comprehensive dissection of all 5 lymph node levels on one side of the neck (Assist.) (Anaes.) | \$1885.50 |
| 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 (Assist.) (Anaes.) | \$3305.00 |
| 31450 | Laparoscopic division of adhesions, as an independent procedure, where the time taken is 1 hour or less (Assist.) (Anaes.) | \$756.20 |
| 31452 | Laparoscopic division of adhesions, as an independent procedure, where the time taken is more than 1 hour (Assist.) (Anaes.) | \$1365.40 |
| 31454 | Laparoscopy with drainage of pus, bile or blood, as an independent procedure (Assist.) (Anaes.) | \$1064.10 |
| 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.) | \$432.60 |
| 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 clinic ally indicated (Anaes.) | \$519.10 |
| 31460 | Percutaneous gastrostomy tube, jejunal extension to, including any associated imaging services (Assist.) (Anaes.) | \$661.60 |
| 31462 | Operative feeding jejunostomy performed in conjunction with major upper gastro- intestinal resection (Assist.) (Anaes.) | \$1009.90 |
| 31464 | Antireflux operation by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopic technique - not being a service to which item 30601 applies (Assist.) (Anaes.) | \$1887.10 |
| 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 (Assist.) (Anaes.) | \$2554.30 |
| 31468 | Para-oesophageal hiatus hernia, repair of, with complete reduction of hernia, resection of sac and repair of hiatus, with or without fundoplication (Assist.) (Anaes.) | \$2787.20 |
| 31470 | Laparoscopic splenectomy, on a person 10 years of age or over (Anaes.) (Assist.) | \$1385.30 |
| 31472 | Cholecystoduodenostomy, cholecystoenterostomy, choledochojejunostomy or Roux-en -y as a bypass procedure where prior biliary surgery has been performed (Assist.) (Anaes.) | \$2060.50 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 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.) | \$498.20 |
| 31503 | Breast, benign lesion more than 50mm in diameter, excision of (Assist.) (Anaes.) | \$671.90 |
| 31506 | Breast, abnormality detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of (Assist.) (Anaes.) | \$747.80 |
| 31509 | Breast, malignant tumour, open surgical biopsy of, with or without frozen section histology (Anaes.) | \$643.20 |
| 31512 | Breast, malignant tumour, complete local excision of, with or without frozen section histology (Assist.) (Anaes.) | \$1249.20 |
| 31515 | Breast, tumour site, re-excision of following open biopsy or incomplete excision of malignant tumour (Assist.) (Anaes.) | \$832.30 |
| 31516 | Breast, malignant tumour, complete local excision of, with or without frozen section histology when targeted intraoperative radiotherapy (using an Intrabeam device) is performed concurrently, if the requirements of item 15900 are met for the patient (Anaes.) (Assist.) | \$1379.40 |
| 31519 | Breast, total mastectomy (h) (Assist.) (Anaes.) | \$1198.10 |
| 31524 | Breast, subcutaneous mastectomy (h) (Assist.) (Anaes.) | \$1985.60 |
| 31525 | Breast, mastectomy for gynecomastia, with or without liposuction (suction assisted lipolysis), not being a service associated with a service to which item 45585 applies (h) (Assist.) (Anaes.) | \$846.30 |
| 31530 | Breast, biopsy of solid tumour or tissue of, using a vacuum-assisted breast biopsy device under imaging guidance, for histological examination, where imaging has demonstrated:(a) microcalcification of lesion; or(b) impalpable lesion less than 1cm in diameter- including pre-operative localisation of lesion where performed, not being a service to which items 31539, 31545 or 31548 apply | \$1074.70 |
| 31533 | Fine needle aspiration of an impalpable breast lesion detected by mammography or ultrasound, imaging guided - but not including imaging (Anaes.) | \$248.70 |
| 31536 | Breast, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques - but not including imaging, not being a service to which item 31539, 31542 or 31545 applies (Anaes.) | \$341.70 |
| 31539 | Breast, biopsy of solid tumour or tissue of, using a bore-enbloc stereotactic biopsy, for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons, and where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, not being a service to which item 31530, 31536 or 31548 applies (Anaes.) | \$706.20 |
| 31542 | Breast, initial guidewire localisation of lesion, by hookwire or similar device, when conducted by a radiologist as determined by the Royal Australian and New Zealand College of Radiologists, using interventional imaging techniques prior to using a bore-enbloc stereotactic biopsy - including imaging not being a service associated with a service to which item 31536 applies (Anaes.) | \$348.80 |
| 31545 | Breast, biopsy of solid tumour or tissue of, using a bore-enbloc stereotactic biopsy, for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons; where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, including initial guidewire localisation of lesion, by hookwire or similar device, using interventional imaging techniques and including imaging not being a service associated with a service to which item 31530, 31536 or 31548 applies (Anaes.) | \$1054.50 |
| 31548 | Breast, biopsy of solid tumour or tissue of, using mechanical biopsy device, for histological examination, not being a service to which items 31530, 31539 or 31545 apply (Anaes.) | \$268.90 |
| 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.) | \$391.00 |
| 31554 | Breast, microdochotomy of, for benign or malignant condition (Assist.) (Anaes.) | \$837.10 |
| 31557 | Breast central ducts, excision of, for benign condition (Assist.) (Anaes.) | \$664.50 |
| 31560 | Accessory breast tissue, excision of (Assist.) (Anaes.) | \$665.20 |
| 31563 | Inverted nipple, surgical eversion of (Anaes.) | \$440.60 |
| 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 (Assist.) (Anaes.) | \$1425.60 |
| 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 (Assist.) (Anaes.) | \$1754.20 |
| 31575 | Sleeve gastrectomy, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Assist.) (Anaes.) | \$1425.60 |
| 31578 | Gastroplasty (excluding by gastric plication), with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Assist.) (Anaes.) | \$1425.60 |
| 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 (Assist.) (Anaes.) | \$1754.20 |
| 31584 | Surgical reversal of adjustable gastric banding (removal or replacement of gastric band), gastric | \$2582.70 |

| Item No. | Description | Max fee (excl GST) |
|-------------------|---|--------------------|
| | bypass, gastropasty (excluding by gastric plication) or biliopancreatic diversion being services to which items 31569 to 31581 apply (Assist.) (Anaes.) | |
| 31587 | Adjustment of gastric band as an independent procedure including any associated consultation | \$164.40 |
| 31590 | Adjustment of gastric band reservoir, repair, revision or replacement of (Assist.) (Anaes.) | \$422.50 |
| Colorectal | | |
| 32000 | Large intestine, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Assist.) (Anaes.) | \$1996.40 |
| 32003 | Large intestine, resection of, with anastomosis, including right hemicolectomy (Assist.) (Anaes.) | \$2085.80 |
| 32004 | Large intestine, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) without anastomosis, not being a service associated with a service to which item 32000, 32003, 32005 or 32006 applies (Assist.) (Anaes.) | \$2202.60 |
| 32005 | Large intestine, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) with anastomosis, not being a service associated with a service to which item 32000, 32003, 32004 or 32006 applies (Assist.) (Anaes.) | \$2493.70 |
| 32006 | Left hemicolectomy, including the descending and sigmoid colon (including formation of stoma) (Assist.) (Anaes.) | \$2202.60 |
| 32009 | Total colectomy and ileostomy (Assist.) (Anaes.) | \$2632.70 |
| 32012 | Total colectomy and ileorectal anastomosis (Assist.) (Anaes.) | \$2908.40 |
| 32015 | Total colectomy with excision of rectum and ileostomy 1 surgeon (Assist.) (Anaes.) | \$3528.50 |
| 32018 | Total colectomy with excision of rectum and ileostomy, combined synchronous ope ration; abdominal resection (including aftercare) (Assist.) (Anaes.) | \$3040.00 |
| 32021 | Total colectomy with excision of rectum and ileostomy, combined synchronous ope ration; perineal resection (Assist.) | \$996.90 |
| 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.) | \$953.40 |
| 32024 | Rectum, high restorative anterior resection with intraperitoneal anastomosis (of the rectum) greater than 10cm from the anal verge excluding resection of sigmoid colon alone not being a service associated with a service to which item 321 03, 32104 or 32106 applies (Assist.) (Anaes.) | \$2648.20 |
| 32025 | Rectum, low restorative anterior resection with extraperitoneal anastomosis (of the rectum) less than 10 cm from the anal verge, with or without covering stoma not being a service associated with a service to which item 32103, 32104 or 3 2106 applies (Assist.) (Anaes.) | \$3525.90 |
| 32026 | Rectum, ultra low restorative resection, with or without covering stoma, where the anastomosis is sited in the anorectal region and is 6cm or less from the anal verge (Assist.) (Anaes.) | \$3800.00 |
| 32028 | Rectum, low or ultra low restorative resection, with peranal sutured coloanal anastomosis, with or without covering stoma (Assist.) (Anaes.) | \$4040.30 |
| 32029 | Colonic reservoir, construction of, being a service associated with a service to which any other item in this Subgroup applies (Assist.) (Anaes.) | \$811.70 |
| 32030 | Rectosigmoidectomy (Hartmann's operation) (Assist.) (Anaes.) | \$1975.10 |
| 32033 | Restoration of bowel following Hartmann's or similar operation, including dismantling of the stoma (Assist.) (Anaes.) | \$2893.10 |
| 32036 | Sacrococcygeal and presacral tumour excision of (Assist.) (Anaes.) | \$3699.80 |
| 32039 | Rectum and anus, abdominoperineal resection of - 1 surgeon (Assist.) (Anaes.) | \$2951.10 |
| 32042 | Rectum and anus, abdominoperineal resection of, combined synchronous operation, abdominal resection (Assist.) (Anaes.) | \$2501.00 |
| 32045 | Rectum and anus, abdominoperineal resection of, combined synchronous operation - perineal resection (Assist.) | \$937.30 |
| 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.) | \$1435.50 |
| 32047 | Perineal proctectomy (Assist.) (Anaes.) | \$1670.60 |
| 32051 | Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy 1 surgeon (Assist.) (Anaes.) | \$4473.90 |
| 32054 | Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Assist.) (Anaes.) | \$4461.10 |
| 32057 | Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir conjoint surgery, perineal surgeon (Assist.) | \$1088.40 |
| 32060 | Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy 1 surgeon (Assist.) (Anaes.) | \$4473.90 |
| 32063 | Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Assist.) (Anaes.) | \$3764.30 |

| Item No. | Description | Max fee (excl GST) |
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| 32066 | Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, perineal surgeon (Assist.) | \$996.90 |
| 32069 | Ileostomy reservoir, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes.) | \$3308.00 |
| 32072 | Sigmoidoscopic examination (with rigid sigmoidoscope), with or without biopsy | \$93.60 |
| 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 | Flexible fibre optic sigmoidoscopy or fibre optic colonoscopy up to the hepatic flexure, with or without biopsy, other than a service associated with a service to which item 32090 or 32093 applies. (Anaes.) | \$213.70 |
| 32087 | Endoscopic examination of the colon up to the hepatic flexure by flexible fibre optic sigmoidoscopy or fibre optic colonoscopy for the removal of 1 or more polyps or the treatment of radiation proctitis, angiodysplasia or post-polypectomy bleeding by argon plasma coagulation, one or more of, other than a service associated with a service to which item 32090 or 32093 applies (Anaes.) | \$393.00 |
| 32088 | Fibre optic colonoscopy examination of the colon beyond the hepatic flexure with or without biopsy, following appositve faecal occult blood test for a participant registered on the national bowel cancer screening program. (Anaes.) | \$521.00 |
| 32089 | Endoscopic examination of the colon beyond the hepatic flexure by fibre optic colonoscopy for the removal of 1 or more polyps, by argon plasma coagulation, following a positive faecal occult blood test for a participant registered on the National Bowel Cancer Screening Program. (Anaes.) | \$731.20 |
| 32090 | Fibre optic colonoscopy examination of colon beyond the hepatic flexure with or without biopsy (Anaes.) | \$640.40 |
| 32093 | Fibre optic colonoscopy examination of colon beyond the hepatic flexure with removal of 1 or more polyps (Anaes.) | \$902.00 |
| 32094 | Endoscopic dilatation of colorectal strictures including colonoscopy (Anaes.) | \$1058.50 |
| 32095 | Endoscopic examination of small bowel with flexible endoscope passed by stoma, with or without biopsies (Anaes.) | \$248.20 |
| 32096 | Rectal biopsy, full thickness, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital (Assist.) (Anaes.) | \$512.20 |
| 32099 | Rectal tumour of 5cm or less in diameter, per anal submucosal excision of (Assist.) (Anaes.) | \$639.20 |
| 32102 | Rectal tumour of greater than 5cm in diameter, indicated by pathological examination, per anal submucosal excision of (Assist.) (Anaes.) | \$1215.20 |
| 32103 | Rectal tumour, of less than 4 cm in diameter, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy or by local excision, other than a service associated with a service to which item 32024, 32025, 32104 or 32106 applies (Assist.) (Anaes.) | \$1495.00 |
| 32104 | Rectal tumour, of 4 cm or greater in diameter, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy or by local excision, other than a service associated with a service to which item 32024, 32025, 32103 or 32106 applies (Assist.) (Anaes.) | \$1938.30 |
| 32105 | Anorectal carcinoma per anal full thickness excision of (Assist.) (Anaes.) | \$937.30 |
| 32106 | Anterolateral intraperitoneal rectal tumour, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy and if removal requires dissection within the peritoneal cavity, other than a service associated with a service to which item 32024, 32025, 32103 or 32104 applies (Assist.) (Anaes.) | \$2630.00 |
| 32108 | Rectal tumour, transsphincteric excision of (Kraske or similar operation) (Assist.) (Anaes.) | \$1940.00 |
| 32111 | Rectal prolapse, Delorme procedure for (Assist.) (Anaes.) | \$1222.10 |
| 32112 | Rectal prolapse, perineal recto- sigmoidectomy for (Assist.) (Anaes.) | \$1493.30 |
| 32114 | Rectal stricture, per anal release of (Anaes.) | \$333.90 |
| 32115 | Rectal stricture, dilatation of (Anaes.) | \$242.90 |
| 32117 | Rectal prolapse, abdominal rectopexy of (Assist.) (Anaes.) | \$1940.00 |
| 32120 | Rectal prolapse, perineal repair of (Assist.) (Anaes.) | \$496.80 |
| 32123 | Anal stricture, anoplasty for (Assist.) (Anaes.) | \$644.00 |
| 32126 | Anal incontinence, Parks' intersphincteric procedure for (Assist.) (Anaes.) | \$926.40 |
| 32129 | Anal sphincter, direct repair of (Assist.) (Anaes.) | \$1222.10 |
| 32131 | Rectocele, transanal repair of rectocele (Assist.) (Anaes.) | \$1029.60 |
| 32132 | Haemorrhoids or rectal prolapse sclerotherapy for (Anaes.) | \$86.60 |
| 32135 | Haemorrhoids or rectal prolapse rubber band ligation of, with or without sclerotherapy, cryotherapy or infra-red therapy for (Anaes.) | \$130.50 |
| 32138 | Haemorrhoidectomy including excision of anal skin tags when performed (Anaes.) | \$704.70 |
| 32139 | Haemorrhoidectomy involving third or fourth degree haemorrhoids, including excision of anal skin tags when performed (Assist.) (Anaes.) | \$704.70 |

| Item No. | Description | Max fee (excl GST) |
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| 32142 | Anal skin tags or anal polyps, excision of 1 or more of (Anaes.) | \$129.90 |
| 32145 | Anal skin tags or anal polyps, excision of 1 or more of, undertaken in the operating theatre of a hospital (Anaes.) | \$259.50 |
| 32147 | Perianal thrombosis, incision of (Anaes.) | \$84.70 |
| 32150 | Operation for fissure-in-ano, including excision or sphincterotomy but excluding dilatation only (Assist.) (Anaes.) | \$492.60 |
| 32153 | Anus, dilatation of, under general anaesthesia, with or without disimpaction of faeces, not being a service associated with a service to which another item in this Group applies (Anaes.) | \$134.30 |
| 32156 | Fistula-in-ano, 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 (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$937.30 |
| 32165 | Anal fistula, repair of by mucosal flap advancement (Assist.) (Anaes.) | \$1222.10 |
| 32166 | Anal fistula - readjustment of Seton (Anaes.) | \$399.10 |
| 32168 | Fistula wound, review of, under general or regional anaesthetic, as an independent procedure (Anaes.) | \$253.20 |
| 32171 | Anorectal examination, with or without biopsy, under general anaesthetic, not being a service associated with a service to which another item in this Group applies (Anaes.) | \$172.30 |
| 32174 | Intra-anal, perianal or ischio-rectal abscess, drainage of (excluding aftercare) (Anaes.) | \$165.10 |
| 32175 | Intra-anal, perianal or ischio-rectal abscess, draining of, undertaken in the operating theatre of a hospital (excluding aftercare) (Anaes.) | \$315.60 |
| 32177 | Anal warts, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.) | \$340.70 |
| 32180 | Anal warts, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.) | \$500.00 |
| 32183 | Intestinal sling procedure prior to radiotherapy (Assist.) (Anaes.) | \$1081.70 |
| 32186 | Colonic lavage, total, intraoperative (Assist.) (Anaes.) | \$1081.70 |
| 32200 | Distal muscle, devascularisation of (Assist.) (Anaes.) | \$523.50 |
| 32203 | Anal or perineal graciloplasty (Assist.) (Anaes.) | \$1222.10 |
| 32206 | Stimulator and electrodes, insertion of, following previous graciloplasty (Assist.) (Anaes.) | \$1104.90 |
| 32209 | Anal or perineal graciloplasty with insertion of stimulator and electrodes (Assist.) (Anaes.) | \$1632.10 |
| 32210 | Gracilis neosphincter pacemaker, replacement of (Anaes.) | \$565.00 |
| 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, percutaneous placement using fluoroscopic guidance (or open placement) and intraoperative test stimulation, to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.) | \$1273.10 |
| 32214 | Neurostimulator or receiver, subcutaneous placement of, involving placement and connection of an extension wire to a sacral nerve electrode using fluoroscopic guidance, to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.) (Assist.) | \$653.20 |
| 32215 | Sacral nerve electrode or electrodes, management, adjustment and electronic programming of the neurostimulator by a medical practitioner, to manage faecal incontinence, other than in a patient who: a) is medically unfit for surgery; or b) is pregnant or planning pregnancy; or c) has irritable bowel syndrome; or d) has congenital anorectal malformations; or e) has active anal abscesses or fistulas; or f) has anorectal organic bowel disease, including cancer; or g) has functional effects of previous pelvic irradiation; or h) has congenital or acquired malformations of the sacrum; or i) has had rectal or anal surgery within the previous 12 months - each day | \$222.50 |
| 32216 | Sacral nerve lead or leads, percutaneous surgical repositioning of, using fluoroscopic guidance (or open surgical repositioning of) and interoperative test stimulation, to correct displacement or unsatisfactory positioning, if the lead was inserted to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient | \$1143.20 |

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| | who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months other than a service to which item 32213 applies (Anaes.) | |
| 32217 | Neurostimulator or receiver, removal of, if the neurostimulator or receiver was inserted to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.) | \$301.10 |
| 32218 | Sacral nerve lead or leads, removal of, if the lead was inserted to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.) | \$300.10 |
| 32220 | Insertion of an artificial bowel sphincter for severe faecal incontinence in the treatment of a patient for whom conservative and other less invasive forms of treatment are contraindicated or have failed. Contraindicated in: (a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases or a scarred or fragile perineum; and (b) patients who have had an adverse reaction or radiopaque solution; and (c) patients who engage in receptive anal intercourse (Assist.) (Anaes.) | \$1600.10 |
| 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. Contraindicated in: (a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases or a scarred or fragile perineum; and (b) patients who have had an adverse reaction to radiopaque solution; and (c) patients who engage in receptive anal intercourse (Assist.) (Anaes.) | \$1628.60 |
| Vascular | | |
| 32500 | Varicose veins where varicosity measures 2.5mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same leg (excluding aftercare) - 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 surgical exploration of one or more incompetent perforating veins - 1 leg - not being a service associated with a service to which item 32508, 32511, 32514 or 32517 applies on the same leg (Assist.) (Anaes.) | \$1021.80 |
| 32508 | Varicose veins, complete dissection at the sapheno-femoral or sapheno- popliteal junction -1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Assist.) (Anaes.) | \$1034.10 |
| 32511 | Varicose veins, complete dissection at the sapheno-femoral and sapheno- popliteal junction -1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Assist.) (Anaes.) | \$1624.10 |
| 32514 | Varicose veins, ligation of the long or short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in the same territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Assist.) (Anaes.) | \$1786.70 |
| 32517 | Varicose veins, ligation of the long and short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in either territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Assist.) (Anaes.) | \$2376.90 |
| 32520 | Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a laser probe introduced by an endovenous catheter, if it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including radiofrequency diathermy, radiofrequency ablation or cyanoacrylate embolisation; and (c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.) | \$947.60 |
| 32522 | Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) and small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a laser probe introduced by an endovenous catheter, if it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including radiofrequency diathermy, | \$1408.70 |

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| | radiofrequency ablation or cyanoacrylate embolisation, and not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.) | |
| 32523 | Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a radiofrequency catheter introduced by an endovenous catheter, if it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including endovenous laser therapy or cyanoacrylate embolisation; and (c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.) | \$916.00 |
| 32526 | Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) and small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a radiofrequency catheter introduced by an endovenous catheter, if it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including endovenous laser therapy or cyanoacrylate embolisation; and (c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.) | \$1362.00 |
| 32700 | Artery of neck, bypass using vein or synthetic material (Assist.) (Anaes.) | \$2778.40 |
| 32703 | Internal carotid artery, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (Assist.) (Anaes.) | \$2283.20 |
| 32708 | Aortic bypass for occlusive disease using a straight non-bifurcated graft (Assist.) (Anaes.) | \$2721.70 |
| 32710 | Aortic bypass for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac arteries (Assist.) (Anaes.) | \$3170.60 |
| 32711 | Aortic bypass for occlusive disease using a bifurcated graft with 1 or both anastomoses to the common femoral or profunda femoris arteries (Assist.) (Anaes.) | \$3367.70 |
| 32712 | Ilio-femoral bypass grafting (Assist.) (Anaes.) | \$2432.70 |
| 32715 | Axillary or subclavian to femoral bypass grafting to 1 or both femoral arteries (Assist.) (Anaes.) | \$2223.20 |
| 32718 | Femoro-femoral or ilio-femoral cross-over bypass grafting (Assist.) (Anaes.) | \$2302.20 |
| 32721 | Renal artery, bypass grafting to (Assist.) (Anaes.) | \$3649.40 |
| 32724 | Renal arteries (both), bypass grafting to (Assist.) (Anaes.) | \$4150.10 |
| 32730 | Mesenteric vessel (single), bypass grafting to (Assist.) (Anaes.) | \$3149.60 |
| 32733 | Mesenteric vessels (multiple), bypass grafting to (Assist.) (Anaes.) | \$3649.40 |
| 32736 | Inferior mesenteric artery, operation on, when performed in conjunction with another intra-abdominal vascular operation (Assist.) (Anaes.) | \$792.70 |
| 32739 | Femoral artery bypass grafting using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with above knee anastomosis (Assist.) (Anaes.) | \$2506.10 |
| 32742 | Femoral artery bypass grafting using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to below knee popliteal artery (Assist.) (Anaes.) | \$2871.80 |
| 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 (Assist.) (Anaes.) | \$3279.40 |
| 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 (Assist.) (Anaes.) | \$3544.20 |
| 32751 | Femoral artery bypass grafting using synthetic graft, with lower anastomosis above or below the knee (Assist.) (Anaes.) | \$2302.20 |
| 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 (Assist.) (Anaes.) | \$2871.80 |
| 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 (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$778.30 |
| 32763 | Arterial bypass grafting, using vein or synthetic material, not being a service to which another item in this Sub-group applies (Assist.) (Anaes.) | \$2302.20 |
| 32766 | Arterial or venous anastomosis, not being a service to which another item in this Sub-group applies, as an independent procedure (Assist.) (Anaes.) | \$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) (Assist.) (Anaes.) | \$523.90 |
| 33050 | Bypass grafting to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (Assist.) (Anaes.) | \$2821.00 |
| 33055 | Bypass grafting to replace a popliteal aneurysm using a synthetic graft (Assist.) (Anaes.) | \$2264.20 |
| 33070 | Aneurysm in the extremities, ligation, suture closure or excision of, without bypass grafting (Assist.) (Anaes.) | \$1631.00 |

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| 33075 | Aneurysm in the neck, ligation, suture closure or excision of, without bypass grafting (Assist.) (Anaes.) | \$2076.80 |
| 33080 | Intra-abdominal or pelvic aneurysm, ligation, suture closure or excision of, without bypass grafting (Assist.) (Anaes.) | \$2533.00 |
| 33100 | Aneurysm of common or internal carotid artery, or both, replacement by graft of vein or synthetic material (Assist.) (Anaes.) | \$2778.40 |
| 33103 | Thoracic aneurysm, replacement by graft (Assist.) (Anaes.) | \$3899.40 |
| 33109 | Thoraco-abdominal aneurysm, replacement by graft including re-implantation of arteries (Assist.) (Anaes.) | \$4725.20 |
| 33112 | Suprarenal abdominal aortic aneurysm, replacement by graft including re-implantation of arteries (Assist.) (Anaes.) | \$4081.50 |
| 33115 | Infrarenal abdominal aortic aneurysm, replacement by tube graft not being a service associated with a service to which item 33116 applies (Assist.) (Anaes.) | \$2728.30 |
| 33116 | Infrarenal abdominal aortic aneurysm, replacement by tube graft using endovascular repair procedure, excluding associated radiological services (Assist.) (Anaes.) | \$2585.80 |
| 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 (Assist.) (Anaes.) | \$3039.40 |
| 33119 | Infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to one or both iliac arteries using endovascular repair procedure, excluding associated radiological services (Assist.) (Anaes.) | \$2982.90 |
| 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) (Assist.) (Anaes.) | \$3520.90 |
| 33124 | Aneurysm of iliac artery (common, external or internal), replacement by graft - unilateral (Assist.) (Anaes.) | \$2340.20 |
| 33127 | Aneurysms of iliac arteries (common, external or internal), replacement by graft - bilateral (Assist.) (Anaes.) | \$2809.10 |
| 33130 | Aneurysm of visceral artery, excision and repair by direct anastomosis or replacement by graft (Assist.) (Anaes.) | \$2671.60 |
| 33133 | Aneurysm of visceral artery, dissection and ligation of arteries without restoration of continuity (Assist.) (Anaes.) | \$2006.50 |
| 33136 | False aneurysm, repair of, at aortic anastomosis following previous aortic surgery (Assist.) (Anaes.) | \$5066.00 |
| 33139 | False aneurysm, repair of, in iliac artery and restoration of arterial continuity (Assist.) (Anaes.) | \$3075.10 |
| 33142 | False aneurysm, repair of, in femoral artery and restoration of arterial continuity (Assist.) (Anaes.) | \$2871.80 |
| 33145 | Ruptured thoracic aortic aneurysm, replacement by graft (Assist.) (Anaes.) | \$4914.60 |
| 33148 | Ruptured thoraco-abdominal aortic aneurysm, replacement by graft (Assist.) (Anaes.) | \$5604.60 |
| 33151 | Ruptured suprarenal abdominal aortic aneurysm, replacement by graft (Assist.) (Anaes.) | \$5823.20 |
| 33154 | Ruptured infrarenal abdominal aortic aneurysm, replacement by tube graft (Assist.) (Anaes.) | \$4316.10 |
| 33157 | Ruptured infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to iliac arteries (with or without excision or bypass of common iliac aneurysms) (Assist.) (Anaes.) | \$4815.70 |
| 33160 | Ruptured infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to 1 or both femoral arteries (Assist.) (Anaes.) | \$6165.00 |
| 33163 | Ruptured iliac artery aneurysm, replacement by graft (Assist.) (Anaes.) | \$4034.60 |
| 33166 | Ruptured aneurysm of visceral artery, replacement by anastomosis or graft (Assist.) (Anaes.) | \$3728.00 |
| 33169 | Ruptured aneurysm of visceral artery, simple ligation of (Assist.) (Anaes.) | \$2902.30 |
| 33172 | Aneurysm of major artery, replacement by graft, not being a service to which another item in this Sub-group applies (Assist.) (Anaes.) | \$2468.20 |
| 33175 | Ruptured aneurysm in the extremities, ligation, suture closure or excision of, without bypass grafting (Assist.) (Anaes.) | \$2281.70 |
| 33178 | Ruptured aneurysm in the neck, ligation, suture closure or excision of, without bypass grafting (Assist.) (Anaes.) | \$2905.20 |
| 33181 | Ruptured intra-abdominal or pelvic aneurysm, ligation, suture closure or excision of, without bypass grafting (Assist.) (Anaes.) | \$3551.90 |
| 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) (Assist.) (Anaes.) | \$2174.30 |
| 33506 | Innominate or subclavian artery, endarterectomy of, including closure by suture (Assist.) (Anaes.) | \$2249.90 |
| 33509 | Aortic endarterectomy, including closure by suture, not being a service associated with another procedure on the aorta (Assist.) (Anaes.) | \$2725.40 |
| 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 (Assist.) (Anaes.) | \$3015.50 |
| 33515 | Aorto-femoral endarterectomy (1 or both femoral arteries) or bilateral ilio-femoral endarterectomy, | \$3345.70 |

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| | including closure by suture, not being a service associated with a service to which item 33512 applies (Assist.) (Anaes.) | |
| 33518 | Iliac endarterectomy, including closure by suture, not being a service associated with another procedure on the iliac artery (Assist.) (Anaes.) | \$2446.30 |
| 33521 | Ilio-femoral endarterectomy (1 side), including closure by suture (Assist.) (Anaes.) | \$2650.20 |
| 33524 | Renal artery, endarterectomy of (Assist.) (Anaes.) | \$3149.60 |
| 33527 | Renal arteries (both), endarterectomy of (Assist.) (Anaes.) | \$3649.40 |
| 33530 | Coeliac or superior mesenteric artery, endarterectomy of (Assist.) (Anaes.) | \$3149.60 |
| 33533 | Coeliac and superior mesenteric artery, endarterectomy of (Assist.) (Anaes.) | \$3341.50 |
| 33536 | Inferior mesenteric artery, endarterectomy of, not being a service associated with a service to which another item in this Sub-group applies (Assist.) (Anaes.) | \$2383.00 |
| 33539 | Artery of extremities, endarterectomy of, including closure by suture (Assist.) (Anaes.) | \$1861.00 |
| 33542 | Extended deep femoral endarterectomy where the endarterectomy is at least 7cms long (Assist.) (Anaes.) | \$2673.50 |
| 33545 | Artery, vein or bypass graft, patch grafting to by vein or synthetic material where patch is less than 3cm long (Assist.) (Anaes.) | \$525.30 |
| 33548 | Artery, vein or bypass graft, patch grafting to by vein or synthetic material where patch is 3cm long or greater (Assist.) (Anaes.) | \$1077.90 |
| 33551 | Vein, harvesting of from leg or arm for patch when not performed through same incision as operation (Assist.) (Anaes.) | \$525.30 |
| 33554 | Endarterectomy, in conjunction with an arterial bypass operation to prepare the site for anastomosis - each site (Assist.) (Anaes.) | \$521.60 |
| 33800 | Embolus, removal of, from artery of neck (Assist.) (Anaes.) | \$2278.80 |
| 33803 | Embolectomy or thrombectomy, by abdominal approach, of an artery or bypass graft of trunk (Assist.) (Anaes.) | \$2163.90 |
| 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 (Assist.) (Anaes.) | \$1575.60 |
| 33810 | Inferior vena cava or iliac vein, closed thrombectomy by catheter via the femoral vein (Assist.) (Anaes.) | \$1091.30 |
| 33811 | Inferior vena cava or iliac vein, open removal of thrombus or tumour (Assist.) (Anaes.) | \$3388.40 |
| 33812 | Thrombus, removal of, from femoral or other similar large vein (Assist.) (Anaes.) | \$1802.60 |
| 33815 | Major artery or vein of extremity, repair of wound of, with restoration of continuity, by lateral suture (Assist.) (Anaes.) | \$1644.10 |
| 33818 | Major artery or vein of extremity, repair of wound of, with restoration of continuity, by direct anastomosis (Assist.) (Anaes.) | \$1917.00 |
| 33821 | Major artery or vein of extremity, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Assist.) (Anaes.) | \$2234.70 |
| 33824 | Major artery or vein of neck, repair of wound of, with restoration of continuity, by lateral suture (Assist.) (Anaes.) | \$2093.10 |
| 33827 | Major artery or vein of neck, repair of wound of, with restoration of continuity, by direct anastomosis (Assist.) (Anaes.) | \$2382.60 |
| 33830 | Major artery or vein of neck, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Assist.) (Anaes.) | \$3079.30 |
| 33833 | Major artery or vein of abdomen, repair of wound of, with restoration of continuity by lateral suture (Assist.) (Anaes.) | \$2574.40 |
| 33836 | Major artery or vein of abdomen, repair of wound of, with restoration of continuity by direct anastomosis (Assist.) (Anaes.) | \$3075.10 |
| 33839 | Major artery or vein of abdomen, repair of wound of, with restoration of continuity by means of interposition graft (Assist.) (Anaes.) | \$3582.20 |
| 33842 | Artery of neck, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (Assist.) (Anaes.) | \$1756.00 |
| 33845 | Laparotomy for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (Assist.) (Anaes.) | \$1239.50 |
| 33848 | Extremity, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no other procedure is performed (Assist.) (Anaes.) | \$1239.50 |
| 34100 | Major artery of neck, elective ligation or exploration of, not being a service associated with any other vascular procedure (Assist.) (Anaes.) | \$1370.30 |
| 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, | \$792.80 |

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| | 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.) | |
| 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 (Assist.) (Anaes.) | \$685.00 |
| 34109 | Temporal artery, biopsy of (Assist.) (Anaes.) | \$648.70 |
| 34112 | Arterio-venous fistula of an extremity, dissection and ligation (Assist.) (Anaes.) | \$1658.50 |
| 34115 | Arterio-venous fistula of the neck, dissection and ligation (Assist.) (Anaes.) | \$1861.00 |
| 34118 | Arterio-venous fistula of the abdomen, dissection and ligation (Assist.) (Anaes.) | \$2449.50 |
| 34121 | Arterio-venous fistula of an extremity, dissection and repair of, with restoration of continuity (Assist.) (Anaes.) | \$2143.50 |
| 34124 | Arterio-venous fistula of the neck, dissection and repair of, with restoration of continuity (Assist.) (Anaes.) | \$2143.50 |
| 34127 | Arterio-venous fistula of the abdomen, dissection and repair of, with restoration of continuity (Assist.) (Anaes.) | \$2809.10 |
| 34130 | Surgically created arterio-venous fistula of an extremity, closure of (Assist.) (Anaes.) | \$952.70 |
| 34133 | Scalenotomy (Assist.) (Anaes.) | \$1079.50 |
| 34136 | First rib, resection of portion of (Assist.) (Anaes.) | \$1750.00 |
| 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 (Assist.) (Anaes.) | \$1727.10 |
| 34142 | Coeliac artery, decompression of, for coeliac artery compression syndrome, as an independent procedure (Assist.) (Anaes.) | \$2331.00 |
| 34145 | Popliteal artery, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (Assist.) (Anaes.) | \$1581.60 |
| 34148 | Carotid associated tumour, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is 4cm or less in maximum diameter (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$3786.00 |
| 34154 | Recurrent carotid associated tumour, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Assist.) (Anaes.) | \$4534.40 |
| 34157 | Neck, excision of infected bypass graft, including closure of vessel or vessels (Assist.) (Anaes.) | \$2103.60 |
| 34160 | Aorto-duodenal fistula, repair of, by suture of aorta and repair of duodenum (Assist.) (Anaes.) | \$3940.70 |
| 34163 | Aorto-duodenal fistula, repair of, by insertion of aortic graft and repair of duodenum (Assist.) (Anaes.) | \$5059.00 |
| 34166 | Aorto-duodenal fistula, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo bifemoral grafting (Assist.) (Anaes.) | \$5587.00 |
| 34169 | Infected bypass graft from trunk, excision of, including closure of arteries (Assist.) (Anaes.) | \$3075.10 |
| 34172 | Infected axillo-femoral or femoro-femoral graft, excision of, including closure of arteries (Assist.) (Anaes.) | \$2506.10 |
| 34175 | Infected bypass graft from extremities, excision of including closure of arteries (Assist.) (Anaes.) | \$2302.20 |
| 34500 | Arteriovenous shunt, external, insertion of (Assist.) (Anaes.) | \$545.80 |
| 34503 | Arteriovenous anastomosis of upper or lower limb, in conjunction with another venous or arterial operation (Assist.) (Anaes.) | \$794.60 |
| 34506 | Arteriovenous shunt, external, removal of (Assist.) (Anaes.) | \$403.70 |
| 34509 | Arteriovenous anastomosis of upper or lower limb, not in conjunction with another venous or arterial operation (Assist.) (Anaes.) | \$1885.80 |
| 34512 | Arteriovenous access device, insertion of (Assist.) (Anaes.) | \$2082.20 |
| 34515 | Arteriovenous access device, thrombectomy of (Assist.) (Anaes.) | \$1483.80 |
| 34518 | Stenosis of arteriovenous fistula or prosthetic arteriovenous access device, correction of (Assist.) (Anaes.) | \$2491.50 |
| 34521 | Intra-abdominal artery or vein, cannulation of, for infusion chemotherapy, by open operation (excluding aftercare) (Assist.) (Anaes.) | \$1108.90 |
| 34524 | Arterial cannulation for infusion chemotherapy by open operation, not being a service to which item 34521 applies (excluding after-care) (Assist.) (Anaes.) | \$800.80 |
| 34527 | Central vein catheterisation by open technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterization, on a person 10 years of age or over (Anaes.) | \$966.70 |
| 34528 | Central vein catheterisation by percutaneous technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, on a person 10 years of age or over (Anaes.) | \$528.40 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 34529 | Central vein catheterisation by open technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterization, on a person under 10 years of age (Anaes.) | \$1141.00 |
| 34530 | Central venous line, or other chemotherapy device, removal of, by open surgical procedure in the operating theatre of a hospital on a person 10 years of age or over (Anaes.) | \$370.00 |
| 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) (Assist.) (Anaes.) | \$2389.90 |
| 34534 | Central vein catheterisation by percutaneous technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, on a person under 10 years of age (Anaes.) | \$563.50 |
| 34538 | Central vein catheterisation by percutaneous technique, using subcutaneous tunnelled cuffed catheter or similar device, for the administration of haemodialysis parenteral or nutrition (Anaes.) | \$503.70 |
| 34539 | Tunnelled cuffed catheter, or similar device, removal of, by open surgical procedure (Anaes.) | \$377.90 |
| 34540 | Central venous line, or other chemotherapy device, removal of, by open surgical procedure in the operating theatre of a hospital, on a person under 10 years of age (Anaes.) | \$422.50 |
| 34800 | Inferior vena cava, plication, ligation, or application of caval clip (Assist.) (Anaes.) | \$1827.60 |
| 34803 | Inferior vena cava, reconstruction of or bypass by vein or synthetic material (Assist.) (Anaes.) | \$3563.50 |
| 34806 | Cross leg bypass grafting, saphenous to iliac or femoral vein (Assist.) (Anaes.) | \$1717.50 |
| 34809 | Saphenous vein anastomosis to femoral or popliteal vein for femoral vein bypass (Assist.) (Anaes.) | \$1717.50 |
| 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 (Assist.) (Anaes.) | \$2294.80 |
| 34815 | Vein stenosis, patch angioplasty for, (excluding vein graft stenosis) - using vein or synthetic material (Assist.) (Anaes.) | \$1861.00 |
| 34818 | Venous valve, plication or repair to restore valve competency (Assist.) (Anaes.) | \$2067.80 |
| 34821 | Vein transplant to restore valvular function (Assist.) (Anaes.) | \$2569.50 |
| 34824 | External stent, application of, to restore venous valve competency to superficial vein - 1 stent (Assist.) (Anaes.) | \$1175.00 |
| 34827 | External stents, application of, to restore venous valve competency to superficial vein or veins - more than 1 stent (Assist.) (Anaes.) | \$1288.40 |
| 34830 | External stent, application of, to restore venous valve competency to deep vein (1 stent) (Assist.) (Anaes.) | \$1251.60 |
| 34833 | External stents, application of, to restore venous valve competency to deep vein or veins (more than 1 stent) (Assist.) (Anaes.) | \$1624.10 |
| 35000 | Lumbar sympathectomy (Assist.) (Anaes.) | \$1370.30 |
| 35003 | Cervical or upper thoracic sympathectomy by any surgical approach (Assist.) (Anaes.) | \$1943.90 |
| 35006 | Cervical or upper thoracic sympathectomy, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (Assist.) (Anaes.) | \$2205.50 |
| 35009 | Lumbar sympathectomy, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (Assist.) (Anaes.) | \$1714.20 |
| 35012 | Sacral or pre-sacral sympathectomy (Assist.) (Anaes.) | \$1359.50 |
| 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 (Assist.) (Anaes.) | \$708.40 |
| 35103 | Ischaemic limb, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (Anaes.) | \$448.90 |
| 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.) | \$329.30 |
| 35202 | Major arteries or veins in the neck, abdomen or extremities, access to, as part of re-operation after prior surgery on these vessels (Assist.) (Anaes.) | \$1583.20 |
| 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 (Assist.) (Anaes.) | \$988.60 |
| 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 (Assist.) (Anaes.) | \$1269.40 |
| 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.) | \$1179.60 |
| 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 (Assist.) (Anaes.) | \$2159.40 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 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.) | \$1460.80 |
| 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 (Assist.) (Anaes.) | \$1657.80 |
| 35315 | Peripheral laser angioplasty including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.) | \$1701.70 |
| 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) (Assist.) (Anaes.) | \$682.20 |
| 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) (Assist.) (Anaes.) | \$1230.50 |
| 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) (Assist.) (Anaes.) | \$1576.20 |
| 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 (Assist.) (Anaes.) | \$1558.90 |
| 35324 | Angioscopy not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.) | \$585.00 |
| 35327 | Angioscopy combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.) | \$723.50 |
| 35330 | Insertion of inferior vena caval filter, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.) | \$995.00 |
| 35331 | Retrieval of inferior vena caval filter, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (Anaes.) | \$1118.60 |
| 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) (Assist.) (Anaes.) | \$1466.20 |
| 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) (Assist.) (Anaes.) | \$1341.30 |
| 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) (Assist.) (Anaes.) | \$1118.60 |
| 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) (Assist.) (Anaes.) | \$918.50 |
| 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. | \$610.50 |
| 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 (Assist.) (Anaes.) | \$1432.60 |
| 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 (Assist.) (Anaes.) | \$1074.60 |
| 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 (Assist.) (Anaes.) | \$1432.60 |

| Item No. | Description | Max fee (excl GST) |
|-----------------------|---|--------------------|
| 35412 | Intracranial aneurysm, ruptured or unruptured, endovascular occlusion with detachable coils, and assisted coiling if performed, with parent artery preservation, not for use with liquid embolics only, including aftercare, including intra-operative imaging, but in association with the following pre-operative diagnostic imaging items: - either 60009 or 60010; and - either 60072, 60073, 60075, 60076, 60078 or 60079 (Assist.) (Anaes.) | \$5033.30 |
| 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.) | \$5368.10 |
| Gynaecological | | |
| 35500 | Gynaecological examination under anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.) | \$155.90 |
| 35502 | Intrauterine device, introduction of, for the control of idiopathic menorrhagia, and endometrial biopsy to exclude endometrial pathology, not being a service associated with a service to which another item in this Group applies (Anaes.) | \$154.20 |
| 35503 | Intra uterine contraceptive device, introduction of, if the service is not associated with a service to which another item in this Group applies (other than a service mentioned in item 30062) (Anaes.) | \$103.80 |
| 35506 | Intrauterine contraceptive device, removal of under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.) | \$97.90 |
| 35507 | Vulval or vaginal warts, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Anaes.) | \$336.40 |
| 35508 | Vulval or vaginal warts, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Assist.) (Anaes.) | \$492.00 |
| 35509 | Hymenectomy (Anaes.) | \$183.50 |
| 35513 | Bartholin's cyst, excision of (Anaes.) | \$429.50 |
| 35517 | Bartholin's cyst or gland, marsupialisation of (Anaes.) | \$287.90 |
| 35518 | Ovarian cyst aspiration, for cysts of at least 4cm in diameter in a premenopausal person and at least 2cm in diameter in a postmenopausal person, by abdominal or vaginal route, using interventional imaging techniques and not associated with services provided for assisted reproductive techniques (Anaes.) | \$377.00 |
| 35520 | Bartholin's abscess, incision of (Anaes.) | \$111.20 |
| 35523 | Urethra or urethral caruncle, cauterisation of (Anaes.) | \$126.00 |
| 35527 | Urethral caruncle, excision of (Anaes.) | \$308.20 |
| 35530 | Clitoris, amputation of, where medically indicated (Assist.) (Anaes.) | \$580.00 |
| 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.) | \$569.50 |
| 35536 | Vulva, wide local excision of suspected malignancy or hemivulvectomy, 1 or both procedures (Assist.) (Anaes.) | \$668.00 |
| 35539 | Colposcopically directed CO laser therapy for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 1 anatomical site (Anaes.) | \$523.50 |
| 35542 | Colposcopically directed CO laser therapy for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 2 or more anatomical sites (Assist.) (Anaes.) | \$658.00 |
| 35545 | Colposcopically directed CO laser therapy for condylomata, unsuccessfully treated by other methods (Anaes.) | \$323.60 |
| 35548 | Vulvectomy, radical, for malignancy (Assist.) (Anaes.) | \$1611.80 |
| 35551 | Pelvic lymph glands, excision of (radical) (Assist.) (Anaes.) | \$1427.00 |
| 35554 | Vagina, dilatation of, as an independent procedure including any associated consultation (Anaes.) | \$76.50 |
| 35557 | Vagina, removal of simple tumour (including Gartner duct cyst) (Anaes.) | \$411.60 |
| 35560 | Vagina, partial or complete removal of (Assist.) (Anaes.) | \$1314.00 |
| 35561 | Vaginectomy, radical, for proven invasive malignancy - 1 surgeon (Assist.) (Anaes.) | \$2646.40 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 35562 | Vaginectomy, radical, for proven invasive malignancy, conjoint surgery - abdominal surgeon (including aftercare) (Assist.) (Anaes.) | \$1995.00 |
| 35564 | Vaginectomy, radical, for proven invasive malignancy, conjoint surgery - perineal surgeon (Assist.) | \$1225.00 |
| 35565 | Vaginal reconstruction for congenital absence, gynatresia or urogenital sinus (Assist.) (Anaes.) | \$1531.00 |
| 35566 | Vaginal septum, excision of, for correction of double vagina (Assist.) (Anaes.) | \$769.40 |
| 35568 | Sacrospinous colpopexy for management of upper vaginal prolapse (Assist.) (Anaes.) | \$1200.20 |
| 35569 | Plastic repair to enlarge vaginal orifice (Anaes.) | \$311.50 |
| 35570 | Anterior vaginal compartment repair by vaginal approach for pelvic organ prolapse (involving repair of urethrocele and cystocele), using native tissue without graft, other than a service associated with a service to which item 35573, 35577 or 35578 applies. (Anaes.) (Assist.) | \$1063.80 |
| 35571 | Posterior vaginal compartment repair by vaginal approach for pelvic organ prolapse involving repair of one or more of the following: (a) perineum; (b) rectocele; (c) enterocele; using native tissue without graft, other than a service associated with a service to which item 35573, 35577 or 35578 applies. (Anaes.) (Assist.) | \$1060.60 |
| 35572 | Colpotomy, not being a service to which another item in this Group applies (Anaes.) | \$237.10 |
| 35573 | Anterior and posterior vaginal compartment repair by vaginal approach for pelvic organ prolapse (involving anterior and posterior compartment defects), using native tissue without graft, other than a service associated with a service to which item 35577 or 35578 applies. (Anaes.) (Assist.) | \$1606.00 |
| 35577 | Manchester (Donald Fothergill) operation for pelvic organ prolapse (includes cervical amputation, anterior and posterior native tissue vaginal wall repairs without graft). (Anaes.) (Assist.) | \$1300.60 |
| 35578 | Le fort operation for genital prolapse, not being a service associated with a service to which another item in this Subgroup applies (Assist.) (Anaes.) | \$1308.90 |
| 35595 | Laparoscopic or abdominal pelvic floor repair incorporating the fixation of the uterosacral and cardinal ligaments to rectovaginal and pubocervical fascia for symptomatic upper vaginal vault prolapse (Assist.) (Anaes.) | \$2223.90 |
| 35596 | Fistula between genital and urinary or alimentary tracts, repair of, not being a service to which item 37029, 37333 or 37336 applies (Assist.) (Anaes.) | \$1314.70 |
| 35597 | Sacral colpopexy, laparoscopic or open procedure where graft or mesh secured to vault, anterior and posterior compartment and to sacrum for correction of symptomatic upper vaginal vault prolapse (Assist.) (Anaes.) | \$2938.60 |
| 35599 | Stress incontinence, sling operation for with or without mesh or tape, not being a service associated with a service to which item 30405 applies (Assist.) (Anaes.) | \$1298.80 |
| 35602 | Stress incontinence, combined synchronous abdominovaginal operation for; abdominal procedure, with or without mesh, (including aftercare), not being a service associated with a service to which item 30405 applies (Assist.) (Anaes.) | \$1465.00 |
| 35605 | Stress incontinence, combined synchronous abdominovaginal operation for; vagina I procedure, with or without mesh, (including aftercare), not being a service associated with a service to which item 30405 applies (Assist.) | \$702.00 |
| 35608 | Cervix, cauterisation (other than by chemical means), ionisation, diathermy or biopsy of, with or without dilatation of cervix (Anaes.) | \$123.40 |
| 35611 | Cervix, removal of polyp or polypi, with or without dilatation of cervix, not being a service associated with a service to which item 35608 applies (Anaes.) | \$122.40 |
| 35612 | Cervix, residual stump, removal of, by abdominal approach (Assist.) (Anaes.) | \$980.60 |
| 35613 | Cervix, residual stump, removal of, by vaginal approach (Assist.) (Anaes.) | \$737.30 |
| 35614 | Examination of lower tract by a hinselmanntype colposcope in a patient with a previous abnormal cervical smear screen result or a history of maternal ingestion of oestrogen or where a patient, because of suspicious signs of cancer, has been referred by another medical practitioner (anaes.) | \$122.60 |
| 35615 | Vulva, biopsy of, when performed in conjunction with a service to which item 35 614 applies | \$103.20 |
| 35616 | Endometrium, endoscopic examination of and ablation of, by microwave or thermal balloon or radiofrequency electrosurgery, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage (Anaes.) | \$871.00 |
| 35618 | Cervix, cone biopsy, amputation or repair of, other than a service to which item 35577 or 35578 applies (Anaes.) | \$450.60 |
| 35620 | Endometrial biopsy where malignancy is suspected in patients with abnormal uterine bleeding or post menopausal bleeding (Anaes.) | \$103.50 |
| 35622 | Endometrium, endoscopic ablation of, by laser or diathermy, for chronic refract ory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage, not being a service associated with a service to which item 30390 applies (Anaes.) | \$1153.60 |
| 35623 | Hysteroscopic resection of myoma, or myoma and uterine septum resection (where both are performed), followed by endometrial ablation by laser or diathermy (Anaes.) | \$1576.50 |
| 35626 | Hysteroscopy, including biopsy, performed by a specialist in the practice of his or her specialty where the patient is referred to him or her for the investigation of suspected intrauterine pathology (with or without local anaesthetic), not being a service associated with a service to which item 35627 or 35630 applies | \$160.50 |
| 35627 | Hysteroscopy with dilatation of the cervix performed in the operating theatre of a hospital - not being a service associated with a service to which item 356 26 or 35630 applies (Anaes.) | \$212.80 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 35630 | Hysteroscopy, with endometrial biopsy, performed in the operating theatre of a hospital - not being a service associated with a service to which item 35626 or 35627 applies (Anaes.) | \$362.10 |
| 35633 | Hysteroscopy with uterine adhesiolysis or polypectomy or tubal catheterisation (including for insertion of device for sterilisation) or removal of iud which cannot be removed by other means, 1 or more of (Anaes.) | \$451.10 |
| 35634 | Hysteroscopic resection of uterine septum followed by endometrial ablation by laser or diathermy (Anaes.) | \$1217.30 |
| 35635 | Hysteroscopy involving resection of the uterine septum (Anaes.) | \$754.60 |
| 35636 | Hysteroscopy, involving resection of myoma, or resection of myoma and uterine septum (where both are performed) (Anaes.) | \$913.20 |
| 35637 | Laparoscopy, involving puncture of cysts, diathermy of endometriosis, ventrosus pension, and division of adhesions or similar procedure - 1 or more procedures with or without biopsy - not being a service associated with any other laparoscopic procedure or hysterectomy (Assist.) (Anaes.) | \$788.70 |
| 35638 | Complicated operative laparoscopy, including use of laser when required, for 1 or more of the following procedures; oophorectomy, ovarian cystectomy, myomectomy, salpingectomy or salpingostomy, ablation of moderate or severe endometriosis requiring more than 1 hours operating time, or division of utero-sacral ligaments for significant dysmenorrhoea - not being a service associated with any other intraperitoneal or retroperitoneal procedure except item 30393 (Assist.) (Anaes.) | \$1412.30 |
| 35640 | Uterus, curettage of, with or without dilatation (including curettage for incomplete miscarriage) under general anaesthesia, or under epidural or spinal (intrathecal) nerve block, including procedures to which item 35626, 35627 or 35630 applies, if performed (anaes.) | \$351.30 |
| 35641 | Endometriosis level 4 or 5, laparoscopic resection of, involving any two of the following procedures, resection of the pelvic side wall including dissection of endometriosis or scar tissue from the ureter, resection of the Pouch of Douglas, resection of an ovarian endometrioma greater than 2cms in diameter, dissection of bowel from uterus from the level of the endocervical junction or above: where the operating time exceeds 90 minutes (Assist.) (Anaes.) | \$2687.90 |
| 35643 | Evacuation of the contents of the gravid uterus by curettage or suction curettage other than a service to which item 35640 applies, including procedures to which item 35626, 35627 or 35630 applies, if performed (anaes.) | \$383.90 |
| 35644 | Cervix, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, other than a service associated with a service to which item 35640 or 35647 applies (Anaes.) | \$358.70 |
| 35645 | Cervix, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in association with ablative therapy of additional areas of intraepithelial change in 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35649 applies (Anaes.) | \$610.20 |
| 35646 | Cervix, colposcopy with radical diathermy of, with or without cervical biopsy, for previously confirmed intraepithelial neoplastic changes of the cervix (Anaes.) | \$391.40 |
| 35647 | Cervix, large loop excision of transformation zone together with colposcopy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35644 applies (Anaes.) | \$408.80 |
| 35648 | Cervix, large loop excision diathermy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative treatment of additional areas of intraepithelial change of 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35645 applies (Anaes.) | \$618.70 |
| 35649 | Hysterectomy or uterine myomectomy, abdominal (Assist.) (Anaes.) | \$1055.00 |
| 35653 | Hysterectomy, abdominal, sub total or total, with or without removal of uterine adnexae (Assist.) (Anaes.) | \$1291.50 |
| 35657 | Hysterectomy, vaginal, with or without uterine curettage, not being a service to which item 35673 applies. Note: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim. (Assist.) (Anaes.) | \$1307.20 |
| 35658 | Uterus (at least equivalent in size to a 10 week gravid uterus), debulking of, prior to vaginal removal at hysterectomy (Assist.) (Anaes.) | \$816.60 |
| 35661 | Hysterectomy, abdominal, requiring extensive retroperitoneal dissection with or without exposure of 1 or both ureters, for the management of severe endometriosis, pelvic inflammatory disease or benign pelvic tumours, with or without conservation of ovaries (Assist.) (Anaes.) | \$1712.40 |
| 35664 | Radical hysterectomy with radical excision of pelvic lymph glands (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Assist.) (Anaes.) | \$2812.00 |
| 35667 | Radical hysterectomy without gland dissection (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Assist.) (Anaes.) | \$2374.10 |
| 35670 | Hysterectomy, abdominal, with radical excision of pelvic lymph glands, with or without removal of uterine adnexae (Assist.) (Anaes.) | \$1970.20 |
| 35673 | Hysterectomy, vaginal, (with or without uterine curettage) with salpingectomy, oophorectomy or excision of ovarian cyst, 1 or more, 1 or both sides (Assist.) (Anaes.) | \$1454.90 |

| Item No. | Description | Max fee (excl GST) |
|-------------------|--|--------------------|
| 35674 | Ultrasound guided needling and injection of ectopic pregnancy | \$366.30 |
| 35677 | Ectopic pregnancy, removal of (Assist.) (Anaes.) | \$1032.20 |
| 35678 | Ectopic pregnancy, laparoscopic removal of (Assist.) (Anaes.) | \$1240.40 |
| 35680 | Bicornuate uterus, plastic reconstruction for (Assist.) (Anaes.) | \$1219.10 |
| 35684 | Uterus, suspension or fixation of, as an independent procedure (Assist.) (Anaes.) | \$912.20 |
| 35688 | Sterilisation by transection or resection of fallopian tubes, via abdominal or vaginal routes or via laparoscopy using diathermy or any other method note: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim. (Assist.) (Anaes.) | \$761.60 |
| 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. (Assist.) (Anaes.) | \$298.80 |
| 35694 | Tuboplasty (salpingostomy, salpingolysis or tubal implantation into uterus), unilateral or bilateral, 1 or more procedures (Assist.) (Anaes.) | \$1224.00 |
| 35697 | Microsurgical tuboplasty (salpingostomy, salpingolysis or tubal implantation in to uterus), unilateral or bilateral, 1 or more procedures (Assist.) (Anaes.) | \$1827.30 |
| 35700 | Fallopian tubes, unilateral microsurgical anastomosis of, using operating micro scope (Assist.) (Anaes.) | \$1575.00 |
| 35703 | Hydrotubation of fallopian tubes as a nonrepetitive procedure, not being a service associated with a service to which another item in this Sub-group applies (Anaes.) | \$148.00 |
| 35706 | Rubin test for patency of fallopian tubes (Anaes.) | \$141.40 |
| 35709 | Fallopian tubes, hydrotubation of, as a repetitive postoperative procedure (Anaes.) | \$84.00 |
| 35710 | Falloscopy, unilateral or bilateral, including hysteroscopy and tubal catheterization (Assist.) (Anaes.) | \$926.60 |
| 35713 | Laparotomy, involving oophorectomy, salpingectomy, salpingo-oophorectomy, removal of ovarian, paraovarian, fimbrial or broad ligament cyst - one such procedure, other than a service associated with hysterectomy (anaes.) (assist.) | \$869.40 |
| 35717 | Laparotomy, involving oophorectomy, salpingectomy, salpingo-oophorectomy, removal of ovarian, paraovarian, fimbrial or broad ligament cyst - 2 or more such procedures, unilateral or bilateral, other than a service associated with hysterectomy (anaes.) (assist.) | \$1044.50 |
| 35720 | Radical or debulking operation for advanced gynaecological malignancy, with or without omentectomy (Assist.) (Anaes.) | \$1315.00 |
| 35723 | Retroperitoneal lymph node biopsies from above the level of the aortic bifurcation, for staging or restaging of gynaecological malignancy (Assist.) (Anaes.) | \$943.50 |
| 35726 | Infracolic omentectomy with multiple peritoneal biopsies for staging or restaging of gynaecological malignancy (Assist.) (Anaes.) | \$958.30 |
| 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.) | \$334.10 |
| 35750 | Laparoscopically assisted hysterectomy, including any associated laparoscopy (Assist.) (Anaes.) | \$1553.40 |
| 35753 | Laparoscopically assisted hysterectomy with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst or treatment of moderate endometriosis, one or both sides, including any associated laparoscopy (Assist.) (Anaes.) | \$1819.90 |
| 35754 | Laparoscopically assisted hysterectomy which requires dissection of endometriosis, or other pathology, from the ureter, one or both sides, including any associated laparoscopy, including when performed with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst, or treatment of endometriosis, not being a service to which item 35641 applies (Assist.) (Anaes.) | \$2416.50 |
| 35756 | Laparoscopically assisted hysterectomy, when procedure is completed by open hysterectomy, including any associated laparoscopy (Assist.) (Anaes.) | \$1506.30 |
| 35759 | Procedure for the control of post operative haemorrhage following gynaecological surgery, under general anaesthesia, utilising a vaginal or abdominal and vaginal approach where no other procedure is performed (Assist.) (Anaes.) | \$1086.50 |
| Urological | | |
| 36502 | Pelvic lymphadenectomy, open or laparoscopic, or both, unilateral or bilateral (Assist.) (Anaes.) | \$1475.00 |
| 36503 | Renal transplant, not being a service to which item 36506 or 36509 applies (Assist.) (Anaes.) | \$2640.60 |
| 36506 | Renal transplant, performed by vascular surgeon and urologist operating together vascular anastomosis, including aftercare (Assist.) (Anaes.) | \$1757.90 |
| 36509 | Renal transplant, performed by vascular surgeon and urologist operating together ureterovesical anastomosis, including aftercare (Assist.) | \$1499.70 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 36516 | Nephrectomy, complete (Assist.) (Anaes.) | \$1773.70 |
| 36519 | Nephrectomy, complete, complicated by previous surgery on the same kidney (Assist.) (Anaes.) | \$2477.70 |
| 36522 | Nephrectomy, partial (Assist.) (Anaes.) | \$2285.00 |
| 36525 | Nephrectomy, partial, complicated by previous surgery on the same kidney (Assist.) (Anaes.) | \$3235.00 |
| 36526 | Nephrectomy, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10cms in diameter, where performed if malignancy is clinically suspected but not confirmed by histopathological examination (Assist.) (Anaes.) | \$2665.00 |
| 36527 | Nephrectomy, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour 10cms or more in diameter, or complicated by previous open or laparoscopic surgery on the same kidney, where performed if malignancy is clinically suspected but not confirmed by histopathological examination (Assist.) (Anaes.) | \$3206.30 |
| 36528 | Nephrectomy, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10 cms in diameter (Assist.) (Anaes.) | \$2665.00 |
| 36529 | Nephrectomy, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour 10 cms or more in diameter, or complicated by previous open or laparoscopic surgery on the same kidney (Assist.) (Anaes.) | \$3224.10 |
| 36531 | Nephroureterectomy, complete, including associated bladder repair and any associated endoscopic procedure (Assist.) (Anaes.) | \$2370.60 |
| 36532 | Nephro-ureterectomy, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures (Assist.) (Anaes.) | \$3348.30 |
| 36533 | Nephro-ureterectomy, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures, complicated by previous open or laparoscopic surgery on the same kidney or ureter (Assist.) (Anaes.) | \$3777.20 |
| 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 (Assist.) (Anaes.) | \$1332.10 |
| 36540 | Nephrolithotomy or pyelolithotomy, or both, through the same skin incision, for 1 or 2 stones (Assist.) (Anaes.) | \$2125.00 |
| 36543 | Nephrolithotomy or pyelolithotomy, or both, extended, for staghorn stone or 3 or more stones, including 1 or more of the following: nephrostomy, pyelostomy, pedicle control with or without freezing, calyorrhaphy or pyeloplasty (Assist.) (Anaes.) | \$2506.60 |
| 36546 | Extracorporeal shock wave lithotripsy (ESWL) to urinary tract and posttreatment care for 3 days, including pre-treatment consultations, unilateral (Anaes.) | \$1324.80 |
| 36549 | Ureterolithotomy (Assist.) (Anaes.) | \$1609.30 |
| 36552 | Nephrostomy or pyelostomy, open, as an independent procedure (Assist.) (Anaes.) | \$1408.20 |
| 36558 | Renal cyst or cysts, excision or unroofing of (Assist.) (Anaes.) | \$1335.00 |
| 36561 | Renal biopsy (closed) (Anaes.) | \$320.20 |
| 36564 | Pyeloplasty, (plastic reconstruction of the pelvi-ureteric junction) by open exposure, laparoscopy or laparoscopic assisted techniques (Assist.) (Anaes.) | \$1905.00 |
| 36567 | Pyeloplasty in a kidney that is congenitally abnormal in addition to the presence of PUJ obstruction, or in a solitary kidney, by open exposure (Assist.) (Anaes.) | \$1932.40 |
| 36570 | Pyeloplasty, complicated by previous surgery on the same kidney, by open exposure (Assist.) (Anaes.) | \$2665.00 |
| 36573 | Divided ureter, repair of (Assist.) (Anaes.) | \$1783.20 |
| 36576 | Kidney, exposure and exploration of, including repair or nephrectomy, for trauma, not being a service associated with any other procedure performed on the kidney, renal pelvis or renal pedicle (Assist.) (Anaes.) | \$2380.00 |
| 36579 | Ureterectomy, complete or partial, with or without associated bladder repair, not being a service associated with a service to which item 37000 applies (Assist.) (Anaes.) | \$1525.00 |
| 36585 | Ureter, transplantation of, into skin (Assist.) (Anaes.) | \$1312.90 |
| 36588 | Ureter, reimplantation into bladder (Assist.) (Anaes.) | \$1757.90 |
| 36591 | Ureter, reimplantation into bladder with psoas hitch or Boari flap or both (Assist.) (Anaes.) | \$2167.50 |
| 36594 | Ureter, transplantation of, into intestine (Assist.) (Anaes.) | \$1796.40 |
| 36597 | Ureter, transplantation of, into another ureter (Assist.) (Anaes.) | \$1783.30 |
| 36600 | Ureter, transplantation of, into isolated intestinal segment, unilateral (Assist.) (Anaes.) | \$2149.20 |
| 36603 | Ureters, transplantation of, into isolated intestinal segment, bilateral (Assist.) (Anaes.) | \$2473.50 |
| 36604 | Ureteric stent, passage of through percutaneous nephrostomy tube, using interventional imaging techniques (Anaes.) | \$516.00 |
| 36605 | Ureteric stent, insertion of, with removal of calculus from: (a) the pelvicalyceal system; or (b) ureter; or (c) the pelvicalyceal system and ureter; through a nephrostomy tube using interventional imaging techniques (Anaes.) | \$1222.70 |
| 36606 | Intestinal urinary reservoir, continent, formation of, including formation of non return valves and implantation of ureters (1 or both) into reservoir (Assist.) (Anaes.) | \$4496.20 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 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 imaging techniques (Anaes.) | \$1317.20 |
| 36608 | Ureteric stent, exchange of, percutaneously through either the ileal conduit or bladder, using interventional imaging techniques, not being a service associated with a service to which items 36811 to 36854 apply (Anaes.) | \$516.10 |
| 36609 | Intestinal urinary conduit or ureterostomy, revision of (Assist.) (Anaes.) | \$1434.30 |
| 36612 | Ureter, exploration of, with or without drainage of, as an independent procedure (Assist.) (Anaes.) | \$1259.50 |
| 36615 | Ureterolysis, with or without repositioning of the ureter, for obstruction of the ureter, evident either radiologically or by proximal ureteric dilatation at operation, secondary to retroperitoneal fibrosis, or similar condition (Assist.) (Anaes.) | \$1439.90 |
| 36618 | Reduction ureteroplasty (Assist.) (Anaes.) | \$1150.50 |
| 36621 | Closure of cutaneous ureterostomy (Assist.) (Anaes.) | \$838.70 |
| 36624 | Nephrostomy, percutaneous, using interventional imaging techniques (Assist.) (Anaes.) | \$1057.50 |
| 36627 | Nephroscopy, percutaneous, with or without any 1 or more of; stone extraction, biopsy or diathermy, not being a service to which item 36639, 36642, 36645 or 3 6648 applies (Anaes.) | \$1330.00 |
| 36630 | Nephroscopy, being a service to which item 36627 applies, where, after a substantial portion of the procedure has been performed, it is necessary to discontinue the operation due to bleeding (Assist.) (Anaes.) | \$650.50 |
| 36633 | Nephroscopy, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, not being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (Assist.) (Anaes.) | \$1408.20 |
| 36636 | Nephroscopy, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, being a service associated with a service to which item 36627, 36639, 36642, 3664 5 or 36648 applies (Assist.) (Anaes.) | \$820.00 |
| 36639 | Nephroscopy, percutaneous, with destruction and extraction of 1 or 2 stones using ultrasound or electrohydraulic shock waves or lasers (not being a service to which item 36645 or 36648 applies) (Anaes.) | \$1613.60 |
| 36642 | Nephroscopy, being a service to which item 36639 applies, where, after a substantial portion of the procedure has been performed, it is necessary to discontinue the operation due to bleeding (Assist.) (Anaes.) | \$798.70 |
| 36645 | Nephroscopy, percutaneous, with removal or destruction of a stone greater than 3cm in any dimension, or for 3 or more stones (Assist.) (Anaes.) | \$2053.70 |
| 36648 | Nephroscopy, being a service to which item 36645 applies, where, after a substantial portion of the procedure has been performed, it is necessary to discontinue the operation (Assist.) (Anaes.) | \$1829.00 |
| 36649 | Nephrostomy drainage tube, exchange of - but not including imaging (Assist.) (Anaes.) | \$516.00 |
| 36650 | Nephrostomy tube, removal of, if the ureter has been stented with a double jureteric stent and that stent is left in place, using interventional imaging techniques (Anaes.) | \$282.70 |
| 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 (Assist.) (Anaes.) | \$1249.40 |
| 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 (Assist.) | \$1628.30 |
| 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 (Assist.) (Anaes.) | \$2046.10 |
| 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.) | \$1264.80 |
| 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.) | \$1050.60 |
| 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 | \$222.00 |
| 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 |

| Item No. | Description | Max fee (excl GST) |
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| 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.) | \$276.90 |
| 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.) | \$276.90 |
| 36800 | Bladder, catheterisation of, where no other procedure is performed (Anaes.) | \$52.90 |
| 36803 | Ureteroscopy, of one ureter, with or without any one or more of; cystoscopy, ureteric meatotomy or ureteric dilatation, not being a service associated with a service to which item 36652, 36654, 36656, 36806, 36809, 36812, 36824, 36848 or 36857 applies (Assist.) (Anaes.) | \$893.80 |
| 36806 | Ureteroscopy, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, plus one or more of extraction of stone from the ureter, or biopsy or diathermy of the ureter, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36809, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (Assist.) (Anaes.) | \$1246.20 |
| 36809 | Ureteroscopy, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, plus destruction of stone in the ureter with ultrasound, electrohydraulic or kinetic lithotripsy, or laser, with or without extraction of fragments, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36806, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (Assist.) (Anaes.) | \$1595.60 |
| 36811 | Cystoscopy with insertion of urethral prosthesis (Anaes.) | \$621.00 |
| 36812 | Cystoscopy with urethroscopy, with or without urethral dilatation, not being a service associated with any other urological endoscopic procedure on the lower urinary tract except a service to which item 37327 applies (Anaes.) | \$319.50 |
| 36815 | Cystoscopy, with or without urethroscopy, for the treatment of penile warts or urethral warts, not being a service associated with a service to which item 301 89 applies (Anaes.) | \$456.80 |
| 36818 | Cystoscopy, with ureteric catheterisation including fluoroscopic imaging of the upper urinary tract, unilateral or bilateral, not being a service associated with a service to which item 36824 or 36830 applies (Assist.) (Anaes.) | \$529.70 |
| 36821 | Cystoscopy with 1 or more of; ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or of renal pelvis, unilateral, not being a service associated with a service to which item 36824 or 36830 applies (Assist.) (Anaes.) | \$621.20 |
| 36824 | Cystoscopy with ureteric catheterisation, unilateral or bilateral, not being a service associated with a service to which item 36818 or 36821 applies (Anaes.) | \$440.00 |
| 36825 | Cystoscopy, with endoscopic incision of pelviureteric junction or ureteric structure, including removal or replacement of ureteric stent, not being a service associated with a service to which item 36818, 36821, 36824, 36830 or 36833 applies (Assist.) (Anaes.) | \$1184.80 |
| 36827 | Cystoscopy, with controlled hydrodilatation of the bladder (Anaes.) | \$444.90 |
| 36830 | Cystoscopy, with ureteric meatotomy (Anaes.) | \$389.90 |
| 36833 | Cystoscopy with removal of ureteric stent or other foreign body (Assist.) (Anaes.) | \$536.00 |
| 36836 | Cystoscopy, with biopsy of bladder, not being a service associated with a service to which item 36812, 36830, 36840, 36845, 36848, 36854, 37203, 37206 or 3721 5 applies (Anaes.) | \$440.00 |
| 36840 | Cystoscopy, with resection, diathermy or visual laser destruction of bladder tumour or other lesion of the bladder, not being a service to which item 36845 applies (Anaes.) | \$620.70 |
| 36842 | Cystoscopy, with lavage of blood clots from bladder including any associated diathermy of prostate or bladder and not being a service associated with a service to which item 36812, 36827 to 36863, 37203 or 37206 apply (Assist.) (Anaes.) | \$628.00 |
| 36845 | Cystoscopy, with diathermy, resection or visual laser destruction of multiple tumours in more than 2 quadrants of the bladder or solitary tumour greater than 2cm in diameter (Anaes.) | \$1340.60 |
| 36848 | Cystoscopy with resection of ureterocele (Anaes.) | \$440.70 |
| 36851 | Cystoscopy, with injection into bladder wall, other than a service associated with a service to which item 18375 or 18379 applies (H) (Anaes.) | \$444.90 |
| 36854 | Cystoscopy with endoscopic incision or resection of external sphincter, bladder neck or both (Anaes.) | \$894.00 |
| 36857 | Endoscopic manipulation or extraction of ureteric calculus (Anaes.) | \$702.70 |
| 36860 | Endoscopic examination of intestinal conduit or reservoir (Anaes.) | \$323.80 |
| 36863 | Litholapaxy, with or without cystoscopy (Assist.) (Anaes.) | \$903.00 |
| 37000 | Bladder, partial excision of (Assist.) (Anaes.) | \$1509.80 |
| 37004 | Bladder, repair of rupture (Assist.) (Anaes.) | \$1234.10 |
| 37008 | Cystostomy or cystotomy, suprapubic, not being a service to which item 37011 applies and not being a service associated with other open bladder procedure (Anaes.) | \$799.00 |
| 37011 | Suprapubic stab cystotomy, not being a service associated with a service to which items 37200 to 37221 apply (Anaes.) | \$190.00 |
| 37014 | Bladder, total excision of (Assist.) (Anaes.) | \$2156.10 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 37020 | Bladder diverticulum, excision or obliteration of (Assist.) (Anaes.) | \$1422.10 |
| 37023 | Vesical fistula, cutaneous, operation for (Anaes.) | \$855.00 |
| 37026 | Cutaneous vesicostomy, establishment of (Assist.) (Anaes.) | \$737.20 |
| 37029 | Vesicovaginal fistula, closure of by abdominal approach (Assist.) (Anaes.) | \$1791.50 |
| 37038 | Vesicointestinal fistula, closure of, excluding bowel resection (Assist.) (Anaes.) | \$1327.60 |
| 37040 | Bladder stress incontinence, sling procedure for, using a non-adjustable synthetic male sling system, with or without mesh, other than a service associated with a service to which item 30405, 35599 or 37042 applies (Anaes.) (Assist.) | \$1420.20 |
| 37041 | Bladder aspiration, by needle | \$89.60 |
| 37042 | Bladder stress incontinence, sling procedure for, using autologous fascial sling, with or without mesh, including harvesting of sling, not being a service associated with a service to which item 30405 or 35599 applies (Assist.) (Anaes.) | \$1752.20 |
| 37043 | Bladder stress incontinence, Stamey or similar type needle colposuspension, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Assist.) (Anaes.) | \$1306.20 |
| 37044 | Bladder stress incontinence, suprapubic procedure for, eg Burch colposuspension, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Assist.) (Anaes.) | \$1346.50 |
| 37045 | Continent catheterisation bladder stomas (e.g. mitrofanoff), formation of (Anaes.) (Assist.) | \$2756.10 |
| 37047 | Bladder enlargement using intestine (Assist.) (Anaes.) | \$3166.20 |
| 37050 | Bladder exstrophy closure, not involving sphincter reconstruction (Assist.) (Anaes.) | \$1408.20 |
| 37053 | Bladder transection and re-anastomosis to trigone (Assist.) (Anaes.) | \$1516.70 |
| 37200 | Prostatectomy, open (Assist.) (Anaes.) | \$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, 37206, 37207, 37208, 37245, 37303, 37321 or 37324 applies (Anaes.) | \$1607.30 |
| 37202 | Prostate, transurethral radio- frequency needle ablation of, with or without cystoscopy and with or without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is prostatectomy using diathermy or cold punch) and including services to which item 36854, 37245, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203 or 37207 which had to be discontinued for medical reasons (Anaes.) | \$736.50 |
| 37203 | Prostatectomy (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37201, 37202, 37207, 37208, 37245, 37303, 37321 or 37324 applies (Anaes.) | \$2028.30 |
| 37206 | Prostatectomy (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203, 37207 or 37245 which had to be discontinued for medical reasons (Anaes.) | \$1140.00 |
| 37207 | Prostate, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which items 36854, 37201, 37202, 37203, 37206, 37245, 37321 or 37324 applies (Anaes.) | \$1775.00 |
| 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.) | \$788.30 |
| 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 (Assist.) (Anaes.) | \$2665.00 |
| 37210 | Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, not being a service associated with a service to which item 35551, 36502 or 37375 applies (Assist.) (Anaes.) | \$3275.00 |
| 37211 | Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, with pelvic lymphadenectomy, not being a service associated with a service to which item 35551, 36502 or 37375 applies (Assist.) (Anaes.) | \$3980.00 |
| 37212 | Prostate, open perineal biopsy or open drainage of abscess (Assist.) (Anaes.) | \$489.70 |
| 37215 | Prostate, biopsy of, endoscopic, with or without cystoscopy (Assist.) (Anaes.) | \$800.10 |
| 37217 | Prostate, implantation of radio-opaque fiducial markers into the prostate gland or prostate surgical bed (Anaes.) | \$240.80 |
| 37218 | Prostate, needle biopsy of, or injection into, excluding for insertion of radiopaque markers (Anaes.) | \$265.00 |
| 37219 | Prostate, transrectal needle biopsy of, using transrectal prostatic ultrasound techniques and obtaining 1 or more prostatic specimens, being a service associated with a service to which item 55600 or 55603 applies (Assist.) (Anaes.) | \$537.80 |
| 37220 | Prostate, radioactive seed implantation of, urological component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages t1 (clinically inapparent tumour not palpable or visible by imaging) or t2 (tumour confined within prostate), with a gleason score of less | \$2185.00 |

| Item No. | Description | Max fee (excl GST) |
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| | than or equal to 7 and a prostate specific antigen (psa) of less than or equal to 10ng/ml at the time of diagnosis. The procedure must be performed by a urologist at an approved site in association with a radiation oncologist, and be associated with a service to which item 55603 applies. | |
| 37221 | Prostatic abscess, endoscopic drainage of (Assist.) (Anaes.) | \$950.00 |
| 37223 | Prostatic coil, insertion of, under ultrasound control (Anaes.) | \$393.00 |
| 37224 | Prostate, diathermy or visual laser destruction of lesion of, not being a service associated with a service to which item 37201, 37202, 37203, 37206, 37207, 3 7208 or 37215 applies (Anaes.) | \$627.00 |
| 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 |
| 37230 | Prostate, high-energy transurethral microwave thermotherapy of, with or without cystoscopy and with or without urethroscopy and including services to which item 36854, 37203, 37206, 37207, 37208, 37303, 37321 or 37324 applies (Anaes.) | \$2380.00 |
| 37233 | Prostate, high-energy transurethral microwave thermotherapy of, with or without cystoscopy and with or without urethroscopy and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37203, 37207, 37201, 37230 which had to be discontinued for medical reasons (Anaes.) | \$983.00 |
| 37245 | Prostate, endoscopic enucleation of, using high powered holmiumyag laser and an end-firing, non-contact fibre, with or without tissue morcellation, cystoscopy or urethroscopy, for the treatment of benign prostatic hyperplasia, and other than a service associated with a service to which item 36854, 37201, 37202, 37203, 37206, 37207, 37208, 37303, 37321, or 37324 applies. (Anaes.) | \$2166.60 |
| 37300 | Urethral sounds, passage of, as an independent procedure (Anaes.) | \$87.40 |
| 37303 | Urethral stricture, dilatation of (Anaes.) | \$141.90 |
| 37306 | Urethra, repair of rupture of distal section (Assist.) (Anaes.) | \$1251.00 |
| 37309 | Urethra, repair of rupture of prostatic or membranous segment (Assist.) (Anaes.) | \$1783.60 |
| 37315 | Urethroscopy, as an independent procedure (Anaes.) | \$262.90 |
| 37318 | Urethroscopy, with any 1 or more of - biopsy, diathermy, visual laser destruction of stone or removal of foreign body or stone (Assist.) (Anaes.) | \$530.30 |
| 37321 | Urethral meatotomy, external (Anaes.) | \$180.10 |
| 37324 | Urethrotomy or urethrostomy, internal or external (Anaes.) | \$440.00 |
| 37327 | Urethrotomy, optical, for urethral stricture (Assist.) (Anaes.) | \$619.30 |
| 37330 | Urethrectomy, partial or complete, for removal of tumour (Assist.) (Anaes.) | \$1243.70 |
| 37333 | Urethrovaginal fistula, closure of (Assist.) (Anaes.) | \$988.00 |
| 37336 | Urethrorectal fistula, closure of (Assist.) (Anaes.) | \$1408.20 |
| 37338 | Urethral synthetic male sling system, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, other than a service associated with a service to which item 37340 or 37341 applies (Anaes.) (Assist.) | \$1420.20 |
| 37339 | Periurethral or transurethral injection of materials for the treatment of urinary incontinence, including cystoscopy and urethroscopy, other than a service associated with a service to which item 18375 or 18379 applies (Anaes.) | \$461.30 |
| 37340 | Urethral sling, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, vaginal approach, not being a service associated with a service to which item number 37341 applies (Assist.) (Anaes.) | \$820.10 |
| 37341 | Urethral sling, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, suprapubic or combined supra pubic/vaginal approach, not being a service associated with a service to which item number 37340 applies (Assist.) (Anaes.) | \$1745.00 |
| 37342 | Urethroplasty single stage operation (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$2666.00 |
| 37345 | Urethroplasty 2 stage operation first stage (Assist.) (Anaes.) | \$1430.00 |
| 37348 | Urethroplasty 2 stage operation second stage (Assist.) (Anaes.) | \$1430.00 |
| 37351 | Urethroplasty, not being a service to which another item in this Group applies (Assist.) (Anaes.) | \$536.90 |
| 37354 | Hypospadias, meatotomy and hemircumcision (Assist.) (Anaes.) | \$670.00 |
| 37369 | Urethra, excision of prolapse of (Anaes.) | \$362.40 |
| 37372 | Urethral diverticulum, excision of (Assist.) (Anaes.) | \$904.80 |
| 37375 | Urethral sphincter, reconstruction by bladder tubularisation technique or similar procedure (Assist.) (Anaes.) | \$2380.00 |
| 37381 | Artificial urinary sphincter, insertion of cuff, perineal approach (Assist.) (Anaes.) | \$1525.00 |
| 37384 | Artificial urinary sphincter, insertion of cuff, abdominal approach (Assist.) (Anaes.) | \$2380.00 |
| 37387 | Artificial urinary sphincter, insertion of pressure regulating balloon and pump (Assist.) (Anaes.) | \$665.00 |
| 37390 | Artificial urinary sphincter, revision or removal of, with or without replacement (Assist.) (Anaes.) | \$1771.40 |

| Item No. | Description | Max fee (excl GST) |
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| 37393 | Priapism, decompression by glanular stab caverno-sospongiosum shunt or penile aspiration with or without lavage (Anaes.) | \$442.40 |
| 37396 | Priapism, shunt operation for, not being a service to which item 37393 applies (Assist.) (Anaes.) | \$1312.90 |
| 37402 | Penis, partial amputation of (Assist.) (Anaes.) | \$950.00 |
| 37405 | Penis, complete or radical amputation of (Assist.) (Anaes.) | \$1905.00 |
| 37408 | Penis, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (Assist.) (Anaes.) | \$950.00 |
| 37411 | Penis, repair of avulsion (Assist.) (Anaes.) | \$1637.00 |
| 37415 | Penis, injection of, for the investigation and treatment of impotence - 2 services only in a period of 36 consecutive months | \$88.00 |
| 37417 | Penis, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting (Assist.) (Anaes.) | \$1140.00 |
| 37418 | Penis, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting, involving mobilization of the urethra (Assist.) (Anaes.) | \$1525.00 |
| 37420 | Penis, surgery to inhibit rapid penile drainage causing impotence, by ligation of veins deep to Buck's fascia including 1 or more deep cavernosal veins, with or without pharmacological erection test (Assist.) (Anaes.) | \$648.60 |
| 37423 | Penis, lengthening by translocation of corpora (Assist.) (Anaes.) | \$1905.00 |
| 37426 | Penis, artificial erection device, insertion of, into 1 or both corpora (Assist.) (Anaes.) | \$2000.00 |
| 37429 | Penis, artificial erection device, insertion of pump and pressure regulating reservoir (Assist.) (Anaes.) | \$665.00 |
| 37432 | Penis, artificial erection device, complete or partial revision or removal of components, with or without replacement (Assist.) (Anaes.) | \$1769.80 |
| 37435 | Penis, frenuloplasty as an independent procedure (Anaes.) | \$190.00 |
| 37438 | Scrotum, partial excision of (Assist.) (Anaes.) | \$533.40 |
| 37444 | Ureterolithotomy complicated by previous surgery at the same site of the same ureter (Assist.) (Anaes.) | \$1769.60 |
| 37601 | Spermatocele or epididymal cyst, excision of, 1 or more of, on 1 side (Anaes.) | \$535.90 |
| 37604 | Exploration of scrotal contents, with or without fixation and with or without biopsy, unilateral, not being a service associated with sperm harvesting for ivf (Anaes.) | \$565.00 |
| 37605 | Transcutaneous sperm retrieval, unilateral, from either the testis or the epididymis, for the purposes of intracytoplasmic sperm injection, for male factor infertility, excluding a service to which item 13218 applies. (Anaes.) | \$715.50 |
| 37606 | Open surgical sperm retrieval, unilateral, including the exploration of scrotal contents, with or 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.) | \$1062.70 |
| 37607 | Retroperitoneal lymph node dissection, unilateral, not being a service associated with a service to which item 36528 applies (Assist.) (Anaes.) | \$1778.80 |
| 37610 | Retroperitoneal lymph node dissection, unilateral, not being a service associated with a service to which item 36528 applies, following previous similar retro peritoneal dissection, retroperitoneal irradiation or chemotherapy (Assist.) (Anaes.) | \$2632.30 |
| 37613 | Epididymectomy (Anaes.) | \$570.00 |
| 37616 | Vasovasostomy or vasoepididymostomy, unilateral, using the operating microscope, not being a service associated with sperm harvesting for IVF (Assist.) (Anaes.) | \$2050.50 |
| 37619 | Vasovasostomy or vasoepididymostomy, unilateral, not being a service associated with sperm harvesting for IVF (Assist.) (Anaes.) | \$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.) | \$444.70 |
| 37800 | Patent urachus, excision of, on a person 10 years of age or over. (Anaes.) (Assist.) | \$1011.10 |
| 37801 | Patent urachus, excision of, when performed on a person under 10 years of age (Anaes.) (Assist.) | \$1078.10 |
| 37803 | Undescended testis, orchidopexy for, not being a service to which item 37806 applies, on a person 10 years of age or over. (Anaes.) (Assist.) | \$1002.60 |
| 37804 | Undescended testis, orchidopexy for, not being a service to which item 37807 applies, on a person under 10 years of age (Anaes.) (Assist.) | \$1078.10 |
| 37806 | Undescended testis in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for, on a person 10 years of age or over (Anaes.) (Assist.) | \$1148.20 |
| 37807 | Undescended testis in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for, on a person under 10 years of age (Anaes.) (Assist.) | \$1245.70 |
| 37809 | Undescended testis, revision orchidopexy for, on a person 10 years of age or over. (Anaes.) (Assist.) | \$1119.70 |
| 37810 | Undescended testis, revision orchidopexy for, on a person under 10 years of age (Anaes.) (Assist.) | \$1245.70 |

| Item No. | Description | Max fee (excl GST) |
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| 37812 | Impalpable testis, exploration of groin for, not being a service associated with a service to which items 37803, 37806 and 37809 applies, on a person 10 years of age or over. (Anaes.) (Assist.) | \$1066.20 |
| 37813 | Impalpable testis, exploration of groin for, not being a service associated with a service to which items 37804, 37807 and 37810 applies, on a person under 10 years of age (Anaes.) (Assist.) | \$1150.00 |
| 37815 | Hypospadias, examination under anaesthesia with erection test on a person 10 years of age or over. (Anaes.) | \$179.30 |
| 37816 | Hypospadias, examination under anaesthesia with erection test, on a person under 10 years of age (Anaes.) | \$191.90 |
| 37818 | Hypospadias, glanuloplasty incorporating meatal advancement, on a person 10 years of age or over (Anaes.) (Assist.) | \$883.60 |
| 37819 | Hypospadias, glanuloplasty incorporating meatal advancement, on a person under 10 years of age (Anaes.) (Assist.) | \$1016.60 |
| 37821 | Hypospadias, distal, 1 stage repair, on a person 10 years of age or over. (Anaes.) (Assist.) | \$1600.10 |
| 37822 | Hypospadias, distal, 1 stage repair, on a person under 10 years of age (Anaes.) (Assist.) | \$1723.10 |
| 37824 | Hypospadias, proximal, 1 stage repair on a person 10 years of age or over. (Anaes.) (Assist.) | \$2380.00 |
| 37825 | Hypospadias, proximal, 1 stage repair, on a person under 10 years of age (Anaes.) (Assist.) | \$2395.70 |
| 37827 | Hypospadias, staged repair, first stage, on a person 10 years of age or over. (Anaes.) (Assist.) | \$939.80 |
| 37828 | Hypospadias, staged repair, first stage, on a person under 10 years of age (Anaes.) (Assist.) | \$1103.80 |
| 37830 | Hypospadias, staged repair, second stage, on a person 10 years of age or over (Anaes.) (Assist.) | \$1217.80 |
| 37831 | Hypospadias, staged repair, second stage, on a person under 10 years of age. (Anaes.) (Assist.) | \$1430.20 |
| 37833 | Hypospadias, repair of post-operative urethral fistula, on a person 10 years of age or over. (Anaes.) (Assist.) | \$668.60 |
| 37834 | Hypospadias, repair of post-operative urethral fistula, on a person under 10 years of age (Anaes.) (Assist.) | \$682.40 |
| 37836 | Epispadias, staged repair, first stage (Assist.) (Anaes.) | \$1224.30 |
| 37839 | Epispadias, staged repair, second stage (Assist.) (Anaes.) | \$1387.30 |
| 37842 | Exstrophy of bladder or epispadias, secondary repair with bladder neck tightening, with or without ureteric reimplantation (Assist.) (Anaes.) | \$2940.90 |
| 37845 | Ambiguous genitalia with urogenital sinus, reduction clitoroplasty, with or without endoscopy (Assist.) (Anaes.) | \$1224.30 |
| 37848 | Ambiguous genitalia with urogenital sinus, reduction clitoroplasty, with endoscopy and vaginoplasty (Assist.) (Anaes.) | \$2203.40 |
| 37851 | Congenital adrenal hyperplasia, mixed gonadal dysgenesis or similar condition, vaginoplasty for, with or without endoscopy (Assist.) (Anaes.) | \$1632.30 |
| 37854 | Urethral valve, destruction of, including cystoscopy and urethroscopy (Assist.) (Anaes.) | \$706.90 |
| Cardio-thoracic | | |
| 38200 | Right heart catheterisation, with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurement by any method, shunt detection or exercise stress test (Anaes.) | \$758.50 |
| 38203 | Left heart catheterisation by percutaneous arterial puncture, arteriotomy or percutaneous left ventricular puncture with any one or more of the following fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection or exercise stress test (Anaes.) | \$973.40 |
| 38206 | Right heart catheterisation with left heart catheterisation via the right heart or by any other procedure with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection or exercise stress test (Anaes.) | \$1257.10 |
| 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.) | \$1322.00 |
| 38212 | Cardiac electrophysiological study 4 or more catheter supraventricular tachycardia investigation; or complex tachycardia inductions, or multiple catheter map ping, or acute intravenous antiarrhythmic drug testing with pre and post drug inductions; or catheter ablation to intentionally induce complete AV block; or intraoperative mapping; or electrophysiological services during defibrillator implantation or testing not being a service associated with a service to which item 38209 or 38213 applies (Anaes.) | \$2262.00 |
| 38213 | Cardiac electrophysiological study, for follow-up testing of implanted defibrillator - not being a service associated with a service to which item 38209 or 38212 applies (Anaes.) | \$791.50 |
| 38215 | Selective coronary angiography, placement of catheters and injection of opaque material into the native coronary arteries, not being a service associated with a service to which item 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) | \$681.20 |
| 38218 | Selective coronary angiography, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography, not being a service associated with a service to which item 38215, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) | \$1072.60 |
| 38220 | Selective coronary graft angiography placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service | \$340.80 |

| Item No. | Description | Max fee (excl GST) |
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| | associated with a service to which item 38215, 38218, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies | |
| 38222 | Selective coronary graft angiography, placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies | \$628.10 |
| 38225 | Selective coronary angiography, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38228, 38231, 38234, 38237, 38240 or 38246 applies | \$1029.40 |
| 38228 | Selective coronary angiography, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38231, 38234, 38237, 38240 or 38246 applies | \$1363.60 |
| 38231 | Selective coronary angiography, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into the free coronary graft(s) attached to the aorta (irrespective of the number of grafts), and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38234, 38237, 38240 or 38246 applies | \$1699.90 |
| 38234 | Selective coronary angiography, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38237, 38240 or 38246 applies | \$1363.60 |
| 38237 | Selective coronary angiography, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38240 or 38246 applies | \$1704.40 |
| 38240 | Selective coronary angiography, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts) and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237 or 38246 applies | \$2045.50 |
| 38241 | Use of a coronary pressure wire during selective coronary angiography to measure fractional flow reserve (ffr) and coronary flow reserve (cfr) in one or more intermediate coronary artery or graft lesions (stenosis of 30-70%), to determine whether revascularisation should be performed where previous stress testing has either not been performed or the results are inconclusive (Anaes.) | \$902.50 |
| 38243 | Placement of catheter(s) and injection of opaque material into any coronary vessel(s) or graft(s) prior to any coronary interventional procedure, not being a service associated with a service to which item 38246 applies | \$837.30 |
| 38246 | Selective coronary angiography, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography followed by placement of catheters prior to any coronary interventional procedure, not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38243 applies | \$1704.40 |
| 38256 | Temporary transvenous pacemaking electrode, insertion of (Anaes.) | \$461.90 |
| 38270 | Balloon valvuloplasty or isolated atrial septostomy, including cardiac catheterisations before and after balloon dilatation (Assist.) (Anaes.) | \$1741.70 |
| 38272 | Atrial septal defect closure, with septal occluder or other similar device, by transcatheter approach (Assist.) (Anaes.) | \$1722.40 |
| 38273 | Patent ductus arteriosus, transcatheter closure of, including cardiac catheterisation and any imaging associated with the service (Assist.) (Anaes.) | \$1485.00 |
| 38274 | Ventricular septal defect, transcatheter closure of, with imaging and cardiac catheterisation (Assist.) (Anaes.) | \$1485.00 |
| 38275 | Myocardial biopsy, by cardiac catheterisation (Anaes.) | \$560.70 |
| 38276 | Transcatheter occlusion of left atrial appendage, and cardiac catheterisation performed by the same practitioner, for stroke prevention in a patient who has non-valvular atrial fibrillation and a contraindication to life-long oral anticoagulation therapy, and is at increased risk of thromboembolism demonstrated by: (a) a prior stroke (whether of an ischaemic or unknown type), transient ischaemic attack or non-central nervous system systemic embolism; or (b) at least 2 of the following risk factors: (i) an age of 65 years or more; (ii) hypertension; (iii) diabetes mellitus; (iv) heart failure or left ventricular ejection fraction of 35% or less (or both); (v) vascular disease (prior myocardial infarction, peripheral artery disease or aortic plaque) (Anaes.) (Assist.) | \$1399.30 |
| 38285 | Implantable ecg loop recorder, insertion of, for diagnosis of primary disorder in patients with recurrent unexplained syncope where: - a diagnosis has not been achieved through all other available cardiac investigations; and - a neurogenic cause is not suspected; and - it has been determined that the patient | \$326.20 |

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| | does not have structural heart disease associated with a high risk of sudden cardiac death. Including initial programming and testing, as an admitted patient in an approved hospital (Anaes.) | |
| 38286 | Implantable ecg loop recorder, removal of, as an admitted patient in an approved hospital (Anaes.) | \$296.10 |
| 38287 | Ablation of arrhythmia circuit or focus or isolation procedure involving 1 atrial chamber (Assist.) (Anaes.) | \$3954.30 |
| 38290 | Ablation of arrhythmia circuits or foci, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Assist.) (Anaes.) | \$5032.70 |
| 38293 | Ventricular arrhythmia with mapping and ablation, including all associated electrophysiological studies performed on the same day (Assist.) (Anaes.) | \$5404.40 |
| 38300 | Transluminal balloon angioplasty of 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.) | \$990.90 |
| 38303 | Transluminal balloon angioplasty of more than 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.) | \$1272.70 |
| 38306 | Transluminal stent insertion including associated balloon dilatation for coronary artery, percutaneous or by open exposure, excluding associated radiological services and preparation, and excluding aftertransluminal insertion of stent or stents into 1 occlusion site, including associated balloon dilatation for coronary artery, percutaneous or by open exposure, excluding associated radiological services and preparation, and excluding aftercare care (Assist.) (Anaes.) | \$1469.10 |
| 38309 | Percutaneous transluminal rotational atherectomy of 1 coronary artery, including balloon angioplasty with no stent insertion where:- no lesion of the coronary artery has been stented; and- each lesion of the coronary artery is complex and heavily calcified; and- balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.) | \$1635.80 |
| 38312 | Percutaneous transluminal rotational atherectomy of 1 coronary artery, including balloon angioplasty with insertion of 1 or more stents, where no lesion of the coronary artery has been stented; and each lesion of the coronary artery is complex and heavily calcified; and balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.) | \$2043.40 |
| 38315 | Percutaneous transluminal rotational atherectomy of more than 1 coronary artery, including balloon angioplasty with no stent insertion where:- no lesion of the coronary arteries has been stented; and- each lesion of the coronary arteries is complex and heavily calcified; and- balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.) | \$2309.50 |
| 38318 | Percutaneous transluminal rotational atherectomy of more than 1 coronary artery, including balloon angioplasty, with insertion of 1 or more stents, where:- no lesion of the coronary arteries has been stented; and- each lesion of the coronary arteries is complex and heavily calcified; and- balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Assist.) (Anaes.) | \$2896.40 |
| 38350 | Single chamber permanent transvenous electrode, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) | \$1121.10 |
| 38353 | Permanent cardiac pacemaker, insertion, removal or replacement of, not for cardiac resynchronisation therapy, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) | \$469.30 |
| 38356 | Dual chamber permanent transvenous electrodes, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) | \$1464.70 |
| 38358 | Extraction of chronically implanted transvenous pacing or defibrillator lead or leads, by percutaneous method where the leads have been in situ for greater than six months and require removal with locking stylets, snares and/or extraction sheaths in a facility where cardiac surgery is available, in association with item 61109 or 60509 (Assist.) (Anaes.) | \$5523.90 |
| 38359 | Pericardium, paracentesis of (excluding aftercare) (Anaes.) | \$257.90 |
| 38362 | Intra-aortic balloon pump, percutaneous insertion of (Anaes.) | \$742.20 |
| 38365 | Permanent cardiac synchronisation device (including a cardiac synchronisation device that is capable of defibrillation), insertion, removal or replacement of, for a patient who: (a) has: (i) moderate to severe chronic heart failure (new york heart association (nyha) class iii or iv) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a qrs duration greater than or equal to 120 ms; or (b) satisfied the requirements mentioned in paragraph (a) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode (Anaes.) | \$584.90 |
| 38368 | Permanent transvenous left ventricular electrode, insertion, removal or replacement of through the coronary sinus, for the purpose of cardiac resynchronisation therapy, including right heart catheterisation and any associated venogram of left ventricular veins, other than a service associated with a service to which item 35200 or 38200 applies, for a patient who: (a) has: (i) moderate to severe chronic heart failure (new york heart association (nyha) class iii or iv) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a qrs duration greater than or equal to 120 ms; or (b) has: (i) mild chronic heart failure (new york heart association (nyha) class ii) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a qrs duration greater than or equal to 150 ms; or (c) satisfied the requirements mentioned in paragraph (a) or (b) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode (Anaes.) | \$2350.30 |

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| 38371 | Permanent cardiac synchronisation device capable of defibrillation, insertion, removal or replacement of, for a patient who:(a) has:(i) moderate to severe chronic heart failure (new york heart association (nyha) class iii or iv) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a qrs duration greater than or equal to 120 ms; or (b) has:(i) mild chronic heart failure (new york heart association (nyha) class ii) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and(iv) a qrs duration greater than or equal to 150 ms (Anaes.) | \$552.50 |
| 38384 | Automatic defibrillator, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for, primary prevention of sudden cardiac death in: - patients with a left ventricular ejection fraction of less than or equal to 30% at least one month after a myocardial infarct when the patient has received optimised medical therapy; or - patients with chronic heart failure associated with mild to moderate symptoms (nyha ii and iii) and a left ventricular ejection fraction less than or equal to 35% when the patient has received optimised medical therapy. Not being a service associated with a service to which item 38213 applies (Assist.) (Anaes.) | \$2025.80 |
| 38387 | Automatic defibrillator generator, insertion or replacement of for, primary prevention of sudden cardiac death in: - patients with a left ventricular ejection fraction of less than or equal to 30% at least one month after a myocardial infarct when the patient has received optimised medical therapy; or - patient s with chronic heart failure associated with mild to moderate symptoms (nyha ii and iii) and a left ventricular ejection fraction less than or equal to 35% when the patient has received optimised medical therapy. Not being a service associated with a service to which item 38213 applies, not for defibrillators cap able of cardiac resynchronisation therapy (Assist.) (Anaes.) | \$552.40 |
| 38390 | Automatic defibrillator, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for - not for patients with heart failure or as primary prevention for tachycardia arrhythmias. Not being a service associated with a service to which item 38213 applies (Assist.) (Anaes.) | \$2036.20 |
| 38393 | Automatic defibrillator generator, insertion or replacement of for - not for patients with heart failure or as primary prevention for tachycardia arrhythmias. Not being a service associated with a service to which item 38213 applies. (Assist.) (Anaes.) | \$558.90 |
| 38415 | Empyema, radical operation for, involving resection of rib (Assist.) (Anaes.) | \$765.10 |
| 38418 | Thoracotomy, exploratory, with or without biopsy (Assist.) (Anaes.) | \$1856.80 |
| 38421 | Thoracotomy, with pulmonary decortication (Assist.) (Anaes.) | \$2924.20 |
| 38424 | Thoracotomy, with pleurectomy or pleurodesis, or enucleation of hydatid cysts (Assist.) (Anaes.) | \$1841.00 |
| 38427 | Thoracoplasty (complete) - 3 or more ribs (Assist.) (Anaes.) | \$2265.90 |
| 38430 | Thoracoplasty (in stages) each stage (Assist.) (Anaes.) | \$1247.60 |
| 38436 | Thoracoscopy, with or without division of pleural adhesions, including insertion of intercostal catheter where necessary, with or without biopsy (Anaes.) | \$481.00 |
| 38438 | Pneumonectomy or lobectomy or segmentectomy not being a service associated with a service to which Item 38418 applies (Assist.) (Anaes.) | \$2935.50 |
| 38440 | Lung, wedge resection of (Assist.) (Anaes.) | \$2191.80 |
| 38441 | Radical lobectomy or pneumonectomy including resection of chest wall, diaphragm, pericardium, or formal mediastinal node dissection (Assist.) (Anaes.) | \$3480.80 |
| 38446 | Thoracotomy or sternotomy, for removal of thymus or mediastinal tumour (Assist.) (Anaes.) | \$2264.70 |
| 38447 | Pericardiectomy via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (Assist.) (Anaes.) | \$2941.10 |
| 38448 | Mediastinum, cervical exploration of, with or without biopsy (Assist.) (Anaes.) | \$773.40 |
| 38449 | Pericardiectomy via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass (Assist.) (Anaes.) | \$4100.90 |
| 38450 | Pericardium, transthoracic open surgical drainage of (Assist.) (Anaes.) | \$1675.80 |
| 38452 | Pericardium, sub-xyphoid drainage of (Assist.) (Anaes.) | \$1111.20 |
| 38453 | Tracheal excision and repair without cardiopulmonary bypass (Assist.) (Anaes.) | \$3303.10 |
| 38455 | Tracheal excision and repair of, with cardiopulmonary bypass (Assist.) (Anaes.) | \$4120.90 |
| 38456 | Intrathoracic operation on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than 1 of those organs, not being a service to which another item in this Group applies (Assist.) (Anaes.) | \$2958.40 |
| 38457 | Pectus excavatum or pectus carinatum, repair or radical correction of (Assist.) (Anaes.) | \$2770.30 |
| 38458 | Pectus excavatum, repair of, with implantation of subcutaneous prosthesis (Assist.) (Anaes.) | \$1620.00 |
| 38460 | Sternal wires or wires, removal of (Anaes.) | \$529.50 |
| 38462 | Sternotomy wound, debridement of, not involving reopening of the mediastinum (Anaes.) | \$627.00 |
| 38464 | Sternotomy wound, debridement of, involving curettage of infected bone with or without removal of wires but not involving reopening of the mediastinum (Anaes.) | \$684.70 |
| 38466 | Sternum, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring (Assist.) (Anaes.) | \$1849.00 |
| 38468 | Sternum and mediastinum, reoperation for infection of, involving muscle advancement flaps or greater omentum (Assist.) (Anaes.) | \$2852.00 |
| 38469 | Sternum and mediastinum, reoperation for infection of, involving muscle advancement flaps and greater omentum (Assist.) (Anaes.) | \$3046.60 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 38470 | Permanent myocardial electrode, insertion of, by thoracotomy or sternotomy (Assist.) (Anaes.) | \$1839.70 |
| 38473 | Permanent pacemaker electrode, insertion by open surgical approach (Assist.) (Anaes.) | \$1091.00 |
| 38475 | Valve annuloplasty without insertion of ring, not being a service associated with a service to which item 38480 or 38481 applies (Assist.) (Anaes.) | \$1599.20 |
| 38477 | Valve annuloplasty with insertion of ring not being a service to which item 384 78 applies (Assist.) (Anaes.) | \$3852.00 |
| 38478 | Valve annuloplasty with insertion of ring performed in conjunction with item 38 480 or 38481 (Assist.) (Anaes.) | \$1865.70 |
| 38480 | Valve repair, 1 leaflet (Assist.) (Anaes.) | \$3844.60 |
| 38481 | Valve repair, 2 or more leaflets (Assist.) (Anaes.) | \$4365.50 |
| 38483 | Aortic valve leaflet or leaflets, decalcification of, not being a service to which item 38475, 38477, 38480, 38481, 38488 or 38489 applies (Assist.) (Anaes.) | \$3046.60 |
| 38485 | Mitral annulus, reconstruction of, after decalcification, when performed in association with valve surgery (Assist.) | \$1568.40 |
| 38487 | Mitral valve, open valvotomy of (Assist.) (Anaes.) | \$3046.60 |
| 38488 | Valve replacement with bioprosthesis or mechanical prosthesis (Assist.) (Anaes.) | \$3663.60 |
| 38489 | Valve replacement with allograft (subcoronary or cylindrical implant), or unstented xenograft (Assist.) (Anaes.) | \$4389.10 |
| 38490 | Sub-valvular structures, reconstruction and re-implantation of, associated with mitral and tricuspid valve replacement (Assist.) (Anaes.) | \$1063.70 |
| 38493 | Operative management of acute infective endocarditis, in association with heart valve surgery (Assist.) (Anaes.) | \$3761.20 |
| 38495 | TAVI, for the treatment of symptomatic severe aortic stenosis, performed via transfemoral delivery, unless transfemoral delivery is contraindicated or not feasible, in a TAVI Hospital on a TAVI Patient by a TAVI Practitioner - includes all intraoperative diagnostic imaging that the TAVI Practitioner performs upon the TAVI Patient. (Not payable more than once per patient in a five year period.) (Anaes.) (Assist.) | \$2196.60 |
| 38496 | Artery harvesting (other than internal mammary), for coronary artery bypass (Assist.) (Anaes.) | \$1198.80 |
| 38497 | Coronary artery bypass with cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, not being a service associated with a service to which item 38498, 38500, 38501, 3 8503 or 38504 apply (Assist.) (Anaes.) | \$3924.90 |
| 38498 | Coronary artery bypass with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38500, 38501, 38503, 38504 or 38600 apply (Assist.) (Anaes.) | \$3926.20 |
| 38500 | Coronary artery bypass with cardiopulmonary bypass, using single arterial graft , with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38501, 38503 or 38504 apply (Assist.) (Anaes.) | \$4262.00 |
| 38501 | Coronary artery bypass with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand- by perfusionist is present, not being a service associated with a service to which items 38497, 38498, 38500, 38503, 38504 or 386 00 apply (Assist.) (Anaes.) | \$4264.90 |
| 38503 | Coronary artery bypass with cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38500, 38501 or 38504 apply (Assist.) (Anaes.) | \$4597.80 |
| 38504 | Coronary artery bypass with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand- by perfusionist is present, not being a service associated with a service to which items 38497, 38498, 38500, 38501, 38503 or 38600 apply (Assist.) (Anaes.) | \$4584.60 |
| 38505 | Coronary endarterectomy, by open operation, including repair with 1 or more patch grafts, each vessel (Assist.) (Anaes.) | \$554.00 |
| 38506 | Left ventricular aneurysm, plication of (Assist.) (Anaes.) | \$2879.10 |
| 38507 | Left ventricular aneurysm resection with primary repair (Assist.) (Anaes.) | \$3699.10 |
| 38508 | Left ventricular aneurysm resection with patch reconstruction of the left ventricle (Assist.) (Anaes.) | \$4505.40 |
| 38509 | Ischaemic ventricular septal rupture, repair of (Assist.) (Anaes.) | \$4557.00 |
| 38512 | Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving 1 atrial chamber only (Assist.) (Anaes.) | \$4027.00 |
| 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 (Assist.) (Anaes.) | \$5151.60 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 38518 | Ventricular arrhythmia with mapping and muscle ablation, with or without a neurysmeotomy (Assist.) (Anaes.) | \$5473.30 |
| 38550 | Ascending thoracic aorta, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Assist.) (Anaes.) | \$3893.90 |
| 38553 | Ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Assist.) (Anaes.) | \$5249.30 |
| 38556 | Ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Assist.) (Anaes.) | \$5900.20 |
| 38559 | Aortic arch and ascending thoracic aorta, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Assist.) (Anaes.) | \$4846.10 |
| 38562 | Aortic arch and ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Assist.) (Anaes.) | \$5995.40 |
| 38565 | Aortic arch and ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Assist.) (Anaes.) | \$6735.20 |
| 38568 | Descending thoracic aorta, repair or replacement of, without shunt or cardiopulmonary bypass, by open exposure, percutaneous or endovascular means (Assist.) (Anaes.) | \$3609.10 |
| 38571 | Descending thoracic aorta, repair or replacement of, using shunt or cardiopulmonary bypass (Assist.) (Anaes.) | \$3696.40 |
| 38572 | Operative management of acute rupture or dissection, in conjunction with procedures on the thoracic aorta (Assist.) (Anaes.) | \$3853.00 |
| 38577 | Cannulation for, and supervision and monitoring of, the administration of retro grade cerebral perfusion during deep hypothermic arrest (Assist.) | \$1071.50 |
| 38588 | Cannulation of the coronary sinus for, and supervision of, the retrograde administration of blood or crystalloid for cardioplegia, including pressure monitoring (Assist.) | \$867.30 |
| 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 (Assist.) (Anaes.) | \$2924.00 |
| 38603 | Peripheral cannulation for cardiopulmonary bypass excluding post-operative management (Assist.) (Anaes.) | \$1855.60 |
| 38609 | Intra-aortic balloon pump, insertion of, by arteriotomy (Assist.) (Anaes.) | \$921.60 |
| 38612 | Intra-aortic balloon pump, removal of, with closure of artery by direct suture (Assist.) (Anaes.) | \$950.70 |
| 38613 | Intra-aortic balloon pump, removal of, with closure of artery by patch graft (Assist.) (Anaes.) | \$1193.40 |
| 38615 | Insertion of a left or right ventricular assist device, for use as:(a) a bridge to cardiac transplantation in patients with refractory heart failure who are: (i) currently on a heart transplant waiting list, or (ii) expected to be suitable candidates for cardiac transplantation following a period of support on the ventricular assist device; or (b) acute post cardiectomy support for failure to wean from cardiopulmonary transplantation; or (c) cardio-respiratory support for acute cardiac failure which is likely to recover with short term support of less than 6 weeks; not being a service associated with the use of a ventricular assist device as destination therapy in the management of patients with heart failure who are not expected to be suitable candidates for cardiac transplantation (Anaes.) (Assist.) | \$2924.00 |
| 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 cardiectomy support for failure to wean from cardiopulmonary transplantation; or (c) cardio-respiratory support for acute cardiac failure which is likely to recover with short term support of less than 6 weeks; not being a service associated with the use of a ventricular assist device as destination therapy in the management of patients with heart failure who are not expected to be suitable candidates for cardiac transplantation (Anaes.) (Assist.) | \$3640.70 |
| 38621 | Left or right ventricular assist device, removal of, as an independent procedure (Assist.) (Anaes.) | \$1445.80 |
| 38624 | Left and right ventricular assist device, removal of, as an independent procedure (Assist.) (Anaes.) | \$1632.60 |
| 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 (Assist.) (Anaes.) | \$1353.60 |
| 38637 | Patent diseased coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of (Assist.) (Anaes.) | \$1059.50 |
| 38640 | Re-operation via median sternotomy, for any procedure, including any divisions of adhesions where the time taken to divide the adhesions is 45 minutes or less (Assist.) (Anaes.) | \$1835.50 |
| 38643 | Thoracotomy or sternotomy involving division of adhesions where the time taken to divide the adhesions exceeds 45 minutes (Assist.) (Anaes.) | \$2052.00 |
| 38647 | Thoracotomy or sternotomy involving division of extensive adhesions where the time taken to divide the adhesions exceeds 2 hours (Assist.) (Anaes.) | \$4173.00 |
| 38650 | Myomectomy or myotomy for hypertrophic obstructive cardiomyopathy (Assist.) (Anaes.) | \$3735.40 |
| 38653 | Open heart surgery, not being a service to which another item in this Group applies (Assist.) (Anaes.) | \$3682.20 |
| 38654 | Permanent left ventricular electrode, insertion, removal or replacement of via open thoracotomy, for the purpose of cardiac resynchronisation therapy, for a patient who:(a) has:(i) moderate to severe | \$2364.60 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| | chronic heart failure (new york heart association (nyha) class iii or iv) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a qrs duration greater than or equal to 120 ms; or(b) has:(i) mild chronic heart failure (new york heart association (nyha) class ii) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a qrs duration greater than or equal to 150 ms; or (c) satisfied the requirements mentioned in paragraph (a) or (b) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode (Assist.) (Anaes.) | |
| 38656 | Thoracotomy or median sternotomy for post-operative bleeding (Assist.) (Anaes.) | \$1841.40 |
| 38670 | Cardiac tumour, excision of, involving the wall of the atrium or inter-atrial septum, without patch or conduit reconstruction (Assist.) (Anaes.) | \$3597.10 |
| 38673 | Cardiac tumour, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit (Assist.) (Anaes.) | \$4158.20 |
| 38677 | Cardiac tumour arising from ventricular myocardium, partial thickness excision of (Assist.) (Anaes.) | \$3931.20 |
| 38680 | Cardiac tumour arising from ventricular myocardium, full thickness excision of including repair or reconstruction (Assist.) (Anaes.) | \$4663.20 |
| 38700 | Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.) | \$2041.30 |
| 38703 | Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.) | \$3674.00 |
| 38706 | Aorta, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.) | \$3473.70 |
| 38709 | Aorta, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.) | \$4074.60 |
| 38712 | Aortic interruption, repair of, for congenital heart disease (Assist.) (Anaes.) | \$4960.00 |
| 38715 | Main pulmonary artery, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.) | \$3020.70 |
| 38718 | Main pulmonary artery, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.) | \$4112.10 |
| 38721 | Vena cava, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.) | \$2924.70 |
| 38724 | Vena cava, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.) | \$4074.60 |
| 38727 | Intrathoracic vessels, anastomosis or repair of, without cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Assist.) (Anaes.) | \$2858.30 |
| 38730 | Intrathoracic vessels, anastomosis or repair of, with cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Assist.) (Anaes.) | \$4074.60 |
| 38733 | Systemic pulmonary or cavo-pulmonary shunt, creation of, without cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.) | \$2648.00 |
| 38736 | Systemic pulmonary or cavo-pulmonary shunt, creation of, with cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.) | \$3779.00 |
| 38739 | Atrial septectomy, with or without cardiopulmonary bypass, for congenital heart disease (Assist.) (Anaes.) | \$3406.50 |
| 38742 | Atrial septal defect, closure by open exposure direct suture or patch, for congenital heart disease (Assist.) (Anaes.) | \$3695.80 |
| 38745 | Intra-atrial baffle, insertion of, for congenital heart disease (Assist.) (Anaes.) | \$4091.50 |
| 38748 | Ventricular septectomy, for congenital heart disease (Assist.) (Anaes.) | \$4405.00 |
| 38751 | Ventricular septal defect, closure by direct suture or patch (Assist.) (Anaes.) | \$4116.30 |
| 38754 | Intraventricular baffle or conduit, insertion of, for congenital heart disease (Assist.) (Anaes.) | \$4730.70 |
| 38757 | Extracardiac conduit, insertion of, for congenital heart disease (Assist.) (Anaes.) | \$4405.00 |
| 38760 | Extracardiac conduit, replacement of, for congenital heart disease (Assist.) (Anaes.) | \$3779.00 |
| 38763 | Ventricular myectomy, for relief of ventricular obstruction, right or left, for congenital heart disease (Assist.) (Anaes.) | \$4101.10 |
| 38766 | Ventricular augmentation, right or left, for congenital heart disease (Assist.) (Anaes.) | \$4098.40 |
| 38800 | Thoracic cavity, aspiration of, for diagnostic purposes, not being a service associated with a service to which item 38803 applies | \$74.20 |
| 38803 | Thoracic cavity, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample | \$146.70 |
| 38806 | Intercostal drain, insertion of, not involving resection of rib (excluding aftercare) (Anaes.) | \$257.90 |

| Item No. | Description | Max fee (excl GST) |
|----------------------|---|--------------------|
| 38809 | Intercostal drain, insertion of, with pleurodesis and not involving resection of rib (excluding aftercare) (Anaes.) | \$321.70 |
| 38812 | Percutaneous needle biopsy of lung (Anaes.) | \$405.10 |
| Neurosurgical | | |
| 39000 | Lumbar puncture (Anaes.) | \$172.80 |
| 39003 | Cisternal puncture (Anaes.) | \$174.10 |
| 39006 | Ventricular puncture (not including burr-hole) (Anaes.) | \$405.00 |
| 39009 | Subdural haemorrhage, tap for, each tap (Anaes.) | \$114.90 |
| 39012 | Burr-hole, single, preparatory to ventricular puncture or for inspection purpose - not being a service to which another item applies (Anaes.) | \$456.30 |
| 39013 | Injection under image intensification with 1 or more of contrast media, local anaesthetic or corticosteroid into 1 or more zygo-apophyseal or costo- transverse joints or 1 or more primary posterior rami of spinal nerves (Anaes.) | \$211.60 |
| 39015 | Ventricular reservoir, external ventricular drain or intracranial pressure monitoring device, insertion of - including burr-hole (excluding after-care) (Assist.) (Anaes.) | \$721.00 |
| 39018 | Cerebrospinal fluid reservoir, insertion of (Assist.) (Anaes.) | \$722.90 |
| 39100 | Injection of primary branch of trigeminal nerve with alcohol, cortisone, phenol, or similar substance (Anaes.) | \$420.70 |
| 39106 | Neurectomy, intracranial, for trigeminal neuralgia (Assist.) (Anaes.) | \$2103.60 |
| 39109 | Trigeminal gangliotomy by radiofrequency, balloon or glycerol (Anaes.) | \$1022.10 |
| 39112 | Cranial nerve, intracranial decompression of, using microsurgical techniques (Assist.) (Anaes.) | \$3093.40 |
| 39115 | Percutaneous neurotomy of posterior divisions (or rami) of spinal nerves by any method, including any associated spinal, epidural or regional nerve block (pay able once only in a 30 day period) (Anaes.) | \$180.20 |
| 39118 | Percutaneous neurotomy for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Assist.) (Anaes.) | \$570.30 |
| 39121 | Percutaneous cordotomy (Assist.) (Anaes.) | \$1118.30 |
| 39124 | Cordotomy or myelotomy, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Assist.) (Anaes.) | \$3775.00 |
| 39125 | Intrathecal or epidural spinal catheter insertion or replacement of, and connection to a subcutaneous implanted infusion pump, for the management of chronic intractable pain (Assist.) (Anaes.) | \$659.40 |
| 39126 | Infusion pump, subcutaneous implantation or replacement of, and connection of the pump to an intrathecal or epidural catheter, and filling of reservoir with a therapeutic agent or agents, with or without programming the pump, for the management of chronic intractable pain (Assist.) (Anaes.) | \$701.80 |
| 39127 | Subcutaneous reservoir and spinal catheter, insertion of, for the management of chronic intractable pain (Anaes.) | \$1084.00 |
| 39128 | Infusion pump, subcutaneous implantation of, and intrathecal or epidural spinal catheter insertion of, and connection of pump to catheter, and filling of reservoir with a therapeutic agent or agents, with or without programming the pump, for the management of chronic intractable pain (Assist.) (Anaes.) | \$1265.50 |
| 39130 | Epidural lead, percutaneous placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a maximum of 4 leads (Anaes.) | \$1291.00 |
| 39131 | Electrodes, epidural or peripheral nerve, management of patient and adjustment or reprogramming of neurostimulator by a medical practitioner, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris - each day | \$233.70 |
| 39133 | Removal of subcutaneously implanted infusion pump or removal or repositioning of intrathecal or epidural spinal catheter, for the management of chronic intractable pain (Anaes.) | \$309.60 |
| 39134 | Neurostimulator or receiver, subcutaneous placement of, including placement and connection of extension wires to epidural or peripheral nerve electrodes, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris (Assist.) (Anaes.) | \$659.20 |
| 39135 | Neurostimulator or receiver, that was inserted for the management of chronic in tractable neuropathic pain or pain from refractory angina pectoris, removal of, performed in the operating theatre of a hospital (Anaes.) | \$307.10 |
| 39136 | Lead, epidural or peripheral nerve that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, removal of, performed in the operating theatre of a hospital (Anaes.) | \$309.60 |
| 39137 | Lead, epidural or peripheral nerve that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, surgical repositioning to correct displacement or unsatisfactory positioning, including intraoperative test stimulation, not being a service to which item 39130, 3 9138 or 39139 applies (Anaes.) | \$1143.20 |
| 39138 | Peripheral nerve lead, surgical placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a maximum of 4 leads (Assist.) (Anaes.) | \$1295.80 |
| 39139 | Epidural electrode for management of pain, insertion of 1 or more of by partial or total laminectomy, including implantation of pulse generator (1 or 2 stages) (Assist.) (Anaes.) | \$1961.90 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 39140 | Epidural catheter, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (Anaes.) | \$568.40 |
| 39300 | Cutaneous nerve (including digital nerve), primary repair of, using microsurgical techniques (Assist.) (Anaes.) | \$676.50 |
| 39303 | Cutaneous nerve (including digital nerve), secondary repair of, using microsurgical techniques (Assist.) (Anaes.) | \$929.90 |
| 39306 | Nerve trunk, primary repair of, using microsurgical techniques (Assist.) (Anaes.) | \$1323.90 |
| 39309 | Nerve trunk, secondary repair of, using microsurgical techniques (Assist.) (Anaes.) | \$1568.70 |
| 39312 | Nerve trunk, internal (interfascicular), neurolysis of, using microsurgical techniques (Assist.) (Anaes.) | \$815.30 |
| 39315 | Nerve trunk, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques (Assist.) (Anaes.) | \$1977.80 |
| 39318 | Cutaneous nerve (including digital nerve), nerve graft to, using microsurgical techniques (Assist.) (Anaes.) | \$1308.70 |
| 39321 | Nerve, transposition of (Assist.) (Anaes.) | \$950.10 |
| 39323 | Percutaneous neurotomy by cryotherapy or radiofrequency lesion generator, not being a service to which another item applies (Assist.) (Anaes.) | \$530.70 |
| 39324 | Neurectomy, neurotomy or removal of tumour from superficial peripheral nerve, by open operation (Assist.) (Anaes.) | \$531.60 |
| 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 (Assist.) (Anaes.) | \$946.10 |
| 39330 | Neurolysis by open operation without transposition, not being a service associated with a service to which item 39312 applies (Assist.) (Anaes.) | \$583.00 |
| 39331 | Carpal tunnel release (division of transverse carpal ligament), by any method (Anaes.) | \$602.60 |
| 39333 | Brachial plexus, exploration of, not being a service to which another item in this Group applies (Assist.) (Anaes.) | \$764.00 |
| 39500 | Vestibular nerve, section of, via posterior fossa (Assist.) (Anaes.) | \$3270.00 |
| 39503 | Facio-hypoglossal nerve or facio-accessory nerve, anastomosis of (Assist.) (Anaes.) | \$1853.80 |
| 39600 | Intracranial haemorrhage, burr-hole craniotomy for - including burr-holes (Assist.) (Anaes.) | \$917.00 |
| 39603 | Intracranial haemorrhage, osteoplastic craniotomy or extensive craniectomy and removal of haematoma (Assist.) (Anaes.) | \$2317.30 |
| 39606 | Fractured skull, depressed or comminuted, operation for (Assist.) (Anaes.) | \$1544.30 |
| 39609 | Fractured skull, compound, without dural penetration, operation for (Assist.) (Anaes.) | \$1845.30 |
| 39612 | Fractured skull, compound, depressed or complicated, with dural penetration and brain laceration, operation for (Assist.) (Anaes.) | \$2270.10 |
| 39615 | Fractured skull with rhinorrhoea or otorrhoea, repair of by cranioplasty or endoscopic approach (Anaes.) (Assist.) | \$2317.30 |
| 39640 | Tumour involving anterior cranial fossa, removal of, involving craniotomy, radical excision of the skull base, and dural repair (Assist.) (Anaes.) | \$5947.20 |
| 39642 | Tumour involving anterior cranial fossa, removal of, involving frontal craniotomy with lateral rhinotomy for clearance of paranasal sinus extension, (intracranial procedure) (Assist.) (Anaes.) | \$6532.20 |
| 39646 | Tumour involving anterior cranial fossa, removal of, involving frontal craniotomy with lateral rhinotomy and radical clearance of paranasal sinus and orbital fossa extensions, with intracranial decompression of the optic nerve, (intracranial procedure) (Assist.) (Anaes.) | \$7030.80 |
| 39650 | Tumour involving middle cranial fossa and infra-temporal fossa, removal of, craniotomy and radical or sub-total radical excision, with division and reconstruction of zygomatic arch, (intracranial procedure) (Assist.) (Anaes.) | \$6810.00 |
| 39653 | Petro-clival and clival tumour, removal of, by supra and infratentorial approaches for radical or sub-total radical excision (intracranial procedure), not being a service to which item 39654 or 39656 applies (Assist.) (Anaes.) | \$9593.90 |
| 39654 | Petro-clival and clival tumour, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure), conjoint surgery, principal surgeon (Assist.) (Anaes.) | \$6630.20 |
| 39656 | Petro-clival and clival tumour, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure), conjoint surgery, co-surgeon (Assist.) | \$6600.00 |
| 39658 | Tumour involving the clivus, radical or sub-total radical excision of, involving transoral or transmaxillary approach (Assist.) (Anaes.) | \$5873.00 |
| 39660 | Tumour or vascular lesion of cavernous sinus, radical excision of, involving craniotomy with or without intracranial carotid artery exposure (Assist.) (Anaes.) | \$5906.30 |
| 39662 | Tumour or vascular lesion of foramen magnum, radical excision of, via transcondylar or far lateral suboccipital approach (Assist.) (Anaes.) | \$5873.00 |
| 39700 | Skull tumour, benign or malignant, excision of, excluding cranioplasty (Assist.) (Anaes.) | \$1232.00 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 39703 | Intracranial tumour, cyst or other brain tissue, burr-hole and biopsy of, or drainage of, or both (Assist.) (Anaes.) | \$1100.90 |
| 39706 | Intracranial tumour, biopsy or decompression of via osteoplastic flap or biopsy and decompression of via osteoplastic flap (Assist.) (Anaes.) | \$2320.90 |
| 39709 | Craniotomy for removal of glioma, metastatic carcinoma or any other tumour in cerebrum, cerebellum or brain stem - not being a service to which another item in this Sub-group applies (Assist.) (Anaes.) | \$3088.70 |
| 39712 | Craniotomy for removal of meningioma, pinealoma, cranio-pharyngioma, intraventricular tumour or any other intracranial tumour, not being a service to which another item in this Sub-group applies (Assist.) (Anaes.) | \$5492.00 |
| 39715 | Pituitary tumour, removal of, by transcranial or transphenoidal approach (Assist.) (Anaes.) | \$3958.70 |
| 39718 | Arachnoidal cyst, craniotomy for (Assist.) (Anaes.) | \$1918.60 |
| 39721 | Craniotomy, involving osteoplastic flap, for re-opening post-operatively for haemorrhage, swelling, etc (Assist.) (Anaes.) | \$1544.30 |
| 39800 | Aneurysm, clipping or reinforcement of sac (Assist.) (Anaes.) | \$5481.70 |
| 39803 | Intracranial arteriovenous malformation, excision of (Assist.) (Anaes.) | \$5478.80 |
| 39806 | Aneurysm, or arteriovenous malformation, intracranial proximal artery clipping of (Assist.) (Anaes.) | \$2596.90 |
| 39812 | Intracranial aneurysm or arteriovenous fistula, ligation of cervical vessel or vessels (Assist.) (Anaes.) | \$1260.10 |
| 39815 | Carotid-cavernous fistula, obliteration of - combined cervical and intracranial procedure (Assist.) (Anaes.) | \$3234.90 |
| 39818 | Extracranial to intracranial bypass using superficial temporal artery (Assist.) (Anaes.) | \$3946.50 |
| 39821 | Extracranial to intracranial bypass using saphenous vein graft (Assist.) (Anaes.) | \$4164.90 |
| 39900 | Intracranial infection, drainage of, via burr-hole - including burr-hole (Assist.) (Anaes.) | \$996.30 |
| 39903 | Intracranial abscess, excision of (Assist.) (Anaes.) | \$3039.80 |
| 39906 | Osteomyelitis of skull or removal of infected bone flap, craniectomy for (Assist.) (Anaes.) | \$1544.30 |
| 40000 | Ventriculo-cisternostomy (Torkildsen's operation) (Assist.) (Anaes.) | \$1624.10 |
| 40003 | Cranial or cisternal shunt diversion, insertion of (Assist.) (Anaes.) | \$1772.00 |
| 40006 | Lumbar shunt diversion, insertion of (Assist.) (Anaes.) | \$1390.80 |
| 40009 | Cranial, cisternal or lumbar shunt, revision or removal of (Assist.) (Anaes.) | \$1008.10 |
| 40012 | Third ventriculostomy (open or endoscopic) with or without endoscopic septum pellucidotomy (Assist.) (Anaes.) | \$1977.10 |
| 40015 | Subtemporal decompression (Assist.) (Anaes.) | \$1239.00 |
| 40018 | Lumbar cerebrospinal fluid drain, insertion of (Anaes.) | \$309.60 |
| 40100 | Meningocele, excision and closure of (Assist.) (Anaes.) | \$1324.50 |
| 40103 | Myelomeningocele, excision and closure of, including skin flaps or Z plasty where performed (Assist.) (Anaes.) | \$1797.40 |
| 40106 | Arnold-Chiari malformation, decompression of (Assist.) (Anaes.) | \$2655.00 |
| 40109 | Encephalocele, excision and closure of (Assist.) (Anaes.) | \$2855.00 |
| 40112 | Tethered cord, release of, including lipomeningocele or diastematomyelia (Assist.) (Anaes.) | \$2794.20 |
| 40115 | Craniosynostosis, operation for - single suture (Assist.) (Anaes.) | \$1278.00 |
| 40118 | Craniosynostosis, operation for - more than 1 suture (Assist.) (Anaes.) | \$1690.70 |
| 40600 | Cranioplasty, reconstructive (Assist.) (Anaes.) | \$2063.70 |
| 40700 | Corpus callosum, anterior section of, for epilepsy (Assist.) (Anaes.) | \$4459.10 |
| 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.) | \$522.40 |
| 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.) | \$244.50 |
| 40703 | Corticectomy, topectomy or partial lobectomy for epilepsy (Assist.) (Anaes.) | \$2909.70 |
| 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.) | \$1034.00 |
| 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.) | \$928.40 |
| 40706 | Hemispherectomy for intractable epilepsy (Assist.) (Anaes.) | \$3794.20 |
| 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 | \$291.00 |

| Item No. | Description | Max fee (excl GST) |
|-----------------------------|---|--------------------|
| 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.) | \$522.40 |
| 40709 | Burr-hole placement of intracranial depth or surface electrodes (Assist.) (Anaes.) | \$1320.00 |
| 40712 | Intracranial electrode placement via craniotomy (Assist.) (Anaes.) | \$2680.00 |
| 40800 | Stereotactic anatomical localisation, as an independent procedure (Assist.) (Anaes.) | \$1458.10 |
| 40801 | Functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation, and lesion production in the basal ganglia, brain stem or deep white matter tracts, not being a service associated with deep brain stimulation for parkinson's disease (Assist.) (Anaes.) | \$4480.00 |
| 40803 | Intracranial stereotactic procedure by any method, not being a service to which item 40800 or 40801 applies (Assist.) (Anaes.) | \$2334.40 |
| 40850 | Deep brain stimulation (unilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes (Assist.) (Anaes.) | \$4331.70 |
| 40851 | Deep brain stimulation (bilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes (Assist.) (Anaes.) | \$10125.00 |
| 40852 | Deep brain stimulation (unilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, subcutaneous placement of neurostimulator receiver or pulse generator (Assist.) (Anaes.) | \$870.00 |
| 40854 | Deep brain stimulation (unilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, revision or removal of brain electrode (Anaes.) | \$927.20 |
| 40856 | Deep brain stimulation (unilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, removal or replacement of neurostimulator receiver or pulse generator (Anaes.) | \$655.00 |
| 40858 | Deep brain stimulation (unilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, placement, removal or replacement of extension lead (Anaes.) | \$1328.80 |
| 40860 | Deep brain stimulation (unilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, target localisation incorporating anatomical and physiological techniques, including intra-operative clinical evaluation, for the insertion of a single neurostimulation wire (Anaes.) | \$4174.10 |
| 40862 | Deep brain stimulation (unilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, electronic analysis and programming of neurostimulator pulse generator (Anaes.) | \$334.20 |
| 40903 | Neuroendoscopy, for inspection of an intraventricular lesion, with or without biopsy including burr hole (Assist.) (Anaes.) | \$1425.00 |
| 40905 | Craniotomy, performed in association with items 45767, 45776, 45782 and 45785 or the correction of craniofacial abnormalities (Anaes.) | \$1065.20 |
| Ear, nose and throat | | |
| 41500 | Ear, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.) | \$145.90 |
| 41503 | Ear, removal of foreign body in, involving incision of external auditory canal (Anaes.) | \$457.90 |
| 41506 | Aural polyp, removal of (Anaes.) | \$276.90 |
| 41509 | External auditory meatus, surgical removal of keratosis obturans from, not being a service to which another item in this Group applies (Anaes.) | \$288.30 |
| 41512 | Meatoplasty involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (Assist.) (Anaes.) | \$1131.00 |
| 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, 41560 or 41563 applies (Assist.) (Anaes.) | \$779.60 |
| 41518 | External auditory meatus, removal of exostoses in (Assist.) (Anaes.) | \$1920.00 |
| 41521 | Correction of auditory canal stenosis, including meatoplasty, with or without grafting (Assist.) (Anaes.) | \$2020.00 |
| 41524 | Reconstruction of external auditory canal, being a service associated with a service to which items 41557, 41560 and 41563 apply (Assist.) (Anaes.) | \$585.00 |
| 41527 | Myringoplasty, transcanal approach (Rosen incision) (Assist.) (Anaes.) | \$1137.90 |
| 41530 | Myringoplasty, postaural or endaural approach with or without mastoid inspection (Anaes.) | \$1850.40 |
| 41533 | Atticotomy without reconstruction of the bony defect, with or without myringoplasty (Assist.) (Anaes.) | \$2190.50 |
| 41536 | Atticotomy with reconstruction of the bony defect with or without myringoplasty (Assist.) (Anaes.) | \$2471.60 |
| 41539 | Ossicular chain reconstruction (Assist.) (Anaes.) | \$2131.00 |
| 41542 | Ossicular chain reconstruction and myringoplasty (Assist.) (Anaes.) | \$2301.60 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 41545 | Mastoidectomy (cortical) (Assist.) (Anaes.) | \$1009.70 |
| 41548 | Obliteration of the mastoid cavity (Assist.) (Anaes.) | \$1325.00 |
| 41551 | Mastoidectomy, intact wall technique, with myringoplasty (Assist.) (Anaes.) | \$3062.50 |
| 41554 | Mastoidectomy, intact wall technique, with myringoplasty and ossicular chain re construction (Assist.) (Anaes.) | \$3807.60 |
| 41557 | Mastoidectomy (radical or modified radical) (Assist.) (Anaes.) | \$2140.00 |
| 41560 | Mastoidectomy (radical or modified radical) and myringoplasty (Anaes.) | \$2317.70 |
| 41563 | Mastoidectomy (radical or modified radical), myringoplasty and ossicular chain reconstruction (Assist.) (Anaes.) | \$2960.00 |
| 41564 | Mastoidectomy (radical or modified radical), obliteration of the mastoid cavity, blind sac closure of external auditory canal and obliteration of eustachian tube (Assist.) (Anaes.) | \$3702.00 |
| 41566 | Revision of mastoidectomy (radical, modified radical or intact wall), including myringoplasty (Assist.) (Anaes.) | \$2091.30 |
| 41569 | Decompression of facial nerve in its mastoid portion (Assist.) (Anaes.) | \$2286.10 |
| 41572 | Labyrinthotomy or destruction of labyrinth (Assist.) (Anaes.) | \$1983.70 |
| 41575 | Cerebellopontine angle tumour, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach transmastoid, trans labyrinthine or retromastoid procedure (including aftercare) (Assist.) (Anaes.) | \$4706.70 |
| 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 (Assist.) (Anaes.) | \$7080.80 |
| 41578 | Cerebello pontine angle tumour, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, principal surgeon (Assist.) (Anaes.) | \$4845.00 |
| 41579 | Cerebello-pontine angle tumour, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, co- surgeon (Assist.) | \$3635.00 |
| 41581 | Tumour involving infra-temporal fossa, removal of, involving craniotomy and radical excision of (Assist.) (Anaes.) | \$5383.50 |
| 41584 | Partial temporal bone resection for removal of tumour involving mastoidectomy with or without decompression of facial nerve (Assist.) (Anaes.) | \$3817.30 |
| 41587 | Total temporal bone resection for removal of tumour (Assist.) (Anaes.) | \$5029.30 |
| 41590 | Endolymphatic sac, transmastoid decompression with or without drainage of (Assist.) (Anaes.) | \$2345.00 |
| 41593 | Translabyrinthine vestibular nerve section (Assist.) (Anaes.) | \$2755.70 |
| 41596 | Retrolabyrinthine vestibular nerve section or cochlear nerve section, or both (Assist.) (Anaes.) | \$3465.00 |
| 41599 | Internal auditory meatus, exploration by middle cranial fossa approach with cranial nerve decompression (Assist.) (Anaes.) | \$3465.00 |
| 41603 | Osseo-integration procedure - implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients: - With a permanent or long term hearing loss; and - Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and - With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted. Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.) | \$1260.00 |
| 41604 | Osseo-integration procedure - fixation of transcutaneous abutment implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients: - With a permanent or long term hearing loss; and - Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and - With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted. Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.) | \$470.00 |
| 41608 | Stapedectomy (Assist.) (Anaes.) | \$2140.00 |
| 41611 | Stapes mobilisation (Assist.) (Anaes.) | \$1353.20 |
| 41614 | Round window surgery including repair of cochleotomy (Assist.) (Anaes.) | \$2093.10 |
| 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 (Assist.) (Anaes.) | \$2095.30 |
| 41617 | Cochlear implant, insertion of, including mastoidectomy (Assist.) (Anaes.) | \$3663.90 |
| 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.) | \$2878.70 |
| 41620 | Glomus tumour, transtympanic removal of (Assist.) (Anaes.) | \$1584.20 |
| 41623 | Glomus tumour, transmastoid removal of, including mastoidectomy (Assist.) (Anaes.) | \$2166.20 |
| 41626 | Abscess or inflammation of middle ear, operation for (excluding aftercare) (Anaes.) | \$275.80 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 41629 | Middle ear, exploration of (Assist.) (Anaes.) | \$1010.90 |
| 41632 | Middle ear, insertion of tube for drainage of (including myringotomy) (Anaes.) | \$462.80 |
| 41635 | Clearance of middle ear for granuloma, cholesteatoma and polyp, 1 or more, with or without myringoplasty (Assist.) (Anaes.) | \$2216.40 |
| 41638 | Clearance of middle ear for granuloma, cholesteatoma and polyp, 1 or more, with or without myringoplasty with ossicular chain reconstruction (Assist.) (Anaes.) | \$2743.60 |
| 41641 | Perforation of tympanum, cauterisation or diathermy of (Anaes.) | \$94.70 |
| 41644 | Excision of rim of eardrum perforation, not being a service associated with myringoplasty (Anaes.) | \$273.50 |
| 41647 | Ear toilet requiring use of operating microscope and microinspection of tympanic membrane with or without general anaesthesia (Anaes.) | \$194.70 |
| 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.) | \$220.00 |
| 41653 | Examination of nasal cavity or postnasal space or nasal cavity and postnasal space, under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.) | \$164.00 |
| 41656 | Nasal haemorrhage, posterior, arrest of, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) | \$235.20 |
| 41659 | Nose, removal of foreign body in, other than by simple probing (Anaes.) | \$146.70 |
| 41662 | Nasal polyp or polypi (simple), removal of | \$163.40 |
| 41668 | Nasal polyp or polypi, removal of (Anaes.) | \$478.20 |
| 41671 | Nasal septum, septoplasty, submucous resection or closure of septal perforation (Anaes.) | \$970.00 |
| 41672 | Nasal septum, reconstruction of (Assist.) (Anaes.) | \$1245.00 |
| 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.) | \$173.80 |
| 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.) | \$222.60 |
| 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 |
| 41689 | Turbinectomy or turbinectomies, partial or total, unilateral (Anaes.) | \$265.00 |
| 41692 | Turbinates, submucous resection of, unilateral (Anaes.) | \$360.00 |
| 41698 | Maxillary antrum, proof puncture and lavage of (Anaes.) | \$62.80 |
| 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.) | \$69.80 |
| 41707 | Maxillary artery, transantral ligation of (Assist.) (Anaes.) | \$859.60 |
| 41710 | Antrostomy (radical) (Assist.) (Anaes.) | \$1062.60 |
| 41713 | Antrostomy (radical) with transantral ethmoidectomy or transantral vidian neurectomy (Assist.) (Anaes.) | \$1163.10 |
| 41716 | Antrum, intranasal operation on or removal of foreign body from (Assist.) (Anaes.) | \$569.00 |
| 41719 | Antrum, drainage of, through tooth socket (Anaes.) | \$240.00 |
| 41722 | Oroantral fistula, plastic closure of (Assist.) (Anaes.) | \$1116.70 |
| 41725 | Ethmoidal artery or arteries, transorbital ligation of (unilateral) (Assist.) (Anaes.) | \$860.90 |
| 41728 | Lateral rhinotomy with removal of tumour (Assist.) (Anaes.) | \$1730.60 |
| 41729 | Dermoid of nose, excision of, with intranasal extension (Assist.) (Anaes.) | \$1092.30 |
| 41731 | Frontonasal ethmoidectomy by external approach with or without sphenoidectomy (Assist.) (Anaes.) | \$1609.80 |
| 41734 | Radical frontoethmoidectomy with osteoplastic flap (Assist.) (Anaes.) | \$1963.70 |
| 41737 | Frontal sinus, or ethmoidal sinuses on the one side, intranasal operation on (Assist.) (Anaes.) | \$934.70 |
| 41740 | Frontal sinus, catheterisation of (Anaes.) | \$122.00 |
| 41743 | Frontal sinus, trephine of (Assist.) (Anaes.) | \$649.10 |
| 41746 | Frontal sinus, radical obliteration of (Assist.) (Anaes.) | \$1478.20 |
| 41749 | Ethmoidal sinuses, external operation on (Assist.) (Anaes.) | \$1162.20 |
| 41752 | Sphenoidal sinus, intranasal operation on (Assist.) (Anaes.) | \$571.20 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 41755 | Eustachian tube, catheterisation of (Anaes.) | \$83.40 |
| 41764 | Nasendoscopy or sinoscopy or fibre optic examination of nasopharynx and larynx, one or more of these procedures, unilateral or bilateral examination (Anaes.) | \$227.70 |
| 41767 | Nasopharyngeal angiofibroma, removal of (Assist.) (Anaes.) | \$1304.80 |
| 41770 | Pharyngeal pouch, removal of, with or without cricopharyngeal myotomy (Assist.) (Anaes.) | \$1430.00 |
| 41773 | Pharyngeal pouch, endoscopic resection of (Dohlman's operation) (Assist.) (Anaes.) | \$1149.90 |
| 41776 | Cricopharyngeal myotomy with or without inversion of pharyngeal pouch (Assist.) (Anaes.) | \$1184.80 |
| 41779 | Pharyngotomy (lateral), with or without total excision of tongue (Assist.) (Anaes.) | \$1241.50 |
| 41782 | Partial pharyngectomy via pharyngotomy (Assist.) (Anaes.) | \$1912.40 |
| 41785 | Partial pharyngectomy via pharyngotomy with partial or total glossectomy (Assist.) (Anaes.) | \$2410.00 |
| 41786 | Uvulopalatopharyngoplasty, with or without tonsillectomy, by any means (Assist.) (Anaes.) | \$1488.30 |
| 41787 | Uvulectomy and partial palatotomy with laser incision of the palate, with or without tonsillectomy, 1 or more stages, including any revision procedures within 12 months (Assist.) (Anaes.) | \$1141.00 |
| 41789 | Tonsils or tonsils and adenoids, removal of, in a person aged less than 12 years (including any examination of the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a service to which item 41764 applies (Anaes.) | \$520.70 |
| 41793 | Tonsils or tonsils and adenoids, removal of, in a person 12 years of age or over (including any examination of the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a service to which item 41764 applies (Anaes.) | \$755.00 |
| 41797 | Tonsils or tonsils and adenoids, arrest of haemorrhage requiring general anaesthesia, following removal of (Anaes.) | \$276.90 |
| 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.) | \$320.00 |
| 41804 | Lingual tonsil or lateral pharyngeal bands, removal of (Anaes.) | \$178.00 |
| 41807 | Peritonsillar abscess (quinsy), incision of (Anaes.) | \$135.80 |
| 41810 | Uvulotomy or uvulectomy (Anaes.) | \$71.00 |
| 41813 | Vallecular or pharyngeal cysts, removal of (Assist.) (Anaes.) | \$683.40 |
| 41816 | Oesophagoscopy (with rigid oesophagoscope) (Anaes.) | \$355.50 |
| 41822 | Oesophagoscopy (with rigid oesophagoscope) with biopsy (Anaes.) | \$457.30 |
| 41825 | Oesophagoscopy (with rigid oesophagoscope) with removal of foreign body (Assist.) (Anaes.) | \$683.20 |
| 41828 | Oesophageal stricture, dilatation of, without oesophagoscopy (Anaes.) | \$101.10 |
| 41831 | Oesophagus, endoscopic pneumatic dilatation of, for treatment of achalasia (Anaes.) (Assist.) | \$684.20 |
| 41832 | Oesophagus, balloon dilatation of, using interventional imaging techniques (Anaes.) | \$402.50 |
| 41834 | Laryngectomy (total) (Assist.) (Anaes.) | \$2497.30 |
| 41837 | Vertical hemilaryngectomy including tracheostomy (Assist.) (Anaes.) | \$2416.60 |
| 41840 | Supraglottic laryngectomy including tracheostomy (Assist.) (Anaes.) | \$2933.80 |
| 41843 | Laryngopharyngectomy or primary restoration of alimentary continuity after laryngopharyngectomy using stomach or bowel (Assist.) (Anaes.) | \$2573.10 |
| 41846 | Larynx, direct examination of the supraglottic, glottic and subglottic regions, not being a service associated with any other procedure on the larynx or with the administration of a general anaesthetic (Anaes.) | \$332.20 |
| 41855 | Microlaryngoscopy (Assist.) (Anaes.) | \$636.20 |
| 41858 | Microlaryngoscopy with removal of juvenile papillomata (Assist.) (Anaes.) | \$966.40 |
| 41861 | Microlaryngoscopy with removal of benign lesions of the larynx by laser surgery (Assist.) (Anaes.) | \$1235.00 |
| 41864 | Microlaryngoscopy with removal of tumour (Assist.) (Anaes.) | \$812.00 |
| 41867 | Microlaryngoscopy with arytenoidectomy (Assist.) (Anaes.) | \$1186.10 |
| 41868 | Laryngeal web, division of, using microlaryngoscopic techniques (Anaes.) | \$747.60 |
| 41870 | Injection of vocal cord by teflon, fat, collagen or gelfoam (Assist.) (Anaes.) | \$910.00 |
| 41873 | Larynx, fractured, operation for (Assist.) (Anaes.) | \$1125.00 |
| 41876 | Larynx, external operation on, or laryngofissure, with or without cordectomy (Assist.) (Anaes.) | \$1177.40 |
| 41879 | Laryngoplasty or tracheoplasty, including tracheostomy (Assist.) (Anaes.) | \$1937.10 |
| 41880 | Tracheostomy by a percutaneous technique using sequential dilatation or partial splitting method to allow insertion of a cuffed tracheostomy tube (Anaes.) | \$488.70 |
| 41881 | Tracheostomy by open exposure of the trachea, including separation of the strap muscles or division of the thyroid isthmus, where performed (Assist.) (Anaes.) | \$785.30 |
| 41884 | Cricothyrostomy by direct stab or Seldinger technique, using mini tracheostomy device (Anaes.) | \$176.50 |
| 41885 | Tracheo-oesophageal fistula, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Assist.) (Anaes.) | \$545.00 |

| Item No. | Description | Max fee (excl GST) |
|----------------------|---|--------------------|
| 41886 | Trachea, removal of foreign body in (Anaes.) | \$333.10 |
| 41889 | Bronchoscopy, as an independent procedure (Anaes.) | \$333.10 |
| 41892 | Bronchoscopy with 1 or more endobronchial biopsies or other diagnostic or therapeutic procedures (Anaes.) | \$450.30 |
| 41895 | Bronchus, removal of foreign body in (Assist.) (Anaes.) | \$701.70 |
| 41898 | Fibre optic bronchoscopy with 1 or more transbronchial lung biopsies, with or without bronchial or bronchoalveolar lavage, with or without the use of interventional imaging (Assist.) (Anaes.) | \$491.80 |
| 41901 | Endoscopic laser resection of endobronchial tumours for relief of obstruction including any associated endoscopic procedures (Assist.) (Anaes.) | \$1164.10 |
| 41904 | Bronchoscopy with dilatation of tracheal stricture (Anaes.) | \$474.40 |
| 41905 | Trachea or bronchus, dilatation of stricture and endoscopic insertion of stent (Assist.) (Anaes.) | \$817.70 |
| 41907 | Nasal septum button, insertion of (Anaes.) | \$236.40 |
| 41910 | Duct of major salivary gland, transposition of (Assist.) (Anaes.) | \$749.90 |
| 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 |
| 42506 | Eye, enucleation of, with or without sphere implant (Assist.) (Anaes.) | \$921.40 |
| 42509 | Eye, enucleation of, with insertion of integrated implant (Assist.) (Anaes.) | \$1325.00 |
| 42510 | Eye, enucleation of, with insertion of hydroxyapatite implant or similar coral line implant (Assist.) (Anaes.) | \$1480.00 |
| 42512 | Globe, evisceration of (Assist.) (Anaes.) | \$851.90 |
| 42515 | Globe, evisceration of, and insertion of intrascleral ball or cartilage (Assist.) (Anaes.) | \$1172.80 |
| 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 existing orbital implant (Assist.) (Anaes.) | \$684.70 |
| 42521 | Anophthalmic socket, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (Assist.) (Anaes.) | \$2241.30 |
| 42524 | Orbit, skin graft to, as a delayed procedure (Anaes.) | \$392.90 |
| 42527 | Contracted socket, reconstruction including mucous membrane grafting and stent mould (Assist.) (Anaes.) | \$787.70 |
| 42530 | Orbit, exploration with or without biopsy, requiring removal of bone (Assist.) (Anaes.) | \$1325.00 |
| 42533 | Orbit, exploration of, with drainage or biopsy not requiring removal of bone (Assist.) (Anaes.) | \$778.40 |
| 42536 | Orbit, exenteration of, with or without skin graft and with or without temporal is muscle transplant (Assist.) (Anaes.) | \$1602.10 |
| 42539 | Orbit, exploration of, with removal of tumour or foreign body, requiring removal of bone (Assist.) (Anaes.) | \$2672.90 |
| 42542 | Orbit, exploration of anterior aspect with removal of tumour or foreign body (Assist.) (Anaes.) | \$966.90 |
| 42543 | Orbit, exploration of retrobulbar aspect with removal of tumour or foreign body (Assist.) (Anaes.) | \$1697.80 |
| 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 (Assist.) (Anaes.) | \$2515.00 |
| 42548 | Optic nerve meninges, incision of (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$1212.80 |
| 42554 | Eye, penetrating wound or rupture of, with incarceration or prolapse of uveal tissue repair (Assist.) (Anaes.) | \$1414.50 |
| 42557 | Eye, penetrating wound or rupture of, with incarceration of lens or vitreous repair (Assist.) (Anaes.) | \$1977.00 |
| 42563 | Intraocular foreign body, removal from anterior segment (Assist.) (Anaes.) | \$1040.80 |
| 42569 | Intraocular foreign body, removal from posterior segment (Assist.) (Anaes.) | \$1977.00 |
| 42572 | Orbital abscess or cyst, drainage of (Anaes.) | \$206.70 |
| 42573 | Dermoid, periorbital, excision of, on a person 10 years of age or over (Anaes.) | \$436.20 |
| 42574 | Dermoid, orbital, excision of (Assist.) (Anaes.) | \$939.80 |
| 42575 | Tarsal cyst, extirpation of (Anaes.) | \$158.70 |
| 42576 | Dermoid, periorbital, excision of, on a person under 10 years of age (Anaes.) | \$470.50 |
| 42581 | Ectropion or entropion, tarsal cauterisation of (Anaes.) | \$216.40 |
| 42584 | Tarsorrhaphy (Assist.) (Anaes.) | \$532.30 |
| 42587 | Trichiasis (due to causes other than trachoma), treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.) | \$96.50 |
| 42590 | Canthoplasty, medial or lateral (Assist.) (Anaes.) | \$755.00 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 42593 | Lacrimal gland, excision of palpebral lobe (Anaes.) | \$362.30 |
| 42596 | Lacrimal sac, excision of, or operation on (Assist.) (Anaes.) | \$967.40 |
| 42599 | Lacrimal canalicular system, establishment of patency by closed operation using silicone tubes or similar, 1 eye (Assist.) (Anaes.) | \$1225.60 |
| 42602 | Lacrimal canalicular system, establishment of patency by open operation, 1 eye (Assist.) (Anaes.) | \$1212.50 |
| 42605 | Lacrimal canalculus, immediate repair of (Assist.) (Anaes.) | \$929.70 |
| 42608 | Lacrimal drainage by insertion of glass tube, as an independent procedure (Assist.) (Anaes.) | \$567.10 |
| 42610 | Nasolacrimal tube (unilateral), removal or replacement of, or lacrimal passages, probing for obstruction, unilateral, with or without lavage - under general anaesthesia (Anaes.) | \$187.60 |
| 42611 | Nasolacrimal tube (bilateral), removal or replacement of, or lacrimal passages, probing for obstruction, bilateral, with or without lavage - under general anaesthesia (Anaes.) | \$277.30 |
| 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) | \$92.70 |
| 42615 | Nasolacrimal tube (bilateral), removal or replacement of, or lacrimal passages, probing to establish patency of the lacrimal passage and/or site of obstruction, bilateral, including lavage, not being a service associated with a service to which item 42611 applies (excluding aftercare) | \$141.00 |
| 42617 | Punctum snip operation (Anaes.) | \$233.60 |
| 42620 | Punctum, occlusion of, by use of a plug (Anaes.) | \$121.70 |
| 42622 | Punctum, permanent occlusion of, by use of electrical cautery (Anaes.) | \$161.90 |
| 42623 | Dacryocystorhinostomy (Assist.) (Anaes.) | \$1498.40 |
| 42626 | Dacryocystorhinostomy where a previous dacryocystorhinostomy has been performed (Assist.) (Anaes.) | \$2165.90 |
| 42629 | Conjunctivorhinostomy including dacryocystorhinostomy and fashioning of conjunctival flaps (Assist.) (Anaes.) | \$1651.80 |
| 42632 | Conjunctival peritomy or repair of corneal laceration by conjunctival flap (Anaes.) | \$225.20 |
| 42635 | Corneal perforations, sealing of, with tissue adhesive (Assist.) (Anaes.) | \$577.10 |
| 42638 | Conjunctival graft over cornea (Assist.) (Anaes.) | \$724.60 |
| 42641 | Autoconjunctival transplant, or mucous membrane graft (Assist.) (Anaes.) | \$940.60 |
| 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.) | \$131.30 |
| 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.) | \$138.60 |
| 42651 | Cornea, epithelial debridement for eliminating band keratopathy (Anaes.) | \$310.20 |
| 42653 | Cornea transplantation of (Assist.) (Anaes.) | \$2715.70 |
| 42656 | Cornea, transplantation of, second and subsequent procedures (Assist.) (Anaes.) | \$3237.50 |
| 42662 | Sclera, transplantation of, full thickness, including collection of donor material (Assist.) (Anaes.) | \$1749.20 |
| 42665 | Sclera, transplantation of, superficial or lamellar, including collection of donor material (Assist.) (Anaes.) | \$1165.80 |
| 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 | \$253.10 |
| 42668 | Corneal sutures, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (Anaes.) | \$144.30 |
| 42672 | Corneal incisions, to correct corneal astigmatism of more than 1 1/2 dioptres following anterior segment surgery, including appropriate measurements and calculations, performed as an independent procedure (Assist.) (Anaes.) | \$1703.60 |
| 42673 | Additional corneal incisions, to correct corneal astigmatism of more than 1 1/2 dioptres, including appropriate measurements and calculations, performed in conjunction with other anterior segment surgery (Assist.) (Anaes.) | \$915.00 |
| 42676 | Conjunctiva, biopsy of, as an independent procedure | \$222.00 |
| 42677 | Conjunctiva, cautery of, including treatment of pannus each attendance at which treatment is given including any associated consultation (Anaes.) | \$118.00 |
| 42680 | Conjunctiva, cryotherapy to, for melanotic lesions or similar using CO2 or N2O (Anaes.) | \$610.00 |
| 42683 | Conjunctival cysts, removal of, requiring admission to hospital or approved day-hospital facility (Anaes.) | \$234.40 |
| 42686 | Pterygium, removal of (Anaes.) | \$530.60 |
| 42689 | Pinguecula, removal of, not being a service associated with the fitting of contact lenses (Anaes.) | \$229.40 |
| 42692 | Limbic tumour, removal of, excluding Pterygium (Assist.) (Anaes.) | \$530.70 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 42695 | Limbic tumour, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Assist.) (Anaes.) | \$868.50 |
| 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 (Assist.) (Anaes.) | \$1110.00 |
| 42704 | Intraocular lens, removal or repositioning of by open operation, not being a service associated with a service to which item 42701 applies (Anaes.) | \$818.20 |
| 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 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.) | \$1166.70 |
| 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.) | \$1463.50 |
| 42710 | Intraocular lens, removal of, and replacement with a lens inserted into the posterior chamber and fixated to the iris or sclera (Assist.) (Anaes.) | \$1499.70 |
| 42713 | Iris suturing, McCannell technique or similar, for fixation of intraocular lens or repair of iris defect (Assist.) (Anaes.) | \$720.90 |
| 42716 | Cataract, juvenile, removal of, including subsequent needlings (Assist.) (Anaes.) | \$2600.00 |
| 42719 | Removal of vitreous, and/or both, 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 (Assist.) (Anaes.) | \$996.30 |
| 42725 | Vitreotomy 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.) | \$2573.30 |
| 42731 | Limbal or pars plana lensectomy combined with vitrectomy, not being a service associated with items 42698, 42702, 42719, or 42725 (Assist.) (Anaes.) | \$2944.30 |
| 42734 | Capsulotomy, other than by laser, and other than a service associated with a service to which item 42725 or 42731 applies (Anaes.) (Assist.) | \$576.30 |
| 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. | \$506.50 |
| 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, 1 or more of, as an independent procedure, for a patient requiring anaesthetic services. (Anaes.) | \$506.50 |
| 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.) | \$576.30 |
| 42741 | Posterior juxtасcleral depot injection of a therapeutic substance, for the treatment of subfoveal choroidal neovascularisation due to age-related macular degeneration, 1 or more of (Anaes.) | \$595.70 |
| 42743 | Anterior chamber, irrigation of blood from, as an independent procedure (Assist.) (Anaes.) | \$1212.80 |
| 42744 | Needle revision of glaucoma filtration bleb, following glaucoma filtering procedure (Anaes.) | \$577.60 |
| 42746 | Glaucoma, filtering operation for, where conservative therapies have failed, are likely to fail, or are contraindicated (Assist.) (Anaes.) | \$1829.30 |
| 42749 | Glaucoma, filtering operation for, where previous filtering operation has been performed (Assist.) (Anaes.) | \$2299.00 |
| 42752 | Glaucoma, insertion of drainage device incorporating an extraocular reservoir for, such as a molteno device (Assist.) (Anaes.) | \$2617.10 |
| 42755 | Glaucoma, removal of drainage device incorporating an extraocular reservoir for, such as a molteno device (Anaes.) | \$319.10 |
| 42758 | Goniotomy for the treatment of primary congenital glaucoma, excluding the minimally invasive implantation of glaucoma drainage devices (Anaes.) (Assist.) | \$1356.70 |
| 42761 | Division of anterior or posterior synechiae, as an independent procedure, other than by laser (Assist.) (Anaes.) | \$996.30 |
| 42764 | Iridectomy (including excision of tumour of iris) or iridotomy, as an independent procedure, other than by laser (Assist.) (Anaes.) | \$994.80 |
| 42767 | Tumour, involving ciliary body or ciliary body and iris, excision of (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$595.00 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 42773 | Detached retina, pneumatic retinopexy for, not being a service associated with a service to which item 42776 applies (Assist.) (Anaes.) | \$1728.50 |
| 42776 | Detached retina, buckling or resection operation for (Assist.) (Anaes.) | \$2595.70 |
| 42779 | Detached retina, revision of scleral buckling operation for (Assist.) (Anaes.) | \$3015.60 |
| 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 (Assist.) (Anaes.) | \$625.50 |
| 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.) | \$616.90 |
| 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.) | \$616.90 |
| 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.) | \$616.90 |
| 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.) | \$121.10 |
| 42801 | Episcleral radioactive plaque (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, insertion of (Assist.) (Anaes.) | \$2012.00 |
| 42802 | Episcleral radioactive plaque (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, removal of (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$1038.30 |
| 42806 | Iris tumour, laser photocoagulation of (Assist.) (Anaes.) | \$680.50 |
| 42807 | Photomydriasis, laser | \$585.90 |
| 42808 | Photoiridosyneresis, laser | \$585.90 |
| 42809 | Retina, photocoagulation of, not being a service associated with photodynamic therapy with verteporfin (Assist.) (Anaes.) | \$849.20 |
| 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.) | \$869.00 |
| 42812 | Removal of scleral buckling material, from an eye having undergone previous scleral buckling surgery (Anaes.) | \$320.90 |
| 42815 | Vitreous cavity, removal of silicone oil or other liquid vitreous substitutes from, during a procedure other than that in which the vitreous substitute is inserted (Assist.) (Anaes.) | \$1182.00 |
| 42818 | Retina, cryotherapy to, as an independent procedure, or when performed in conjunction with item 42809 or 42770 (Anaes.) | \$1125.80 |
| 42821 | Ocular Transillumination, for the diagnosis and measurement of intraocular tumours (Anaes.) | \$172.90 |
| 42824 | Retrolubar injection of alcohol or other drug, as an independent procedure | \$131.40 |
| 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 (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$1689.80 |
| 42854 | Ruptured medial palpebral ligament or ruptured extraocular muscle, repair of (Assist.) (Anaes.) | \$708.20 |
| 42857 | Resuturing of wound following intraocular procedures with or without excision of prolapsed iris (Assist.) (Anaes.) | \$783.50 |
| 42860 | Eyelid (upper or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid retractors (Assist.) (Anaes.) | \$1674.20 |
| 42863 | Eyelid, recession of (Assist.) (Anaes.) | \$1489.50 |

| Item No. | Description | Max fee (excl GST) |
|-------------------------------------|---|--------------------|
| 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 (Assist.) (Anaes.) | \$1458.10 |
| 42869 | Eyelid closure in facial nerve paralysis, insertion of foreign implant for (Assist.) (Anaes.) | \$1065.20 |
| 42872 | Eyebrow, elevation of, by skin excision, to correct for a reduced field of vision caused by parietic, involuntional, 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. | \$883.40 |
| 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. | \$962.00 |
| 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. | \$155.90 |
| Operations for osteomyelitis | | |
| 43500 | Operation on phalanx (for acute osteomyelitis) (Anaes.) | \$240.80 |
| 43503 | Operation on sternum, clavicle, rib, ulna, radius, carpus, tibia, fibula, tarsus, skull, mandible or maxilla (other than alveolar margins) (for acute osteomyelitis) 1 bone (Anaes.) | \$392.90 |
| 43506 | Operation on humerus or femur (for acute osteomyelitis) 1 bone (Assist.) (Anaes.) | \$682.20 |
| 43509 | Operation on spine or pelvic bones (for acute osteomyelitis) 1 bone (Assist.) (Anaes.) | \$691.30 |
| 43512 | Operation on scapula, sternum, clavicle, rib, ulna, radius, metacarpus, carpus, phalanx, tibia, fibula, metatarsus, tarsus, mandible or maxilla (other than alveolar margins) (for chronic osteomyelitis) 1 bone or any combination of adjoining bones (Assist.) (Anaes.) | \$683.50 |
| 43515 | Operation on humerus or femur (for chronic osteomyelitis) 1 bone (Assist.) (Anaes.) | \$683.50 |
| 43518 | Operation on spine or pelvic bones (for chronic osteomyelitis) 1 bone (Assist.) (Anaes.) | \$1128.90 |
| 43521 | Operation on skull (for chronic osteomyelitis) (Assist.) (Anaes.) | \$858.80 |
| 43524 | Operation on any combination of adjoining bones, being bones referred to in item 43515, 43518 or 43521 (for chronic osteomyelitis) (Assist.) (Anaes.) | \$1116.70 |
| Paediatric | | |
| 43801 | Intestinal malrotation with or without volvulus, laparotomy for, not involving bowel resection (Assist.) (Anaes.) | \$1686.20 |
| 43804 | Intestinal malrotation with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (Assist.) (Anaes.) | \$1795.50 |
| 43805 | Umbilical, epigastric or linea alba hernia, repair of, on a person under 10 years of age (Anaes.) | \$566.90 |
| 43807 | Duodenal atresia or stenosis, duodenoduodenostomy or duodenojejunosomy for (Assist.) (Anaes.) | \$1958.70 |
| 43810 | Jejunal atresia, bowel resection and anastomosis for, with or without tapering (Assist.) (Anaes.) | \$2285.10 |
| 43813 | Meconium ileus, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intestinal perforation with or without meconium peritonitis (Assist.) (Anaes.) | \$2285.10 |
| 43816 | Ileal atresia, colonic atresia or meconium ileus not being a service associated with a service to which item 43813 applies, laparotomy for (Assist.) (Anaes.) | \$2121.80 |
| 43819 | Agangliosis coli, laparotomy for, with or without frozen section biopsies and formation of stoma (Anaes.) (Assist.) | \$1713.70 |
| 43822 | Anorectal malformation, laparotomy and colostomy for (Assist.) (Anaes.) | \$1713.70 |
| 43825 | Neonatal alimentary obstruction, laparotomy for, not being a service to which any other item in this Subgroup applies (Assist.) (Anaes.) | \$1958.70 |
| 43828 | Acute neonatal necrotising enterocolitis, laparotomy for, with resection, including any anastomoses or stoma formation (Assist.) (Anaes.) | \$2164.10 |
| 43831 | Acute neonatal necrotising enterocolitis where no definitive procedure is possible, laparotomy for (Assist.) (Anaes.) | \$1686.20 |
| 43832 | Branchial fistula, on a person under 10 years of age. Removal of, (Anaes.) (Assist.) | \$1038.90 |
| 43834 | Bowel resection for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (Assist.) (Anaes.) | \$1958.70 |
| 43835 | Strangulated, incarcerated or obstructed hernia, repair of, without bowel resection, on a person under 10 years of age (Anaes.) (Assist.) | \$1078.10 |
| 43837 | Congenital diaphragmatic hernia, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (Assist.) (Anaes.) | \$2448.10 |
| 43838 | Diaphragmatic hernia, congenital repair of, by thoracic or abdominal approach, not being a service to which any of items 31569 to 31581 apply, on a person under 10 years of age (Anaes.) (Assist.) | \$1980.10 |
| 43840 | Congenital diaphragmatic hernia, repair by thoracic or abdominal approach, diagnosed after the first day of life and before 20 days of age (Assist.) (Anaes.) | \$2121.80 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 43841 | Femoral or inguinal hernia or infantile hydrocele, repair of, not being a service to which item 30403 or 43835 applies, on a person under 10 years of age (Anaes.) (Assist.) | \$960.70 |
| 43843 | Oesophageal atresia (with or without repair of tracheo-oesophageal fistula), complete correction of, not being a service to which item 43846 applies (Assist.) (Anaes.) | \$3264.40 |
| 43846 | Oesophageal atresia (with or without repair of tracheo-oesophageal fistula), complete correction of, in infant of birth weight less than 1500 grams (Assist.) (Anaes.) | \$3509.00 |
| 43849 | Oesophageal atresia, gastrostomy for (Assist.) (Anaes.) | \$897.80 |
| 43852 | Oesophageal atresia, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (Anaes.) (Assist.) | \$2856.00 |
| 43855 | Oesophageal atresia, delayed primary anastomosis for (Assist.) (Anaes.) | \$3019.70 |
| 43858 | Oesophageal atresia, cervical oesophagostomy for (Anaes.) (Assist.) | \$1060.70 |
| 43861 | Congenital cystadenomatoid malformation or congenital lobar emphysema, thoracotomy and lung resection for (Assist.) (Anaes.) | \$2937.90 |
| 43864 | Gastroschisis, operation for (Assist.) (Anaes.) | \$2203.40 |
| 43867 | Gastroschisis or exomphalos, secondary operation for, with removal of silo (Anaes.) (Assist.) | \$1224.30 |
| 43870 | Exomphalos containing small bowel only, operation for (Assist.) (Anaes.) | \$1713.70 |
| 43873 | Exomphalos containing small bowel and other viscera, operation for (Assist.) (Anaes.) | \$2285.10 |
| 43876 | Sacrococcygeal teratoma, excision of, by posterior approach (Assist.) (Anaes.) | \$1958.70 |
| 43879 | Sacrococcygeal teratoma, excision of, by combined posterior and abdominal approach (Assist.) (Anaes.) | \$2285.10 |
| 43882 | Cloacal exstrophy, operation for (Assist.) (Anaes.) | \$2937.90 |
| 43900 | Tracheo-oesophageal fistula without atresia, division and repair of (Assist.) (Anaes.) | \$1958.70 |
| 43903 | Oesophageal atresia or corrosive oesophageal stricture, oesophageal replacement for, utilizing gastric tube, jejunum or colon (Assist.) (Anaes.) | \$3264.40 |
| 43906 | Oesophagus, resection of congenital, anastomotic or corrosive stricture and anastomosis, not being a service to which item 43903 applies (Assist.) (Anaes.) | \$2856.00 |
| 43909 | Tracheomalacia, aortopexy for (Assist.) (Anaes.) | \$2856.00 |
| 43912 | Thoracotomy and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal teratoma (Assist.) (Anaes.) | \$2698.40 |
| 43915 | Eventration, plication of diaphragm for (Anaes.) (Assist.) | \$2128.40 |
| 43930 | Hypertrophic pyloric stenosis, pyloromyotomy for (Assist.) (Anaes.) | \$784.50 |
| 43933 | Idiopathic intussusception, laparotomy and manipulative reduction of (Assist.) (Anaes.) | \$918.30 |
| 43936 | Intussusception, laparotomy and resection with anastomosis (Assist.) (Anaes.) | \$1713.70 |
| 43939 | Ventral hernia following neonatal closure of exomphalos or gastroschisis, repair of (Assist.) (Anaes.) | \$1305.90 |
| 43942 | Abdominal wall vitello intestinal remnant, excision of (Anaes.) | \$444.90 |
| 43945 | Patent vitello intestinal duct, excision of (Assist.) (Anaes.) | \$1713.70 |
| 43948 | Umbilical granuloma, excision of, under general anaesthesia (Anaes.) | \$245.10 |
| 43951 | Gastro-oesophageal reflux with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (Assist.) (Anaes.) | \$1534.70 |
| 43954 | Gastro-oesophageal reflux with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (Assist.) (Anaes.) | \$1877.10 |
| 43957 | Gastro-oesophageal reflux, laparotomy and fundoplication for, with or without hiatus hernia, in child with neurological disease, with gastrostomy (Assist.) (Anaes.) | \$2040.10 |
| 43960 | Anorectal malformation, perineal anoplasty of (Assist.) (Anaes.) | \$717.70 |
| 43963 | Anorectal malformation, posterior sagittal anorectoplasty of (Assist.) (Anaes.) | \$2856.00 |
| 43966 | Anorectal malformation, posterior sagittal anorectoplasty of, with laparotomy (Assist.) (Anaes.) | \$3264.40 |
| 43969 | Persistent cloaca, total correction of, with genital repair using posterior sagittal approach, with or without laparotomy (Assist.) (Anaes.) | \$4488.50 |
| 43972 | Choledochal cyst, resection of, with 1 duct anastomosis (Assist.) (Anaes.) | \$3316.90 |
| 43975 | Choledochal cyst, resection of, with 2 duct anastomoses (Assist.) (Anaes.) | \$3835.70 |
| 43978 | Biliary atresia, portoenterostomy for (Assist.) (Anaes.) | \$3264.40 |
| 43981 | Nephroblastoma, neuroblastoma or other malignant tumour, laparotomy (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Assist.) (Anaes.) | \$897.80 |
| 43984 | Nephroblastoma, radical nephrectomy for (Assist.) (Anaes.) | \$2285.10 |
| 43987 | Neuroblastoma, radical excision of (Assist.) (Anaes.) | \$2529.90 |
| 43990 | Aganglioneuroblastoma coli, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends to sigmoid colon (Anaes.) (Assist.) | \$3101.20 |

| Item No. | Description | Max fee (excl GST) |
|---|---|--------------------|
| 43993 | Aganglioneosis 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.) | \$3345.90 |
| 43996 | Aganglioneosis coli, total colectomy for total colonic aganglioneosis with ileoanal pull-through, with or without side to side ileocolic anastomosis (Anaes.) (Assist.) | \$3754.00 |
| 43999 | Aganglioneosis coli, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.) | \$469.50 |
| 44101 | Rectum, examination of, on a person under 2 years of age, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.) | \$531.50 |
| 44102 | Rectum, examination of, on a person 2 years of age or over, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.) | \$496.40 |
| 44104 | Rectal prolapse, submucosal or perirectal injection for, on a person under 2 years of age, under general anaesthesia (Anaes.) | \$93.30 |
| 44105 | Rectal prolapse, submucosal or perirectal injection for, on a person 2 years of age or over, under general anaesthesia (Anaes.) | \$79.40 |
| 44108 | Inguinal hernia repair at age less than 12 months (Anaes.) (Assist.) | \$865.80 |
| 44111 | Obstructed or strangulated inguinal hernia, repair, at age, less than 12 months including orchidopexy when performed (Anaes.) (Assist.) | \$1013.90 |
| 44114 | Inguinal hernia repair at age less than 12 months when orchidopexy also required (Anaes.) (Assist.) | \$1013.90 |
| 44130 | Lymphadenectomy, for atypical mycobacterial infection or other granulomatous disease (Assist.) (Anaes.) | \$852.00 |
| 44133 | Torticollis, open division of sternomastoid muscle for (Assist.) (Anaes.) | \$710.90 |
| 44136 | Ingrown toe nail, operation for, under general anaesthesia (Anaes.) | \$323.50 |
| Amputations | | |
| 44325 | Hand, midcarpal or transmetacarpal, amputation of (Assist.) (Anaes.) | \$568.80 |
| 44328 | Hand, forearm or through arm, amputation of (Assist.) (Anaes.) | \$630.90 |
| 44331 | Amputation at shoulder (Assist.) (Anaes.) | \$1040.40 |
| 44334 | Interscapulothoracic amputation (Assist.) (Anaes.) | \$2215.80 |
| 44338 | 1 digit of foot, amputation of (Anaes.) | \$276.50 |
| 44342 | 2 digits of 1 foot, amputation of (Anaes.) | \$484.50 |
| 44346 | 3 digits of 1 foot, amputation of (Assist.) (Anaes.) | \$496.70 |
| 44350 | 4 digits of 1 foot, amputation of (Assist.) (Anaes.) | \$510.20 |
| 44354 | 5 digits of 1 foot, amputation of (Assist.) (Anaes.) | \$644.90 |
| 44358 | Toe, including metatarsal or part of metatarsal each toe, amputation of (Anaes.) | \$352.80 |
| 44359 | One or more toes of one foot, amputation of, including if performed, excision of 1 or more metatarsal bones of the foot, performed for diabetic or other micro vascular disease, excluding aftercare (Assist.) (Anaes.) | \$505.20 |
| 44361 | Foot at ankle (Syme, Pirogoff types), amputation of (Assist.) (Anaes.) | \$630.90 |
| 44364 | Foot, midtarsal or transmetatarsal, amputation of (Assist.) (Anaes.) | \$567.10 |
| 44367 | Amputation through thigh, at knee or below knee (Assist.) (Anaes.) | \$1006.80 |
| 44370 | Amputation at hip (Assist.) (Anaes.) | \$1275.00 |
| 44373 | Hindquarter, amputation of (Assist.) (Anaes.) | \$2617.40 |
| 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 31376 (Anaes.) | \$1059.00 |
| 45003 | Single stage local myocutaneous flap repair to one defect, simple and small not in association with any of items 31356 to 31376 (Anaes.) | \$1151.80 |
| 45006 | Single stage large myocutaneous flap repair to 1 defect, (pectoralis major, latissimus dorsi, or similar large muscle) (Assist.) (Anaes.) | \$2004.70 |
| 45009 | Single stage local muscle flap repair to 1 defect, simple and small (Assist.) (Anaes.) | \$749.30 |
| 45012 | Single stage large muscle flap repair to 1 defect, (pectoralis major, gastrocnemius, gracilis or similar large muscle) (Assist.) (Anaes.) | \$1242.00 |
| 45015 | Muscle or myocutaneous flap, delay of (Anaes.) | \$735.00 |
| 45018 | Dermis, dermofat or fascia graft (excluding transfer of fat by injection), if the service is not associated with neurosurgical services for spinal disorders mentioned in any of items 51011 to 51171 (Anaes.) (Assist.) | \$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 | \$796.80 |

| Item No. | Description | Max fee (excl GST) |
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| | photo-damage involves: (i) a solar keratosis load exceeding 30 individual lesions; or (ii) solar lentigenes; or (iii) freckling, yellowing or leathering of the skin; or (iv) solar keratoses 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.) | |
| 45021 | Abrasive therapy for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.) | \$380.00 |
| 45024 | Abrasive therapy for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.) | \$945.00 |
| 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 | Angioma, cauterisation of or injection into, where undertaken in the operating theatre of a hospital (Anaes.) | \$233.70 |
| 45030 | Angioma (haemangioma or lymphangioma or both) of skin and subcutaneous tissue (excluding facial muscle or breast) or mucous surface, small, excision and suture of (Anaes.) | \$240.40 |
| 45033 | Angioma (haemangioma or lymphangioma or both), large or involving deeper tissue including facial muscle or breast, excision and suture of (Anaes.) | \$462.00 |
| 45035 | Angioma (haemangioma or lymphangioma or both) large and deep, involving muscles or nerves, excision of (Assist.) (Anaes.) | \$1373.40 |
| 45036 | Angioma (haemangioma or lymphangioma or both) of neck, deep, excision of (Assist.) (Anaes.) | \$2169.40 |
| 45039 | Arteriovenous malformation (3 cms or less) of superficial tissue, excision of (Anaes.) | \$470.60 |
| 45042 | Arteriovenous malformation, (greater than 3 cms), excision of (Assist.) (Anaes.) | \$602.90 |
| 45045 | Arteriovenous malformation on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.) | \$592.40 |
| 45048 | Lymphoedematous tissue or lymphangiectasis, of lower leg and foot, or thigh, or upper arm, or forearm and hand, major excision of (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$434.20 |
| 45200 | Single stage local flap, if indicated to repair one defect, simple and small, excluding flap for male pattern baldness and excluding h-flap or double advancement flap not in association with any of items 31356 to 31376 (Anaes.) | \$545.90 |
| 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 or 31376)-may be claimed only once per defect (Anaes.) | \$645.00 |
| 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.) | \$645.00 |
| 45203 | Single stage local flap, if indicated to repair one defect, complicated or large, excluding flap for male pattern baldness and excluding h-flap or double advancement flap not in association with any of items 31356 to 31376 (Anaes.) (Assist.) | \$779.40 |
| 45206 | Single stage local flap if indicated to repair one defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals and excluding h-flap or double advancement flap not in association with any of items 31356 to 31376 (Anaes.) | \$735.40 |
| 45207 | H-flap or double advancement flap if indicated to repair one defect, on eyelid, eyebrow or forehead not in association with any of items 31356 to 31376 (Anaes.) | \$711.80 |
| 45209 | Direct flap repair (cross arm, abdominal or similar), first stage (Assist.) (Anaes.) | \$910.00 |
| 45212 | Direct flap repair (cross arm, abdominal or similar), second stage (Anaes.) | \$451.60 |
| 45215 | Direct flap repair, cross leg, first stage (Assist.) (Anaes.) | \$1965.00 |
| 45218 | Direct flap repair, cross leg, second stage (Assist.) (Anaes.) | \$889.60 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 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.) | \$231.60 |
| 45227 | Indirect flap or tubed pedicle, formation of (Assist.) (Anaes.) | \$863.60 |
| 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 (Assist.) (Anaes.) | \$964.80 |
| 45236 | Indirect flap or tubed pedicle, spreading of pedicle, as a separate procedure (Anaes.) | \$767.40 |
| 45239 | Direct, indirect or local flap, revision of, by incision and suture, not being a service to which item 45240 applies (Anaes.) | \$503.30 |
| 45240 | Direct, indirect or local flap, revision of, by liposuction, not being a service to which item 45239, 45497, 45498 or 45499 applies (Anaes.) | \$507.50 |
| 45400 | Free grafting (split skin) of a granulating area, small (Anaes.) | \$396.60 |
| 45403 | Free grafting (split skin) of a granulating area, extensive (Assist.) (Anaes.) | \$790.50 |
| 45406 | Free grafting (split skin) to burns, including excision of burnt tissue - involving not more than 3% of total body surface (Assist.) (Anaes.) | \$917.10 |
| 45409 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 3% or more but less than 6% of total body surface (Assist.) (Anaes.) | \$1156.90 |
| 45412 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 6% or more but less than 9% of total body surface (Assist.) (Anaes.) | \$1706.90 |
| 45415 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 9% or more but less than 12% of total body surface (Assist.) (Anaes.) | \$1731.70 |
| 45418 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 12% or more but less than 15 per cent of total body surface (Assist.) (Anaes.) | \$1730.70 |
| 45439 | Free grafting (split skin) to 1 defect, including elective dissection, small (Anaes.) | \$552.00 |
| 45442 | Free grafting (split skin) to 1 defect, including elective dissection, extensive (Assist.) (Anaes.) | \$1124.00 |
| 45445 | Free grafting (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of and removal of mould) (Assist.) (Anaes.) | \$1066.60 |
| 45448 | Free grafting (split skin) to 1 defect, including elective dissection on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, not being a service to which item 45442 or 45445 applies (Anaes.) | \$720.70 |
| 45451 | Free grafting (full thickness) to 1 defect, excluding grafts for male pattern baldness (Assist.) (Anaes.) | \$909.90 |
| 45460 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 15 percent or more but less than 20 percent of total body surface - one surgeon (Assist.) (Anaes.) | \$2218.90 |
| 45461 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 15 percent or more but less than 20 percent of total body surface - conjoint surgery, principal surgeon (Assist.) (Anaes.) | \$2261.20 |
| 45462 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 15 percent or more but less than 20 percent of total body surface - conjoint surgery, co-surgeon (Assist.) | \$1193.40 |
| 45464 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 20 percent or more but less than 30 percent of total body surface - one surgeon (Assist.) (Anaes.) | \$5130.00 |
| 45465 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 20 percent or more but less than 30 percent of total body surface - conjoint surgery, principal surgeon (Assist.) (Anaes.) | \$2413.00 |
| 45466 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 20 percent or more but less than 30 percent of total body surface - conjoint surgery, co-surgeon (Assist.) | \$1819.80 |
| 45468 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 30 percent or more but less than 40 percent of total body surface - conjoint surgery, principal surgeon (Assist.) (Anaes.) | \$3244.50 |
| 45469 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 30 percent or more but less than 40 percent of total body surface - conjoint surgery, co-surgeon (Assist.) | \$2651.70 |
| 45471 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 40 percent or more but less than 50 percent of total body surface - conjoint surgery, principal surgeon (Assist.) (Anaes.) | \$4078.20 |
| 45472 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 40 percent or more but less than 50 percent of total body surface - conjoint surgery, co-surgeon (Assist.) | \$3076.20 |
| 45474 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 50 percent or more but less than 60 percent of total body surface - conjoint surgery, principal surgeon (Assist.) (Anaes.) | \$4909.80 |
| 45475 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 50 percent or more but less than 60 percent of total body surface - conjoint surgery, co-surgeon (Assist.) | \$3704.40 |
| 45477 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 60 percent or more but less than 70 percent of total body surface - conjoint surgery, principal surgeon (Assist.) (Anaes.) | \$5741.40 |
| 45478 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 60 percent or more but less than 70 percent of total body surface - conjoint surgery, co-surgeon (Assist.) | \$4330.50 |

| Item No. | Description | Max fee (excl GST) |
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| 45480 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 70 percent or more but less than 80 percent of total body surface - conjoint surgery, principal surgeon (Assist.) (Anaes.) | \$6572.60 |
| 45481 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 70 percent or more but less than 80 percent of total body surface - conjoint surgery, co-surgeon (Assist.) | \$4959.10 |
| 45483 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 80 percent or more of total body surface - conjoint surgery, principal surgeon (Assist.) (Anaes.) | \$7488.60 |
| 45484 | Free grafting (split skin) to burns, including excision of burnt tissue - involving 80 percent or more of total body surface - conjoint surgery, co- surgeon (Assist.) | \$5650.30 |
| 45485 | Free grafting (split skin) to burns, including excision of burnt tissue - upper eyelid, nose, lip, ear or palm of the hand (Assist.) (Anaes.) | \$1571.40 |
| 45486 | Free grafting (split skin) to burns, including excision of burnt tissue - forehead, cheek, anterior aspect of the neck, chin, plantar aspect of the foot, heel or genitalia (Assist.) (Anaes.) | \$1031.40 |
| 45487 | Free grafting (split skin) to burns, including excision of burnt tissue - whole of toe (Assist.) (Anaes.) | \$718.80 |
| 45488 | Free grafting (split skin) to burns, including excision of burnt tissue - the whole of 1 digit of the hand (Assist.) (Anaes.) | \$798.70 |
| 45489 | Free grafting (split skin) to burns, including excision of burnt tissue - the whole of 2 digits of the hand (Assist.) (Anaes.) | \$1198.30 |
| 45490 | Free grafting (split skin) to burns, including excision of burnt tissue - the whole of 3 digits of the hand (Assist.) (Anaes.) | \$1852.50 |
| 45491 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 4 digits of the hand (Assist.) (Anaes.) | \$1996.90 |
| 45492 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 5 digits of the hand (Assist.) (Anaes.) | \$3082.80 |
| 45493 | Free grafting (split skin) to burns, including excision of burnt tissue - portion of digit of hand (Assist.) (Anaes.) | \$965.00 |
| 45494 | Free grafting (split skin) to burns, including excision of burnt tissue - whole of face (excluding ears) (Assist.) (Anaes.) | \$3155.80 |
| 45496 | Flap, free tissue transfer using microvascular techniques - revision of, by open operation (Anaes.) | \$810.30 |
| 45497 | Flap, free tissue transfer using microvascular techniques, or any autogenous breast reconstruction - complete revision of, by liposuction (Anaes.) | \$633.60 |
| 45498 | Flap, free tissue transfer using microvascular techniques, or any autogenous breast reconstruction - staged revision of, by liposuction - first stage (Anaes.) | \$510.90 |
| 45499 | Flap, free tissue transfer using microvascular techniques, or any autogenous breast reconstruction - staged revision of, by liposuction - second stage (Anaes.) | \$379.90 |
| 45500 | Microvascular repair using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Assist.) (Anaes.) | \$2090.50 |
| 45501 | Microvascular anastomosis of artery using microsurgical techniques, for re-imp of limb or digit (Assist.) (Anaes.) | \$3444.30 |
| 45502 | Microvascular anastomosis of vein using microsurgical techniques, for re-implantation of limb or digit (Assist.) (Anaes.) | \$4005.00 |
| 45503 | Micro-arterial or micro-venous graft using microsurgical techniques (Assist.) (Anaes.) | \$3915.10 |
| 45504 | Microvascular anastomosis of artery using microsurgical techniques, for free transfer of tissue including setting in of free flap (Assist.) (Anaes.) | \$3421.10 |
| 45505 | Microvascular anastomosis of vein using microsurgical techniques, for free transfer of tissue including setting in of free flap (Assist.) (Anaes.) | \$3407.90 |
| 45506 | Scar, of face or neck, not more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty (Anaes.) | \$422.50 |
| 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.) | \$580.90 |
| 45515 | Scar, other than on face or neck, not more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty (Anaes.) | \$359.00 |
| 45518 | Scar, other than on face or neck, more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty (Anaes.) | \$459.40 |
| 45519 | Extensive burn scars of skin (more than 1 percent of body surface area), excision of, for correction of scar contracture (Assist.) (Anaes.) | \$1050.00 |
| 45520 | Reduction mammoplasty (unilateral) with surgical repositioning of nipple, in the context of breast cancer or developmental abnormality of the breast (Anaes.) (Assist.) | \$2200.00 |
| 45522 | Reduction mammoplasty (unilateral) without surgical repositioning of the nipple: (a) excluding the treatment of gynaecomastia; and (b) not with insertion of any prosthesis (Anaes.) (Assist.) | \$1545.00 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 45524 | Mammoplasty, augmentation (unilateral) in the context of: (a) breast cancer; or (b) developmental abnormality of the breast, if there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least: (i) 20% in normally shaped breasts; or (ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds. Applicable only once per occasion on which the service is provided (Anaes.) (Assist.) | \$1605.00 |
| 45527 | Breast reconstruction (unilateral), following mastectomy, using a permanent prosthesis (Anaes.) (Assist.) | \$1610.00 |
| 45528 | Mammoplasty, augmentation, bilateral (other than a service to which item 45527 applies), if: (a) reconstructive surgery is indicated because of: (i) developmental malformation of breast tissue (excluding hypomastia); or (ii) disease of or trauma to the breast (other than trauma resulting from previous elective cosmetic surgery); or (iii) amastia secondary to a congenital endocrine disorder; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.) | \$2415.00 |
| 45530 | Breast reconstruction (unilateral), using a latissimus dorsi or other large muscle or myocutaneous flap, including repair of secondary skin defect, if required, excluding repair of muscular aponeurotic layer, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177 or 30179 applies (H) (Anaes.) (Assist.) | \$2375.00 |
| 45533 | breast reconstruction using breast sharing technique (first stage) including breast reduction, transfer of complex skin and breast tissue flap, split skin graft to pedicle of flap or other similar procedure (Assist.) (Anaes.) | \$2690.00 |
| 45536 | Breast reconstruction using breast sharing technique (second stage) including division of pedicle, inseting of breast flap, with closure of donor site or other similar procedure (Assist.) (Anaes.) | \$879.40 |
| 45539 | Breast reconstruction (unilateral), following mastectomy, using tissue expansion - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Assist.) (Anaes.) | \$2300.20 |
| 45542 | Breast reconstruction (unilateral), following mastectomy, using tissue expansion - removal of tissue expansion unit and insertion of permanent prosthesis (Assist.) (Anaes.) | \$1320.00 |
| 45545 | Nipple or areola or both, reconstruction of, by any surgical technique (Assist.) (Anaes.) | \$1220.60 |
| 45546 | Nipple or areola or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple | \$353.40 |
| 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 (Anaes.) (Assist.) | \$1870.00 |
| 45558 | Breast ptosis, correction by mastopexy of (bilateral), if: (a) at least two-thirds of the breast tissue, including the nipple, lies inferior to the infra-mammary fold where the nipple is located at the most dependent, inferior part of the breast contour; and (b) if the patient has been pregnant—the correction is performed not less than 1 year, or more than 7 years, after completion of the most recent pregnancy of the patient; and (c) photographic evidence (including anterior, left lateral and right lateral views), with a marker at the level of the inframammary fold, demonstrating the clinical need for this service, is documented in the patient notes Applicable only once per lifetime (Anaes.) (Assist.) | \$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 or vein using microsurgical techniques, for supercharging of pedicled flaps (Assist.) (Anaes.) | \$3487.50 |
| 45562 | Free transfer of tissue involving raising of tissue on vascular or neurovascular pedicle, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Assist.) (Anaes.) | \$2112.80 |
| 45563 | Neurovascular island flap, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Assist.) (Anaes.) | \$2110.60 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 45564 | Free transfer of tissue reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, inseting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) | \$5017.20 |
| 45565 | Free transfer of tissue reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, inseting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies conjoint surgery, conjoint specialist surgeon (H) (Assist.) | \$3664.50 |
| 45566 | Tissue expansion not being a service to which item 45539 or 45542 applies - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Assist.) (Anaes.) | \$2096.40 |
| 45568 | Tissue expander, removal of, with complete excision of fibrous capsule (Assist.) (Anaes.) | \$820.40 |
| 45569 | Closure of abdomen with reconstruction of umbilicus, with or without lipectomy, being a service associated with items 45562, 45564, 45565 or 45530 (Assist.) (Anaes.) | \$1430.00 |
| 45570 | Closure of abdomen, repair of musculoaponeurotic layer, being a service associated with item 45569 (Assist.) (Anaes.) | \$1895.00 |
| 45572 | Intra-operative tissue expansion performed during an operation when combined with a service to which another item in Group T8 applies including expansion injections and excluding treatment of male pattern baldness (Anaes.) | \$565.70 |
| 45575 | Facial nerve paralysis, free fascia graft for (Assist.) (Anaes.) | \$1440.40 |
| 45578 | Facial nerve paralysis, muscle transfer for (Assist.) (Anaes.) | \$1604.90 |
| 45581 | Facial nerve palsy, 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 applies, if: (a) the liposuction is for: (i) the treatment of Barraquer-Simons syndrome, lymphoedema or macrodystrophia lipomatosa; or (ii) the reduction of a buffalo hump that is secondary to an endocrine disorder or pharmacological treatment of a medical condition; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) | \$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 |
| 45590 | Orbital cavity, reconstruction of a wall or floor, with or without foreign implant (Assist.) (Anaes.) | \$1015.00 |
| 45593 | Orbital cavity, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Assist.) (Anaes.) | \$1190.00 |
| 45596 | Maxilla, total resection of (Assist.) (Anaes.) | \$1960.00 |
| 45597 | Maxilla, total resection of both maxillae (Assist.) (Anaes.) | \$2133.90 |
| 45599 | Mandible, total resection of both sides, including condylectomies where performed (Assist.) (Anaes.) | \$1317.20 |
| 45602 | Mandible, including lower border, or maxilla, sub-total resection of (Assist.) (Anaes.) | \$1353.10 |
| 45605 | Mandible or maxilla, segmental resection of, for tumours or cysts (Assist.) (Anaes.) | \$1128.00 |
| 45608 | Mandible, hemimandibular reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (Assist.) (Anaes.) | \$1686.50 |
| 45611 | Mandible, condylectomy (Assist.) (Anaes.) | \$1265.00 |
| 45614 | Eyelid, whole thickness reconstruction of, other than by direct suture only (Assist.) (Anaes.) | \$1125.90 |
| 45617 | Upper eyelid, reduction of, if: (a) the reduction is for any of the following: (i) skin redundancy that causes a visual field defect (confirmed by an optometrist or ophthalmologist) or intertriginous inflammation of the eyelid; (ii) herniation of orbital fat in exophthalmos; (iii) facial nerve palsy; (iv) post-traumatic scarring; (v) the restoration of symmetry of contralateral upper eyelid in respect of one of the conditions mentioned in subparagraphs (i) to (iv); and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) | \$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 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 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.) | \$1419.20 |
| 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.) | \$1795.90 |
| 45625 | Ptosis of eyelid, correction of eyelid height by revision of levator sutures within one week of primary repair by levator resection or advancement, performed in the operating theatre of a hospital (Anaes.) | \$366.70 |
| 45626 | Ectropion or entropion, correction of (unilateral) (Anaes.) | \$655.00 |
| 45629 | Symblepharon, grafting for (Assist.) (Anaes.) | \$1110.00 |
| 45632 | Rhinoplasty, partial, involving correction of lateral or alar cartilages, if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) | \$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 (Anaes.) (Assist.) | \$2985.00 |
| 45645 | Choanal atresia, repair of by puncture and dilatation (Anaes.) | \$396.00 |
| 45646 | Choanal atresia, correction by open operation with bone removal (Assist.) (Anaes.) | \$1952.30 |
| 45647 | Face, contour restoration of 1 region, using autogenous bone or cartilage graft (not being a service to which item 45644 applies) (Assist.) (Anaes.) | \$2955.90 |
| 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.) | \$704.20 |
| 45656 | Composite graft (chondrocutaneous or chondromucosal) to nose, ear or eyelid (Assist.) (Anaes.) | \$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 multiple costal cartilage grafts to form a framework, including the harvesting and sculpturing of the cartilage and its insertion, for congenital absence, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) - performed by a specialist in the practice of his or her specialty (Assist.) (Anaes.) | \$5526.60 |
| 45661 | External ear, complex total reconstruction of, elevation of costal cartilage framework using cartilage previously stored in abdominal wall, including the use of local skin and fascia flaps and full thickness skin graft to cover cartilage (second stage) - performed by a specialist in the practice of his or her specialty (Assist.) (Anaes.) | \$2450.60 |
| 45662 | Congenital atresia, reconstruction of external auditory canal (Assist.) (Anaes.) | \$1278.60 |
| 45665 | Lip, eyelid or ear, full thickness wedge excision of, with repair by direct sutures (Anaes.) | \$624.10 |
| 45668 | Vermilionectomy, by surgical excision (Anaes.) | \$626.00 |
| 45669 | Vermilionectomy for biopsy-confirmed cellular atypia, using carbon dioxide laser or erbium laser excision - ablation (Anaes.) | \$646.40 |
| 45671 | Lip or eyelid reconstruction using full thickness flap (Abbe or similar), first stage (Assist.) (Anaes.) | \$1610.00 |
| 45674 | Lip or eyelid reconstruction using full thickness flap (Abbe or similar), second stage (Anaes.) | \$483.40 |
| 45675 | Macrocheilia or macroglossia, operation for (Assist.) (Anaes.) | \$926.40 |
| 45676 | Macrostomia, operation for (Assist.) (Anaes.) | \$1104.20 |
| 45677 | Cleft lip, unilateral primary repair, 1 stage, without anterior palate repair (Assist.) (Anaes.) | \$1050.00 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 45680 | Cleft lip, unilateral - primary repair, 1 stage, with anterior palate repair (Assist.) (Anaes.) | \$1198.30 |
| 45683 | Cleft lip, bilateral - primary repair, 1 stage, without anterior palate repair (Assist.) (Anaes.) | \$1331.30 |
| 45686 | Cleft lip, bilateral - primary repair, 1 stage, with anterior palate repair (Assist.) (Anaes.) | \$1733.40 |
| 45689 | Cleft lip, lip adhesion procedure, unilateral or bilateral (Assist.) (Anaes.) | \$600.00 |
| 45692 | Cleft lip, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.) | \$576.90 |
| 45695 | Cleft lip, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Assist.) (Anaes.) | \$1075.00 |
| 45698 | Cleft lip, primary columella lengthening procedure, bilateral (Anaes.) | \$812.10 |
| 45701 | Cleft lip reconstruction using full thickness flap (Abbe or similar), first stage (Assist.) (Anaes.) | \$2320.80 |
| 45704 | Cleft lip reconstruction using full thickness flap (Abbe or similar), second stage (Anaes.) | \$576.40 |
| 45707 | Cleft palate, primary repair (Assist.) (Anaes.) | \$1408.20 |
| 45710 | Cleft palate, secondary repair, closure of fistula using local flaps (Anaes.) | \$941.80 |
| 45713 | Cleft palate, secondary repair, lengthening procedure (Assist.) (Anaes.) | \$1068.40 |
| 45714 | Oro-nasal fistula, plastic closure of, including services to which item 45200, 45203 or 45239 applies (Assist.) (Anaes.) | \$1519.00 |
| 45716 | Velo-pharyngeal incompetence, pharyngeal flap for, or pharyngoplasty for (Anaes.) | \$1768.80 |
| 45720 | Mandible or maxilla, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.) | \$1853.00 |
| 45723 | Mandible or maxilla, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.) | \$2495.00 |
| 45726 | Mandible or maxilla, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.) | \$2361.50 |
| 45729 | Mandible or maxilla, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.) | \$3170.00 |
| 45731 | Mandible or maxilla, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.) | \$2684.90 |
| 45732 | Mandible or maxilla, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.) | \$3615.00 |
| 45735 | Mandible and maxilla, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.) | \$3092.00 |
| 45738 | Mandible and maxilla, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.) | \$3815.60 |
| 45741 | Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.) | \$3137.60 |
| 45744 | Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.) | \$4565.00 |
| 45747 | Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty (when performed) and transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.) | \$3423.10 |
| 45752 | Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.) | \$4353.90 |
| 45753 | Midfacial osteotomies - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Assist.) (Anaes.) | \$3857.10 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 45754 | Midfacial osteotomies - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Assist.) (Anaes.) | \$5017.00 |
| 45755 | Temporomandibular partial or total meniscectomy (Assist.) (Anaes.) | \$650.90 |
| 45758 | Temporo-mandibular joint, arthroplasty (Assist.) (Anaes.) | \$1261.80 |
| 45761 | Genioplasty, including transposition of nerves and vessels and bone grafts taken from the same site (Assist.) (Anaes.) | \$1580.00 |
| 45767 | Hypertelorism, correction of, intracranial (Assist.) (Anaes.) | \$4446.50 |
| 45770 | Hypertelorism, correction of, subcranial (Assist.) (Anaes.) | \$3406.20 |
| 45773 | Treacher Collins Syndrome, periorbital correction of, with rib and iliac bone grafts (Assist.) (Anaes.) | \$3104.30 |
| 45776 | Orbital dystopia (unilateral), correction of, with total repositioning of 1 orbit, intracranial (Assist.) (Anaes.) | \$3174.10 |
| 45779 | Orbital dystopia (unilateral), correction of, with total repositioning of 1 orbit, extracranial (Assist.) (Anaes.) | \$2282.40 |
| 45782 | Frontoorbital advancement, unilateral (Assist.) (Anaes.) | \$1889.70 |
| 45785 | Cranial vault reconstruction for oxycephaly, brachycephaly, turricephaly or similar condition (bilateral fronto-orbital advancement) (Assist.) (Anaes.) | \$2953.10 |
| 45788 | Glenoid fossa, zygomatic arch and temporal bone, reconstruction of, (Obwegeser technique) (Assist.) (Anaes.) | \$2983.60 |
| 45791 | Absent condyle and ascending ramus in hemifacial microsomia, construction of, not including harvesting of graft material (Assist.) (Anaes.) | \$1577.10 |
| 45794 | Osseo-integration procedure - extra-oral, implantation of titanium fixture, not for implantable bone conduction hearing system device (Anaes.) | \$1235.00 |
| 45797 | Osseo-integration procedure, fixation of transcutaneous abutment, not for implantable bone conduction hearing system device (Anaes.) | \$371.60 |
| 45799 | Aspiration biopsy of 1 or more jaw cysts as an independent procedure to obtain material for diagnostic purposes and not being a service associated with an operative procedure on the same day (Anaes.) | \$72.00 |
| 45801 | Tumour, cyst, ulcer or scar, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 45803 applies (Anaes.) | \$264.80 |
| 45803 | Tumours, cysts, ulcers or scars, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Assist.) (Anaes.) | \$626.20 |
| 45805 | Tumour, cyst, ulcer or scar, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.) | \$420.00 |
| 45807 | Tumour, cyst (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), ulcer or scar (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, removal of, not being a service to which another item in this subgroup applies, involving muscle, bone, or other deep tissue (Anaes.) | \$465.40 |
| 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 (Assist.) (Anaes.) | \$712.20 |
| 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 (Assist.) (Anaes.) | \$965.20 |
| 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 (Assist.) (Anaes.) | \$1127.90 |
| 45815 | Operation on mandible or maxilla (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Assist.) (Anaes.) | \$687.90 |
| 45817 | Operation on skull for osteomyelitis (Assist.) (Anaes.) | \$822.40 |
| 45819 | Operation on any combination of adjoining bones in the oral and maxillofacial region, being bones referred to in item 45817 (Assist.) (Anaes.) | \$1964.90 |
| 45821 | Bone growth stimulator in the oral and maxillofacial region, insertion of (Assist.) (Anaes.) | \$719.00 |
| 45823 | Arch bars, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia where undertaken in the operating theatre of a hospital (Anaes.) | \$265.00 |
| 45825 | Mandibular or palatal exostosis, excision of (Assist.) (Anaes.) | \$651.70 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 45827 | Mylohyoid ridge, reduction of (Assist.) (Anaes.) | \$610.50 |
| 45829 | Maxillary tuberosity, reduction of (Anaes.) | \$466.00 |
| 45831 | Papillary hyperplasia of the palate, removal of - less than 5 lesions (Assist.) (Anaes.) | \$610.50 |
| 45833 | Papillary hyperplasia of the palate, removal of - 5 to 20 lesions (Assist.) (Anaes.) | \$718.80 |
| 45835 | Papillary hyperplasia of the palate, removal of - more than 20 lesions (Assist.) (Anaes.) | \$891.90 |
| 45837 | Vestibuloplasty, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Assist.) (Anaes.) | \$1107.40 |
| 45839 | Floor of mouth lowering (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Assist.) (Anaes.) | \$1107.40 |
| 45841 | Alveolar ridge augmentation with bone or alloplast or both - unilateral (Assist.) (Anaes.) | \$911.00 |
| 45843 | Alveolar ridge augmentation - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Assist.) (Anaes.) | \$705.00 |
| 45845 | Osseo-integration procedure - intra- oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) | \$967.30 |
| 45847 | Osseo-integration procedure - fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) | \$352.40 |
| 45849 | Maxillary sinus, bone graft to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Assist.) (Anaes.) | \$1124.10 |
| 45851 | Temporomandibular joint, manipulation of, performed in the operating theatre of a hospital, not being a service associated with a service to which another item in this subgroup applies (Anaes.) | \$269.80 |
| 45853 | Absent condyle and ascending ramus in hemifacial microsomia, construction of, not including harvesting of graft material (Assist.) (Anaes.) | \$1577.10 |
| 45855 | Temporomandibular joint, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Assist.) (Anaes.) | \$723.50 |
| 45857 | Temporomandibular joint, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedure of that joint, not being a service associated with any other arthroscopic procedure of the temporomandibular joint (Assist.) (Anaes.) | \$1157.50 |
| 45859 | Temporomandibular joint, arthrotomy of, not being a service to which another item in this subgroup applies (Assist.) (Anaes.) | \$583.50 |
| 45861 | Temporomandibular joint, open surgical exploration of, with or without microsurgical techniques (Assist.) (Anaes.) | \$1692.60 |
| 45863 | Temporomandibular joint, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Assist.) (Anaes.) | \$2249.10 |
| 45865 | Arthrocentesis, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Assist.) (Anaes.) | \$561.20 |
| 45867 | Temporomandibular joint, synovectomy of, not being a service to which another item in this subgroup applies (Assist.) (Anaes.) | \$553.00 |
| 45869 | Temporomandibular joint, open surgical exploration of, with or without meniscus or capsular surgery, including partial or total meniscectomy when performed, with or without microsurgical techniques (Assist.) (Anaes.) | \$2103.60 |
| 45871 | Temporomandibular joint, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Assist.) (Anaes.) | \$3260.00 |
| 45873 | Temporomandibular joint, surgery of, involving procedures to which items 45863, 45867, 45869 and 45871 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Assist.) (Anaes.) | \$2885.10 |
| 45875 | Temporomandibular joint, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Subgroup applies (Assist.) (Anaes.) | \$1075.90 |
| 45877 | Temporomandibular joint, arthrodesis of, with synovectomy if performed, not being a service to which another item in this subgroup applies (Assist.) (Anaes.) | \$833.20 |
| 45879 | Temporomandibular joint or joints, application of external fixator to, other than for treatment of fractures (Assist.) (Anaes.) | \$780.00 |
| 45882 | The treatment of a premalignant lesion of the oral mucosa by a treatment using cryotherapy, diathermy or carbon dioxide laser. | \$76.10 |
| 45885 | Facial, mandibular or lingual artery or vein or artery and vein, ligation of, not being a service to which item 41707 applies (Assist.) (Anaes.) | \$808.90 |
| 45888 | Foreign body, in the oral and maxillofacial region, deep, removal of using interventional imaging techniques (Assist.) (Anaes.) | \$726.70 |
| 45891 | Single-stage local flap where indicated, repair to 1 defect, using temporalis muscle (Assist.) (Anaes.) | \$1098.40 |
| 45894 | Free grafting, in the oral and maxillofacial region, (mucosa or split skin) of a granulating area (Anaes.) | \$446.90 |
| 45897 | Alveolar cleft (congenital) unilateral, grafting of, including plastic closure of associated oro- nasal fistulae and ridge augmentation (Assist.) (Anaes.) | \$1883.10 |

| Item No. | Description | Max fee (excl GST) |
|---------------------|---|--------------------|
| 45900 | Mandible, fixation by intermaxillary wiring, excluding wiring for obesity | \$461.90 |
| 45939 | Peripheral branches of the trigeminal nerve, cryosurgery of, for pain relief (Assist.) (Anaes.) | \$866.10 |
| 45945 | Mandible, treatment of a dislocation of, requiring open reduction (Anaes.) | \$210.20 |
| 45975 | Maxilla, unilateral or bilateral, treatment of fracture of, not requiring splinting | \$228.60 |
| 45978 | Mandible, treatment of fracture of, not requiring splinting | \$279.20 |
| 45981 | Zygomatic bone, treatment of fracture of, not requiring surgical reduction | \$164.20 |
| 45984 | Maxilla, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction not involving plate(s) (Assist.) (Anaes.) | \$1091.70 |
| 45987 | Mandible, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Assist.) (Anaes.) | \$1230.90 |
| 45990 | Maxilla, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction involving the use of plate(s) (Assist.) (Anaes.) | \$1598.50 |
| 45993 | Mandible, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Assist.) (Anaes.) | \$1800.50 |
| 45996 | Mandible, treatment of a closed fracture of, involving a joint surface (Anaes.) | \$422.90 |
| Hand surgery | | |
| 46300 | Inter-phalangeal joint or metacarpophalangeal joint, arthrodesis of, with synovectomy if performed (Assist.) (Anaes.) | \$701.70 |
| 46303 | Carpometacarpal joint, arthrodesis of, with synovectomy if performed (Assist.) (Anaes.) | \$738.20 |
| 46306 | Inter-phalangeal joint or metacarpophalangeal joint - interposition arthroplasty of and including tendon transfers or realignment on the 1 ray (Assist.) (Anaes.) | \$1118.50 |
| 46307 | Interphalangeal joint or metacarpophalangeal joint - volar plate arthroplasty of or traumatic deformity including tendon transfers or realignment on the 1 ray (Assist.) (Anaes.) | \$1016.10 |
| 46309 | Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 1 joint (Assist.) (Anaes.) | \$1027.20 |
| 46312 | Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 2 joints (Assist.) (Anaes.) | \$1299.00 |
| 46315 | Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 3 joints (Assist.) (Anaes.) | \$1745.10 |
| 46318 | Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 4 joints (Assist.) (Anaes.) | \$2354.00 |
| 46321 | Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 5 or more joints (Assist.) (Anaes.) | \$2603.40 |
| 46324 | Carpal bone replacement arthroplasty including associated tendon transfer or realignment when performed (Assist.) (Anaes.) | \$1694.10 |
| 46325 | Carpal bone replacement or resection arthroplasty using adjacent tendon or other soft tissue including associated tendon transfer or realignment when performed (Assist.) (Anaes.) | \$1700.40 |
| 46327 | Inter-phalangeal joint or metacarpophalangeal joint, arthrotomy of (Anaes.) | \$443.30 |
| 46330 | Inter-phalangeal joint or metacarpophalangeal joint, ligamentous or capsular repair with or without arthrotomy (Assist.) (Anaes.) | \$766.40 |
| 46333 | Inter-phalangeal joint or metacarpophalangeal joint, ligamentous repair of, using free tissue graft or implant (Assist.) (Anaes.) | \$1126.70 |
| 46336 | Inter-phalangeal joint or metacarpophalangeal joint, synovectomy, capsulectomy or debridement of, not being a service associated with any other procedure related to that joint (Assist.) (Anaes.) | \$669.40 |
| 46339 | Extensor tendons or flexor tendons of hand or wrist, synovectomy of (Assist.) (Anaes.) | \$919.30 |
| 46342 | Distal radioulnar joint or carpometacarpal joint or joints, synovectomy of (Assist.) (Anaes.) | \$919.30 |
| 46345 | Distal radioulnar joint, reconstruction or stabilisation of, including fusion, or ligamentous arthroplasty and excision of distal ulna, when performed (Assist.) (Anaes.) | \$1126.40 |
| 46348 | Digit, synovectomy of flexor tendon or tendons - 1 digit (Anaes.) | \$485.00 |
| 46351 | Digit, synovectomy of flexor tendon or tendons - 2 digits (Assist.) (Anaes.) | \$753.20 |
| 46354 | Digit, synovectomy of flexor tendon or tendons - 3 digits (Assist.) (Anaes.) | \$1001.60 |
| 46357 | Digit, synovectomy of flexor tendon or tendons - 4 digits (Assist.) (Anaes.) | \$1250.00 |
| 46360 | Digit, synovectomy of flexor tendon or tendons - 5 digits (Assist.) (Anaes.) | \$1498.40 |
| 46363 | Tendon sheath of hand or wrist, open operation on, for stenosing tenovaginitis (Anaes.) | \$461.40 |
| 46366 | Dupuytren's contracture, subcutaneous fasciotomy for - each hand (Anaes.) | \$329.10 |
| 46369 | Dupuytren's contracture, palmar fasciectomy for - 1 hand (Anaes.) | \$464.40 |
| 46372 | Dupuytren's contracture, fasciectomy for, from 1 ray, including dissection of nerves - 1 hand (Assist.) (Anaes.) | \$850.00 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 46375 | Dupuytren's contracture, fasciectomy for, from 2 rays, including dissection of nerves - 1 hand (Assist.) (Anaes.) | \$1008.20 |
| 46378 | Dupuytren's contracture, fasciectomy for, from 3 or more rays, including dissection of nerves - 1 hand (Assist.) (Anaes.) | \$1340.20 |
| 46381 | Inter-phalangeal joint, joint capsule release when performed in conjunction with operation for Dupuytren's contracture - each procedure (Assist.) (Anaes.) | \$593.80 |
| 46384 | Z plasty (or similar local flap procedure) when performed in conjunction with operation for Dupuytren's contracture - 1 such procedure (Assist.) (Anaes.) | \$593.80 |
| 46387 | Dupuytren's contracture, fasciectomy for, from 1 ray, including dissection of nerves - operation for recurrence in that ray (Assist.) (Anaes.) | \$1221.90 |
| 46390 | Dupuytren's contracture, fasciectomy for, from 2 rays, including dissection of nerves - operation for recurrence in those rays (Assist.) (Anaes.) | \$1644.40 |
| 46393 | Dupuytren's contracture, fasciectomy for, from 3 or more rays, including dissection of nerves - operation for recurrence in those rays (Assist.) (Anaes.) | \$1899.40 |
| 46396 | Phalanx or metacarpal of the hand, osteotomy or osteectomy of, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.) | \$677.50 |
| 46399 | Phalanx or metacarpal of the hand, osteotomy of, with internal fixation (Assist.) (Anaes.) | \$991.40 |
| 46402 | Phalanx or metacarpal, bone grafting of, for pseudarthrosis (non-union), including obtaining of graft material (Assist.) (Anaes.) | \$1046.40 |
| 46405 | Phalanx or metacarpal, bone grafting of, for pseudarthrosis (non-union), involving internal fixation and including obtaining of graft material (Assist.) (Anaes.) | \$1223.20 |
| 46408 | Tendon, reconstruction of, by tendon graft (Assist.) (Anaes.) | \$1326.60 |
| 46411 | Flexor tendon pulley, reconstruction of, by graft (Assist.) (Anaes.) | \$835.60 |
| 46414 | Artificial tendon prosthesis, insertion of in preparation for tendon grafting (Assist.) (Anaes.) | \$1012.30 |
| 46417 | Tendon transfer for restoration of hand function, each transfer (Assist.) (Anaes.) | \$1001.60 |
| 46420 | Extensor tendon of hand or wrist, primary repair of, each tendon (Anaes.) | \$414.50 |
| 46423 | Extensor tendon of hand or wrist, secondary repair of, each tendon (Assist.) (Anaes.) | \$669.40 |
| 46426 | Flexor tendon of hand or wrist, primary repair of, proximal to A1 pulley, each tendon (Assist.) (Anaes.) | \$681.20 |
| 46429 | Flexor tendon of hand or wrist, secondary repair of, proximal to A1 pulley, each tendon (Assist.) (Anaes.) | \$835.60 |
| 46432 | Flexor tendon of hand, primary repair of, distal to A1 pulley, each tendon (Assist.) (Anaes.) | \$912.90 |
| 46435 | Flexor tendon of hand, secondary repair of, distal to A1 pulley, each tendon (Assist.) (Anaes.) | \$1026.70 |
| 46438 | Mallet finger, closed pin fixation of (Anaes.) | \$350.00 |
| 46441 | Mallet finger, open repair of, including pin fixation when performed (Assist.) (Anaes.) | \$680.80 |
| 46442 | Mallet finger with intra-articular fracture involving more than one-third of base of terminal phalanx - open reduction (Assist.) (Anaes.) | \$581.50 |
| 46444 | Boutonniere deformity without joint contracture, reconstruction of (Assist.) (Anaes.) | \$994.40 |
| 46447 | Boutonniere deformity with joint contracture, reconstruction of (Assist.) (Anaes.) | \$1208.70 |
| 46450 | Extensor tendon, tenolysis of, following tendon injury, repair or graft (Anaes.) | \$468.90 |
| 46453 | Flexor tendon, tenolysis of, following tendon injury, repair or graft (Assist.) (Anaes.) | \$758.90 |
| 46456 | Finger, percutaneous tenotomy of (Anaes.) | \$187.90 |
| 46459 | Operation for osteomyelitis on distal phalanx (Anaes.) | \$485.00 |
| 46462 | Operation for osteomyelitis on middle or proximal phalanx, metacarpal or carpus (Assist.) (Anaes.) | \$604.70 |
| 46464 | Amputation of a supernumerary complete digit (Anaes.) | \$434.60 |
| 46465 | Amputation of single digit, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) | \$472.60 |
| 46468 | Amputation of 2 digits, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Assist.) (Anaes.) | \$1010.00 |
| 46471 | Amputation of 3 digits, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Assist.) (Anaes.) | \$1126.40 |
| 46474 | Amputation of 4 digits, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Assist.) (Anaes.) | \$1298.30 |
| 46477 | Amputation of 5 digits, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Assist.) (Anaes.) | \$1597.90 |
| 46480 | Amputation of single digit, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover, including metacarpal (Assist.) (Anaes.) | \$746.50 |
| 46483 | Revision of amputation stump to provide adequate soft tissue cover (Assist.) (Anaes.) | \$593.80 |

| Item No. | Description | Max fee (excl GST) |
|--------------------|---|--------------------|
| 46486 | Nail bed, accurate reconstruction of nail bed laceration using magnification, undertaken in the operating theatre of a hospital (Anaes.) | \$476.70 |
| 46489 | Nail bed, secondary exploration and accurate repair of nail bed deformity using magnification, undertaken in the operating theatre of a hospital (Assist.) (Anaes.) | \$544.60 |
| 46492 | Contracture of digits of hand, flexor or extensor, correction of, involving tissues deeper than skin and subcutaneous tissue (Assist.) (Anaes.) | \$700.50 |
| 46494 | Ganglion of hand, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.) | \$421.60 |
| 46495 | Ganglion or mucous cyst of distal digit, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) | \$401.10 |
| 46498 | Ganglion of flexor tendon sheath, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) | \$451.60 |
| 46500 | Ganglion of dorsal wrist joint, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.) | \$538.10 |
| 46501 | Ganglion of volar wrist joint, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.) | \$658.60 |
| 46502 | Recurrent ganglion of dorsal wrist joint, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.) | \$585.60 |
| 46503 | Recurrent ganglion of volar wrist joint, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.) | \$728.80 |
| 46504 | Neurovascular island flap, for pulp innervation (Assist.) (Anaes.) | \$2182.40 |
| 46507 | Digit or ray, transposition or transfer of, on vascular pedicle, complete procedure (Assist.) (Anaes.) | \$2464.80 |
| 46510 | Macrodactyly, surgical reduction of enlarged elements - each digit (Assist.) (Anaes.) | \$902.90 |
| 46513 | Digital nail of finger or thumb, removal of, not being a service to which item 46516 applies (Anaes.) | \$100.00 |
| 46516 | Digital nail of finger or thumb, removal of, in the operating theatre of a hospital (Anaes.) | \$221.00 |
| 46519 | Middle palmar, thenar or hypothenar spaces of hand, drainage of (excluding aftercare) (Anaes.) | \$273.90 |
| 46522 | Flexor tendon sheath of finger or thumb - open operation and drainage for infection (Assist.) (Anaes.) | \$848.60 |
| 46525 | Pulp space infection, paronychia of hand, incision for, when performed in an operating theatre of a hospital, not being a service to which another item in this Group applies (excluding after-care) (Anaes.) | \$101.20 |
| 46528 | Ingrowing nail of finger or thumb, wedge resection for, including removal of segment of nail, ungual fold and portion of the nail bed (Anaes.) | \$300.00 |
| 46531 | Ingrowing nail of finger or thumb, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.) | \$150.80 |
| 46534 | Nail plate injury or deformity, radical excision of nail germinal matrix (Anaes.) | \$456.10 |
| Orthopaedic | | |
| 47000 | Mandible, treatment of dislocation of, by closed reduction (Anaes.) | \$105.50 |
| 47003 | Clavicle, treatment of dislocation of, by closed reduction (Anaes.) | \$120.00 |
| 47006 | Clavicle, treatment of dislocation of, by open reduction (Anaes.) | \$331.90 |
| 47009 | Shoulder, treatment of dislocation of, requiring general anaesthesia, not being a service to which item 47012 applies (Anaes.) | \$289.80 |
| 47012 | Shoulder, treatment of dislocation of, requiring general anaesthesia, open reduction (Assist.) (Anaes.) | \$647.00 |
| 47015 | Shoulder, treatment of dislocation of, not requiring general anaesthesia | \$120.00 |
| 47018 | Elbow, treatment of dislocation of, by closed reduction (Anaes.) | \$299.40 |
| 47021 | Elbow, treatment of dislocation of, by open reduction (Assist.) (Anaes.) | \$508.00 |
| 47024 | Radioulnar joint, distal or proximal, treatment of dislocation of, by closed reduction, not being a service associated with fracture or dislocation in the same region (Anaes.) | \$369.30 |
| 47027 | Radioulnar joint, distal or proximal, treatment of dislocation of, by open reduction, not being a service associated with fracture or dislocation in the same region (Assist.) (Anaes.) | \$500.70 |
| 47030 | Carpus, or carpus on radius and ulna, or carpometacarpal joint, treatment of dislocation of, by closed reduction (Anaes.) | \$359.40 |
| 47033 | Carpus, or carpus on radius and ulna, or carpometacarpal joint, treatment of dislocation of, by open reduction (Assist.) (Anaes.) | \$508.00 |
| 47036 | Interphalangeal joint, treatment of dislocation of, by closed reduction (Anaes.) | \$120.00 |
| 47039 | Interphalangeal joint, treatment of dislocation of, by open reduction (Anaes.) | \$217.20 |
| 47042 | Metacarpophalangeal joint, treatment of dislocation of, by closed reduction (Anaes.) | \$161.90 |
| 47045 | Metacarpophalangeal joint, treatment of dislocation of, by open reduction (Anaes.) | \$292.10 |
| 47048 | Hip, treatment of dislocation of, by closed reduction (Anaes.) | \$567.70 |
| 47051 | Hip, treatment of dislocation of, by open reduction (Assist.) (Anaes.) | \$826.70 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 47054 | Knee, treatment of dislocation of, by closed reduction (Assist.) (Anaes.) | \$535.20 |
| 47057 | Patella, treatment of dislocation of, by closed reduction (Anaes.) | \$179.40 |
| 47060 | Patella, treatment of dislocation of, by open reduction (Anaes.) | \$240.40 |
| 47063 | Ankle or tarsus, treatment of dislocation of, by closed reduction (Anaes.) | \$358.90 |
| 47066 | Ankle or tarsus, treatment of dislocation of, by open reduction (Assist.) (Anaes.) | \$649.10 |
| 47069 | Toe, treatment of dislocation of, by closed reduction (Anaes.) | \$100.10 |
| 47072 | Toe, treatment of dislocation of, by open reduction (Anaes.) | \$181.30 |
| 47301 | Phalanx, middle or proximal, treatment of fracture of, by closed reduction, requiring anaesthesia, not provided on the same occasion as a service described in item 47304, 47307, 47310, 47313, 47316 or 47319 (Anaes.) | \$135.30 |
| 47304 | Metacarpal, treatment of fracture of, by closed reduction, requiring anaesthesia, not provided on the same occasion as a service described in item 47301, 47307, 47310, 47313, 47316 or 47319 (Anaes.) | \$154.20 |
| 47307 | Phalanx or metacarpal, treatment of fracture of, by closed reduction with percutaneous k wire fixation (Anaes.) (Assist.) | \$311.70 |
| 47310 | Phalanx or metacarpal, treatment of fracture of, by open reduction with fixation (Anaes.) (Assist.) | \$514.20 |
| 47313 | Phalanx or metacarpal, treatment of intra articular fracture of, by closed reduction with percutaneous k wire fixation (Anaes.) (Assist.) | \$498.70 |
| 47316 | Phalanx or metacarpal, treatment of intra articular fracture of, by open reduction with fixation, not provided on the same occasion as a service to which item 47319 applies (Anaes.) (Assist.) | \$989.50 |
| 47319 | Middle phalanx, proximal end, treatment of intra articular fracture of, by open reduction with fixation, not provided on the same occasion as a service to which item 47316 applies (Anaes.) (Assist.) | \$1012.90 |
| 47348 | Carpus (excluding scaphoid), treatment of fracture of, not being a service to which item 47351 applies (Anaes.) | \$166.50 |
| 47351 | Carpus (excluding scaphoid), treatment of fracture of, by open reduction (Anaes.) | \$457.10 |
| 47354 | Carpal scaphoid, treatment of fracture of, not being a service to which item 47 357 applies (Anaes.) | \$300.00 |
| 47357 | Carpal scaphoid, treatment of fracture of, by open reduction (Assist.) (Anaes.) | \$847.50 |
| 47361 | Radius or ulna, or radius and ulna, distal end of, treatment of fracture of, by cast immobilisation, other than a service associated with a service to which item 47362, 47364, 47367, 47370 or 47373 applies | \$205.50 |
| 47362 | Radius or ulna, or radius and ulna, distal end of, treatment of fracture of, by closed reduction, requiring general or major regional anaesthesia, but excluding local infiltration, other than a service associated with a service to which item 47361, 47364, 47367, 47370 or 47373 applies (Anaes.) | \$307.90 |
| 47364 | Radius or ulna, distal end of, not involving joint surface, treatment of fracture of, by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (Anaes.) (Assist.) | \$436.30 |
| 47367 | Radius, distal end of, treatment of fracture of, by closed reduction with percutaneous fixation, other than a service associated with a service to which item 47361 or 47362 applies (Anaes.) (Assist.) | \$348.50 |
| 47370 | Radius, distal end of, treatment of intra articular fracture of, by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (Anaes.) (Assist.) | \$632.60 |
| 47373 | Ulna, distal end of, treatment of intra articular fracture of, by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (Anaes.) (Assist.) | \$451.90 |
| 47378 | Radius or ulna, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47381, 47384, 47385 or 47386 applies (Anaes.) | \$300.00 |
| 47381 | Radius or ulna, shaft of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) | \$488.10 |
| 47384 | Radius or ulna, shaft of, treatment of fracture of, by open reduction (Assist.) (Anaes.) | \$649.90 |
| 47385 | Radius or ulna, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction undertaken in the operating theatre of a hospital (Assist.) (Anaes.) | \$560.20 |
| 47386 | Radius or ulna, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by open reduction or internal fixation (Assist.) (Anaes.) | \$921.00 |
| 47387 | Radius and ulna, shafts of, treatment of fracture of, by cast immobilisation, not being a service to which item 47390 or 47393 applies (Assist.) (Anaes.) | \$483.10 |
| 47390 | Radius and ulna, shafts of, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) | \$787.20 |
| 47393 | Radius and ulna, shafts of, treatment of fracture of, by open reduction (Assist.) (Anaes.) | \$1050.40 |
| 47396 | Olecranon, treatment of fracture of, not being a service to which item 47399 applies (Anaes.) | \$333.10 |
| 47399 | Olecranon, treatment of fracture of, by open reduction (Assist.) (Anaes.) | \$762.00 |
| 47402 | Olecranon, treatment of fracture of, involving excision of olecranon fragment and reimplantation of tendon (Assist.) (Anaes.) | \$705.00 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 47405 | Radius, treatment of fracture of head or neck of, closed reduction of (Anaes.) | \$333.10 |
| 47408 | Radius, treatment of fracture of head or neck of, open reduction of, including internal fixation and excision where performed (Assist.) (Anaes.) | \$797.30 |
| 47411 | Humerus, treatment of fracture of tuberosity of, not being a service to which item 47417 applies (Anaes.) | \$199.80 |
| 47414 | Humerus, treatment of fracture of tuberosity of, by open reduction (Anaes.) | \$530.80 |
| 47417 | Humerus, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by closed reduction (Assist.) (Anaes.) | \$506.30 |
| 47420 | Humerus, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by open reduction (Assist.) (Anaes.) | \$1288.40 |
| 47423 | Humerus, proximal, treatment of fracture of, not being a service to which item 47426, 47429 or 47432 applies (Anaes.) | \$414.60 |
| 47426 | Humerus, proximal, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) | \$820.00 |
| 47429 | Humerus, proximal, treatment of fracture of, by open reduction (Assist.) (Anaes.) | \$856.30 |
| 47432 | Humerus, proximal, treatment of intra-articular fracture of, by open reduction (Assist.) (Anaes.) | \$1041.10 |
| 47435 | Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Assist.) (Anaes.) | \$802.40 |
| 47438 | Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (Assist.) (Anaes.) | \$1274.80 |
| 47441 | Humerus, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction (Assist.) (Anaes.) | \$1642.90 |
| 47444 | Humerus, shaft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies (Anaes.) | \$417.60 |
| 47447 | Humerus, shaft of, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) | \$655.60 |
| 47450 | Humerus, shaft of, treatment of fracture of, by internal or external (Assist.) (Anaes.) | \$968.70 |
| 47451 | Humerus, shaft of, treatment of fracture of, by intramedullary fixation (Assist.) (Anaes.) | \$1159.90 |
| 47453 | Humerus, distal, (supracondylar or condylar), treatment of fracture of, not being a service to which item 47456 or 47459 applies (Assist.) (Anaes.) | \$466.70 |
| 47456 | Humerus, distal (supracondylar or condylar), treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) | \$764.30 |
| 47459 | Humerus, distal (supracondylar or condylar), treatment of fracture of, by open reduction, undertaken in the operating theatre of a hospital (Assist.) (Anaes.) | \$1017.30 |
| 47462 | Clavicle, treatment of fracture of, not being a service to which item 47465 applies (Anaes.) | \$199.80 |
| 47465 | Clavicle, treatment of fracture of, by open reduction (Anaes.) | \$565.00 |
| 47466 | Sternum, treatment of fracture of, not being a service to which item 47467 applies (Anaes.) | \$199.80 |
| 47467 | Sternum, treatment of fracture of, by open reduction (Anaes.) | \$437.50 |
| 47468 | Scapula, neck or glenoid region of, treatment of fracture of, by open reduction (Assist.) (Anaes.) | \$918.40 |
| 47471 | Ribs (1 or more), treatment of fracture of - each attendance | \$76.10 |
| 47474 | Pelvic ring, treatment of fracture of, not involving disruption of pelvic ring or acetabulum | \$364.00 |
| 47477 | Pelvic ring, treatment of fracture of, with disruption of pelvic ring or acetabulum | \$455.20 |
| 47480 | Pelvic ring, treatment of fracture of, requiring traction (Assist.) (Anaes.) | \$1094.10 |
| 47483 | Pelvic ring, treatment of fracture of, requiring control by external fixation (Assist.) (Anaes.) | \$1095.90 |
| 47486 | Pelvic ring, treatment of fracture of, by open reduction and involving internal fixation of anterior segment, including diastasis of pubic symphysis (Assist.) (Anaes.) | \$1803.40 |
| 47489 | Pelvic ring, treatment of fracture of, by open reduction and involving internal fixation of posterior segment (including sacro-iliac joint), with or without fixation of anterior segment (Assist.) (Anaes.) | \$2735.20 |
| 47492 | Acetabulum, treatment of fracture of, and associated dislocation of hip (Anaes.) | \$417.10 |
| 47495 | Acetabulum, treatment of fracture of, and associated dislocation of hip, requiring traction (Assist.) (Anaes.) | \$920.00 |
| 47498 | Acetabulum, treatment of fracture of, and associated dislocation of hip, requiring internal fixation, with or without traction (Assist.) (Anaes.) | \$1367.60 |
| 47501 | Acetabulum, treatment of single column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.) | \$1919.90 |
| 47504 | Acetabulum, treatment of T-shape fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.) | \$2735.20 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 47507 | Acetabulum, treatment of transverse fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.) | \$2934.00 |
| 47510 | Acetabulum, treatment of double column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Assist.) (Anaes.) | \$2735.20 |
| 47513 | Sacro-iliac joint disruption, treatment of, requiring internal fixation, being a service associated with a service to which items 47501 to 47510 apply (Assist.) (Anaes.) | \$666.70 |
| 47516 | Femur, treatment of fracture of, by closed reduction or traction (Assist.) (Anaes.) | \$841.20 |
| 47519 | Femur, treatment of trochanteric or subcapital fracture of, by internal fixation (Assist.) (Anaes.) | \$1661.50 |
| 47522 | Femur, treatment of subcapital fracture of, by hemi-arthroplasty (Assist.) (Anaes.) | \$1442.90 |
| 47525 | Femur, treatment of fracture of, for slipped capital femoral epiphysis (Assist.) (Anaes.) | \$1662.80 |
| 47528 | Femur, treatment of fracture of, by internal fixation or external fixation (Assist.) (Anaes.) | \$1459.00 |
| 47531 | Femur, treatment of fracture of shaft, by intramedullary fixation and cross fixation (Assist.) (Anaes.) | \$1860.60 |
| 47534 | Femur, condylar region of, treatment of intra-articular (T-shaped condylar) fracture of, requiring internal fixation, with or without internal fixation of 1 or more osteochondral fragments (Assist.) (Anaes.) | \$2125.50 |
| 47537 | Femur, condylar region of, treatment of fracture of, requiring internal fixation of 1 or more osteochondral fragments, not being a service associated with a service to which item 47534 applies (Assist.) (Anaes.) | \$832.40 |
| 47540 | Hip spica or shoulder spica, application of, as an independent procedure (Anaes.) | \$416.40 |
| 47543 | Tibia, plateau of, treatment of medial or lateral fracture of, not being a service to which item 47546 or 47549 applies (Anaes.) | \$400.20 |
| 47546 | Tibia, plateau of, treatment of medial or lateral fracture of, by closed reduction (Anaes.) | \$656.80 |
| 47549 | Tibia, plateau of, treatment of medial or lateral fracture of, by open reduction (Assist.) (Anaes.) | \$884.70 |
| 47552 | Tibia, plateau of, treatment of both medial and lateral fractures of, not being a service to which item 47555 or 47558 applies (Assist.) (Anaes.) | \$712.10 |
| 47555 | Tibia, plateau of, treatment of both medial and lateral fractures of, by closed reduction (Anaes.) | \$1095.90 |
| 47558 | Tibia, plateau of, treatment of both medial and lateral fractures of, by open reduction (Assist.) (Anaes.) | \$1498.60 |
| 47561 | Tibia, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47564, 47567, 47570 or 47573 applies (Anaes.) | \$483.10 |
| 47564 | Tibia, shaft of, treatment of fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) | \$787.20 |
| 47565 | Tibia, shaft of, treatment of fracture of, by internal fixation or external fixation (Assist.) (Anaes.) | \$1378.20 |
| 47566 | Tibia, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (Assist.) (Anaes.) | \$1749.20 |
| 47567 | Tibia, shaft of, treatment of intra-articular fracture of, by closed reduction, with or without treatment of fibular fracture (Assist.) (Anaes.) | \$916.00 |
| 47570 | Tibia, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (Assist.) (Anaes.) | \$1057.90 |
| 47573 | Tibia, shaft of, treatment of intra-articular fracture of, by open reduction, with or without treatment of fibular fracture (Assist.) (Anaes.) | \$1334.80 |
| 47576 | Fibula, treatment of fracture of (Anaes.) | \$199.80 |
| 47579 | Patella, treatment of fracture of, not being a service to which item 47582 or 47585 applies (Anaes.) | \$283.40 |
| 47582 | Patella, treatment of fracture of, by excision of patella or pole with reattachment of tendon (Assist.) (Anaes.) | \$654.00 |
| 47585 | Patella, treatment of fracture of, by internal fixation (Assist.) (Anaes.) | \$827.80 |
| 47588 | Knee joint, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar or tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Assist.) (Anaes.) | \$2554.90 |
| 47591 | Knee joint, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar and tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Assist.) (Anaes.) | \$3105.80 |
| 47594 | Ankle joint, treatment of fracture of, not being a service to which item 47597 applies (Anaes.) | \$383.20 |
| 47597 | Ankle joint, treatment of fracture of, by closed reduction (Anaes.) | \$621.90 |
| 47600 | Ankle joint, treatment of fracture of, by internal fixation of 1 of malleolus, fibula or diastasis (Assist.) (Anaes.) | \$850.50 |
| 47603 | Ankle joint, treatment of fracture of, by internal fixation of more than 1 of malleolus, fibula or diastasis (Assist.) (Anaes.) | \$1084.70 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 47606 | Calcaneum or talus, treatment of fracture of, not being a service to which item 47609, 47612, 47615 or 47618 applies, with or without dislocation (Anaes.) | \$417.10 |
| 47609 | Calcaneum or talus, treatment of fracture of, by closed reduction, with or without dislocation (Assist.) (Anaes.) | \$677.80 |
| 47612 | Calcaneum or talus, treatment of intra- articular fracture of, by closed reduction, with or without dislocation (Assist.) (Anaes.) | \$814.30 |
| 47615 | Calcaneum or talus, treatment of fracture of, by open reduction, with or without dislocation (Assist.) (Anaes.) | \$920.00 |
| 47618 | Calcaneum or talus, treatment of intra- articular fracture of, by open reduction, with or without dislocation (Assist.) (Anaes.) | \$1226.50 |
| 47621 | Tarso-metatarsal, treatment of intra- articular fracture of, by closed reduction, with or without dislocation (Assist.) (Anaes.) | \$784.50 |
| 47624 | Tarso-metatarsal, treatment of fracture of, by open reduction, with or without dislocation (Assist.) (Anaes.) | \$1110.10 |
| 47627 | Tarsus (excluding calcaneum or talus), treatment of fracture of (Anaes.) | \$283.40 |
| 47630 | Tarsus (excluding calcaneum or talus), treatment of fracture of, by open reduction, with or without dislocation (Assist.) (Anaes.) | \$650.60 |
| 47633 | Metatarsal, 1 of, treatment of fracture of (Anaes.) | \$199.80 |
| 47636 | Metatarsal, 1 of, treatment of fracture of, by closed reduction (Anaes.) | \$300.00 |
| 47639 | Metatarsal, 1 of, treatment of fracture of, by open reduction (Anaes.) | \$494.00 |
| 47642 | Metatarsals, 2 of, treatment of fracture of (Anaes.) | \$267.10 |
| 47645 | Metatarsals, 2 of, treatment of fracture of, by closed reduction (Anaes.) | \$437.90 |
| 47648 | Metatarsals, 2 of, treatment of fracture of, by open reduction (Assist.) (Anaes.) | \$609.10 |
| 47651 | Metatarsals, 3 or more of, treatment of fracture of (Anaes.) | \$417.10 |
| 47654 | Metatarsals, 3 or more of, treatment of fracture of, by closed reduction (Assist.) (Anaes.) | \$694.80 |
| 47657 | Metatarsals, 3 or more of, treatment of fracture of, by open reduction (Assist.) (Anaes.) | \$911.40 |
| 47663 | Phalanx of great toe, treatment of fracture of, by closed reduction (Anaes.) | \$250.20 |
| 47666 | Phalanx of great toe, treatment of fracture of, by open reduction (Anaes.) | \$581.10 |
| 47672 | Phalanx of toe (other than great toe), 1 of, treatment of fracture of, by open reduction (Anaes.) | \$208.70 |
| 47678 | Phalanx of toe (other than great toe), more than 1 of, treatment of fracture of, by open reduction (Anaes.) | \$325.80 |
| 47726 | Bone graft, harvesting of, via separate incision, in conjunction with another service - autogenous - small quantity (Anaes.) | \$355.00 |
| 47729 | Bone graft, harvesting of, via separate incision, in conjunction with another service - autogenous - large quantity (Anaes.) | \$590.00 |
| 47732 | Vascularised pedicle bone graft, harvesting of, in conjunction with another service (Assist.) (Anaes.) | \$857.20 |
| 47735 | Nasal bones, treatment of fracture of, not being 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 (Assist.) (Anaes.) | \$1066.10 |
| 47753 | Maxilla, treatment of fracture of, requiring splinting, wiring of teeth, circum osseous fixation or external fixation (Assist.) (Anaes.) | \$1020.00 |
| 47756 | Mandible, treatment of fracture of, requiring splinting, wiring of teeth, circum osseous fixation or external fixation (Assist.) (Anaes.) | \$952.50 |
| 47762 | Zygomatic bone, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.) | \$562.40 |
| 47765 | Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Assist.) (Anaes.) | \$938.90 |
| 47768 | Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Assist.) (Anaes.) | \$1200.00 |
| 47771 | Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Assist.) (Anaes.) | \$1380.00 |
| 47774 | Maxilla, treatment of fracture of, requiring open operation (Assist.) (Anaes.) | \$845.80 |
| 47777 | Mandible, treatment of fracture of, requiring open reduction (Assist.) (Anaes.) | \$771.50 |
| 47780 | Maxilla, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Assist.) (Anaes.) | \$1002.90 |
| 47783 | Mandible, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Assist.) (Anaes.) | \$1002.90 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 47786 | Maxilla, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Assist.) (Anaes.) | \$1800.00 |
| 47789 | Mandible, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Assist.) (Anaes.) | \$1416.00 |
| 47900 | Bone cyst, injection into or aspiration of (Anaes.) | \$326.10 |
| 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.) | \$100.00 |
| 47906 | Digital nail of toe, removal of, in the operating theatre of a hospital (Anaes.) | \$218.30 |
| 47912 | Pulp space infection, paronychia of foot, incision for, not being a service to which another item in this Group applies (excluding aftercare) (Anaes.) | \$100.00 |
| 47915 | Ingrowing nail of toe, wedge resection for, with removal of segment of nail, unguis fold and portion of the nail bed (Anaes.) | \$316.00 |
| 47916 | Ingrowing nail of toe, partial resection of nail, with destruction of nail matrix by phenolisation, electrocautery, laser, sodium hydroxide or acid but not including excision of nail bed (Anaes.) | \$150.80 |
| 47918 | Ingrowing toenail, radical excision of nailbed (Anaes.) | \$454.40 |
| 47920 | Bone growth stimulator, insertion of (Assist.) (Anaes.) | \$734.50 |
| 47921 | Orthopaedic pin or wire, insertion of, as an independent procedure (Anaes.) | \$250.30 |
| 47924 | Buried wire, pin or screw, 1 or more of, which were inserted for internal fixation purposes, removal of requiring incision and suture, not being a service to which item 47927 or 47930 applies - per bone (Anaes.) | \$72.30 |
| 47927 | Buried wire, pin or screw, 1 or more of, which were inserted for internal fixation purposes, removal of, in the operating theatre of a hospital - per bone (Anaes.) | \$288.20 |
| 47930 | Plate, rod or nail and associated wires, pins or screws, 1 or more of, all of which were inserted for internal fixation purposes, removal of, not being a service associated with a service to which item 47924 or 47927 applies - per bone (Assist.) (Anaes.) | \$554.10 |
| 47933 | Small exostosis (not more than 20mm of growth above bone), excision of, or simple removal of bunion and any associated bursa, not being a service associated with a service for removal of bursa (Anaes.) | \$444.40 |
| 47936 | Large exostosis (greater than 20mm growth above bone), excision of (Assist.) (Anaes.) | \$545.00 |
| 47948 | External fixation, removal of, in the operating theatre of a hospital (Anaes.) | \$310.30 |
| 47951 | External fixation, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.) | \$363.80 |
| 47954 | Tendon, repair of, as an independent procedure (Assist.) (Anaes.) | \$792.40 |
| 47957 | Tendon, large, lengthening of, as an independent procedure (Assist.) (Anaes.) | \$637.80 |
| 47960 | Tenotomy, subcutaneous, not being a service to which another item in this Group applies (Anaes.) | \$280.00 |
| 47963 | Tenotomy, open, with or without tenoplasty, not being a service to which another item in this Group applies (Anaes.) | \$509.70 |
| 47966 | Tendon or ligament transfer, as an independent procedure (Assist.) (Anaes.) | \$957.90 |
| 47969 | Tenosynovectomy, not being a service to which another item in this Group applies (Assist.) (Anaes.) | \$577.40 |
| 47972 | Tendon sheath, open operation for teno- vaginitis, not being a service to which another item in this Group applies (Anaes.) | \$478.90 |
| 47975 | Forearm or calf, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (Assist.) (Anaes.) | \$798.00 |
| 47978 | Forearm or calf, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) | \$558.10 |
| 47981 | Forearm, calf or interosseous muscle space of hand, decompression fasciotomy of, not being a service to which another item applies (Anaes.) | \$371.30 |
| 47982 | Forage (Drill decompression), of neck or head of femur, or both (Assist.) (Anaes.) | \$709.60 |
| 48200 | Femur, bone graft to (Assist.) (Anaes.) | \$1460.70 |
| 48203 | Femur, bone graft to, with internal fixation (Assist.) (Anaes.) | \$1768.80 |
| 48206 | Tibia, bone graft to (Assist.) (Anaes.) | \$1102.20 |
| 48209 | Tibia, bone graft to, with internal fixation (Assist.) (Anaes.) | \$1390.20 |
| 48212 | Humerus, bone graft to (Assist.) (Anaes.) | \$1085.70 |
| 48215 | Humerus, bone graft to, with internal fixation (Assist.) (Anaes.) | \$1393.80 |
| 48218 | Radius or ulna, bone graft to (Assist.) (Anaes.) | \$1086.50 |
| 48221 | Radius and ulna, bone graft to, with internal fixation of 1 or both bones (Assist.) (Anaes.) | \$1445.70 |
| 48224 | Radius or ulna, bone graft to (Assist.) (Anaes.) | \$722.00 |
| 48227 | Radius or ulna, bone graft to, with internal fixation of 1 or both bones (Assist.) (Anaes.) | \$1026.40 |
| 48230 | Scaphoid, bone graft to, for non-union (Assist.) (Anaes.) | \$976.00 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 48233 | Scaphoid, bone graft to, for non-union, with internal fixation (Assist.) (Anaes.) | \$1272.80 |
| 48236 | Scaphoid, bone graft to, for mal-union, including osteotomy, bone graft and internal fixation (Assist.) (Anaes.) | \$1552.30 |
| 48239 | Bone graft, not being a service to which another item in this Group applies (Assist.) (Anaes.) | \$882.00 |
| 48242 | Bone graft, with internal fixation, not being a service to which another item in this Group applies (Assist.) (Anaes.) | \$1378.30 |
| 48400 | Phalanx, metatarsal, accessory bone or sesamoid bone, osteotomy or osteectomy of, excluding services to which item 49848 or 49851 applies, any of items 49848, 49851, 47933 or 47936 apply (Assist.) (Anaes.) | \$661.50 |
| 48403 | Phalanx or metatarsal, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Assist.) (Anaes.) | \$1075.00 |
| 48406 | Fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Assist.) (Anaes.) | \$680.80 |
| 48409 | Fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, osteotomy or osteectomy, with internal fixation, and excluding services to which items 47933 or 47936 apply (Assist.) (Anaes.) | \$1113.70 |
| 48412 | Humerus, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Assist.) (Anaes.) | \$1220.70 |
| 48415 | Humerus, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Assist.) (Anaes.) | \$1538.50 |
| 48418 | Tibia, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Assist.) (Anaes.) | \$1208.50 |
| 48421 | Tibia, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Assist.) (Anaes.) | \$1807.10 |
| 48424 | Femur or pelvis, osteotomy or osteectomy of, other than a service associated with surgery for femoroacetabular impingement, or to which item 47933 or 47936 applies (H) (Anaes.) (Assist.) | \$1718.10 |
| 48427 | Femur or pelvis, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Assist.) (Anaes.) | \$1788.90 |
| 48500 | Femur, epiphysiodesis of (Assist.) (Anaes.) | \$633.90 |
| 48503 | Tibia and fibula, epiphysiodesis of (Assist.) (Anaes.) | \$631.90 |
| 48506 | Femur, tibia and fibula, epiphysiodesis of (Assist.) (Anaes.) | \$936.90 |
| 48509 | Epiphysiodesis, staple arrest of hemiepiphysis (Anaes.) | \$417.10 |
| 48512 | Epiphysiolysis, operation to prevent closure of plate (Assist.) (Anaes.) | \$1749.30 |
| 48900 | Shoulder, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both (Assist.) (Anaes.) | \$551.20 |
| 48903 | Shoulder, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination (Assist.) (Anaes.) | \$1130.60 |
| 48906 | Shoulder, repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff, or both - not being a service associated with a service to which item 48900 applies (Assist.) (Anaes.) | \$1083.20 |
| 48909 | Shoulder, repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination, not being a service associated with a service to which item 48903 applies (Assist.) (Anaes.) | \$1686.20 |
| 48912 | Shoulder, arthrotomy of (Assist.) (Anaes.) | \$632.30 |
| 48915 | Shoulder, hemi-arthroplasty of (Assist.) (Anaes.) | \$1508.50 |
| 48918 | Shoulder, total replacement arthroplasty of, including any associated rotator cuff repair (Assist.) (Anaes.) | \$3127.70 |
| 48921 | Shoulder, total replacement arthroplasty, revision of (Assist.) (Anaes.) | \$3015.50 |
| 48924 | Shoulder, total replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or both (Assist.) (Anaes.) | \$3601.90 |
| 48927 | Shoulder prosthesis, removal of (Assist.) (Anaes.) | \$649.90 |
| 48930 | Shoulder, stabilisation procedure for recurrent anterior or posterior dislocation (Assist.) (Anaes.) | \$1700.80 |
| 48933 | Shoulder, stabilisation procedure for multi-directional instability, anterior or posterior (or both) repair when performed (Assist.) (Anaes.) | \$2009.00 |
| 48936 | Shoulder, synovectomy of, as an independent procedure (Assist.) (Anaes.) | \$1461.60 |
| 48939 | Shoulder, arthrodesis of, with synovectomy if performed (Assist.) (Anaes.) | \$2225.00 |
| 48942 | Shoulder, arthrodesis of, with synovectomy if performed, with removal of prosthesis, requiring bone grafting or internal fixation (Assist.) (Anaes.) | \$2739.20 |
| 48945 | Shoulder, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region (Assist.) (Anaes.) | \$531.20 |
| 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 | \$1325.60 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| | - not being a service associated with any other arthroscopic procedure of the shoulder region (Assist.) (Anaes.) | |
| 48951 | Shoulder, arthroscopic division of coraco-acromial ligament including acromioplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Assist.) (Anaes.) | \$1732.50 |
| 48954 | Shoulder, arthroscopic total synovectomy of, including release of contracture when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Assist.) (Anaes.) | \$1809.10 |
| 48957 | Shoulder, arthroscopic stabilisation of, for recurrent instability including labral repair or reattachment when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Assist.) (Anaes.) | \$2237.80 |
| 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 (Assist.) (Anaes.) | \$1977.70 |
| 49100 | Elbow, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture (Assist.) (Anaes.) | \$666.10 |
| 49103 | Elbow, ligamentous stabilisation of (Assist.) (Anaes.) | \$1443.10 |
| 49106 | Elbow, arthrodesis of, with synovectomy if performed (Assist.) (Anaes.) | \$1828.10 |
| 49109 | Elbow, total synovectomy of (Assist.) (Anaes.) | \$1488.20 |
| 49112 | Elbow, silastic or other replacement of radial head (Assist.) (Anaes.) | \$1415.70 |
| 49115 | Elbow, total joint replacement of (Assist.) (Anaes.) | \$2687.70 |
| 49116 | Elbow, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Assist.) (Anaes.) | \$2857.30 |
| 49117 | Elbow, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Assist.) (Anaes.) | \$3646.70 |
| 49118 | Elbow, diagnostic arthroscopy of, including biopsy and lavage, not being a service associated with any other arthroscopic procedure of the elbow (Assist.) (Anaes.) | \$556.10 |
| 49121 | Elbow, arthroscopic surgery involving any 1 or more of: drilling of defect, removal of loose body; release of contracture or adhesions; chondroplasty; or osteoplasty - not being a service associated with any other arthroscopic procedure of the elbow (Assist.) (Anaes.) | \$1280.40 |
| 49200 | Wrist, arthrodesis of, with synovectomy if performed, with or without bone graft and internal fixation of the radiocarpal joint (Assist.) (Anaes.) | \$1593.90 |
| 49203 | Wrist, limited arthrodesis of the intercarpal joint, with synovectomy if performed, with or without bone graft (Assist.) (Anaes.) | \$1239.70 |
| 49206 | Wrist, proximal carpectomy of, including styloidectomy when performed (Assist.) (Anaes.) | \$1142.20 |
| 49209 | Wrist, total replacement arthroplasty of (Assist.) (Anaes.) | \$1610.60 |
| 49210 | Wrist, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Assist.) (Anaes.) | \$1879.60 |
| 49211 | Wrist, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Assist.) (Anaes.) | \$2285.80 |
| 49212 | Wrist, arthrotomy of (Anaes.) | \$466.10 |
| 49215 | Wrist, reconstruction of, including repair of single or multiple ligaments or capsules, including associated arthrotomy (Assist.) (Anaes.) | \$1280.00 |
| 49218 | Wrist, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy) - not being a service associated with any other arthroscopic procedure of the wrist joint (Assist.) (Anaes.) | \$637.50 |
| 49221 | Wrist, arthroscopic surgery of, involving any 1 or more of: drilling of defect; removal of loose body, release of adhesions; local synovectomy; or debridement of one area - not being a service associated with any other arthroscopic procedure of the wrist joint (Assist.) (Anaes.) | \$1343.50 |
| 49224 | Wrist, arthroscopic debridement of 2 or more distinct areas; or osteoplasty including excision of the distal ulna; or total synovectomy, not being a service associated with any other arthroscopic procedure of the wrist (Assist.) (Anaes.) | \$1418.20 |
| 49227 | Wrist, arthroscopic pinning of osteochondral fragment or stabilisation procedure for ligamentous disruption - not being a service associated with any other arthroscopic procedure of the wrist joint (Assist.) (Anaes.) | \$1444.40 |
| 49300 | Sacroiliac joint arthrodesis of (Assist.) (Anaes.) | \$1300.00 |
| 49303 | Hip, arthrotomy of, including lavage, drainage or biopsy when performed, other than a service associated with surgery for femoroacetabular impingement (H) (Anaes.) (Assist.) | \$1048.30 |
| 49306 | Hip arthrodesis of, with synovectomy if performed (Assist.) (Anaes.) | \$2072.40 |
| 49309 | Hip, arthrodesis or excision arthroplasty of, including removal of prosthesis (Austin Moore or similar (non cement)) (Assist.) (Anaes.) | \$1550.10 |
| 49312 | Hip, arthrodesis or excision arthroplasty of, including removal of prosthesis (cemented, porous coated or similar) (Assist.) (Anaes.) | \$1828.10 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 49315 | Hip, arthroplasty of, unipolar or bipolar (Assist.) (Anaes.) | \$1626.00 |
| 49318 | Hip, total replacement arthroplasty of, including minor bone grafting (Assist.) (Anaes.) | \$2730.40 |
| 49319 | Hip, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Assist.) (Anaes.) | \$5233.80 |
| 49321 | Hip, total replacement arthroplasty of, including major bone grafting, including obtaining of graft (Assist.) (Anaes.) | \$3104.20 |
| 49324 | Hip, total replacement arthroplasty of, revision procedure including removal of prosthesis (Assist.) (Anaes.) | \$3650.70 |
| 49327 | Hip, total replacement arthroplasty of, revision procedure requiring bone grafting to acetabulum, including obtaining of graft (Assist.) (Anaes.) | \$4157.90 |
| 49330 | Hip, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (Assist.) (Anaes.) | \$4295.70 |
| 49333 | Hip, total replacement arthroplasty of, revision procedure requiring bone grafting to both acetabulum and femur, including obtaining of graft (Assist.) (Anaes.) | \$4729.40 |
| 49336 | Hip, treatment of a fracture of the femur where revision total hip replacement is required as part of the treatment of the fracture (not including intra-operative fracture), being a service associated with a service to which items 49324 to 49333 apply (Assist.) (Anaes.) | \$692.40 |
| 49339 | Hip, revision total replacement of, requiring anatomic specific allograft of proximal femur greater than 5 cm in length (Assist.) (Anaes.) | \$5388.90 |
| 49342 | Hip, revision total replacement of, requiring anatomic specific allograft of acetabulum (Assist.) (Anaes.) | \$5721.10 |
| 49345 | Hip, revision total replacement of, requiring anatomic specific allograft of both femur and acetabulum (Assist.) (Anaes.) | \$6393.10 |
| 49346 | Hip, revision arthroplasty with replacement of acetabular liner or ceramic head, not requiring removal of femoral component or acetabular shell (Assist.) (Anaes.) | \$1636.50 |
| 49360 | Hip, diagnostic arthroscopy of, not being a service associated with any other arthroscopic procedure of the hip (Assist.) (Anaes.) | \$669.40 |
| 49363 | Hip, diagnostic arthroscopy of, with synovial biopsy, not being a service associated with any other orthroscopic procedure of the hip (Assist.) (Anaes.) | \$801.90 |
| 49366 | Hip, arthroscopic surgery of, other than a service associated with another arthroscopic procedure of the hip, or a service associated with surgery for femoroacetabular impingement (H) (Anaes.) (Assist.) | \$1515.30 |
| 49500 | Knee, arthrotomy of, involving 1 or more of; capsular release, biopsy or lavage, or removal of loose body or foreign body (Assist.) (Anaes.) | \$723.10 |
| 49503 | Knee, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon (not being a service to which another item in this Group applies) - any 1 procedure (Assist.) (Anaes.) | \$953.00 |
| 49506 | Knee, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon (not being a service to which another item in this Group applies) - any 2 or more procedures (Assist.) (Anaes.) | \$1412.50 |
| 49509 | Knee, total synovectomy or arthrodesis with synovectomy if performed (Assist.) (Anaes.) | \$1460.30 |
| 49512 | Knee, arthrodesis of, with synovectomy if performed, with removal of prosthesis (Assist.) (Anaes.) | \$2087.20 |
| 49515 | Knee, removal of prosthesis, cemented or uncemented, including associated cement, as the first stage of a 2 stage procedure (Assist.) (Anaes.) | \$1833.50 |
| 49517 | Knee, hemiarthroplasty of (Assist.) (Anaes.) | \$2625.20 |
| 49518 | Knee, total replacement arthroplasty of (Assist.) (Anaes.) | \$2727.00 |
| 49519 | Knee, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Assist.) (Anaes.) | \$5145.30 |
| 49521 | Knee, total replacement arthroplasty of, requiring major bone grafting to femur or tibia, including obtaining of graft (Assist.) (Anaes.) | \$3066.70 |
| 49524 | Knee, total replacement arthroplasty of, requiring major bone grafting to femur and tibia, including obtaining of graft (Assist.) (Anaes.) | \$3611.00 |
| 49527 | Knee, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Assist.) (Anaes.) | \$3101.20 |
| 49530 | Knee, total replacement arthroplasty of, revision procedure, requiring bone grafting to femur or tibia, including obtaining of graft and including removal of prosthesis (Assist.) (Anaes.) | \$3835.20 |
| 49533 | Knee, total replacement arthroplasty of, revision procedure, requiring bone grafting to both femur and tibia, including obtaining of graft and including removal of prosthesis (Assist.) (Anaes.) | \$4333.40 |
| 49534 | Knee, patello-femoral joint of, total replacement arthroplasty as a primary procedure (Assist.) (Anaes.) | \$1140.00 |
| 49536 | Knee, repair or reconstruction of, for chronic instability (open or arthroscopic, or both) involving either cruciate or collateral ligaments, including notchplasty when performed, not being a service associated with any other arthroscopic procedure of the knee (Assist.) (Anaes.) | \$1860.50 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 49539 | Knee, reconstructive surgery of cruciate ligament or ligaments (open or arthroscopic, or both), including notchplasty when performed and surgery to other internal derangements, not being a service to which another item in this Group applies or a service associated with any other arthroscopic procedure of the knee (Assist.) (Anaes.) | \$2107.90 |
| 49542 | Knee, reconstructive surgery of cruciate ligament or ligaments (open or arthroscopic, or both), including notchplasty, meniscus repair, extracapsular procedure and debridement when performed, not being a service associated with any other arthroscopic procedure of the knee (Assist.) (Anaes.) | \$2822.50 |
| 49545 | Knee, revision arthrodesis of, with synovectomy if performed (Assist.) (Anaes.) | \$1333.50 |
| 49548 | Knee, revision of patello-femoral stabilisation (Assist.) (Anaes.) | \$1928.60 |
| 49551 | Knee, revision of procedures to which item 49536, 49539 or 49542 applies (Assist.) (Anaes.) | \$2821.20 |
| 49554 | Knee, revision of total replacement of, by anatomic specific allograft of tibia or femur (Assist.) (Anaes.) | \$3611.60 |
| 49557 | Knee, diagnostic arthroscopy of (including biopsy, simple trimming of meniscal margin or plica) - not being a service associated with any other arthroscopic procedure of the knee region (Assist.) (Anaes.) | \$573.70 |
| 49558 | Knee, arthroscopic surgery of, involving 1 or more of: debridement, osteoplasty or chondroplasty - not associated with any other arthroscopic procedure of the knee region (Assist.) (Anaes.) | \$532.40 |
| 49559 | Knee, arthroscopic surgery of, involving chondroplasty requiring multiple drilling or carbon fibre (or similar) implant; including any associated debridement or osteoplasty - not associated with any other arthroscopic procedure of the knee region (Assist.) (Anaes.) | \$825.30 |
| 49560 | Knee, arthroscopic surgery of, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release - not being a service associated with any other arthroscopic procedure of the knee region (Assist.) (Anaes.) | \$1145.60 |
| 49561 | Knee, arthroscopic surgery of, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release; where the procedure includes associated debridement, osteoplasty or chondroplasty - not associated with any other arthroscopic procedure of the knee region (Assist.) (Anaes.) | \$1369.20 |
| 49562 | Knee, arthroscopic surgery of, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release; where the procedure includes chondroplasty requiring multiple drilling or carbon fibre (or similar) implant and associated debridement or osteoplasty - not associated with any other arthroscopic procedure of the knee region (Assist.) (Anaes.) | \$1500.10 |
| 49563 | Knee, arthroscopic surgery of, involving 1 or more of: meniscus repair; osteochondral graft; or chondral graft - not associated with any other arthroscopic procedure of the knee region (Assist.) (Anaes.) | \$1622.40 |
| 49564 | Knee, patello-femoral stabilisation of, combined arthroscopic and open procedure, including lateral release, medial capsulorrhaphy and tendon transfer, not being a service associated with any other arthroscopic procedure of the knee (Assist.) (Anaes.) | \$1906.90 |
| 49566 | Knee, arthroscopic total synovectomy of, not being a service associated with any other arthroscopic procedure of the knee (Assist.) (Anaes.) | \$1754.70 |
| 49569 | Knee, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (Assist.) (Anaes.) | \$1448.90 |
| 49700 | Ankle, diagnostic arthroscopy of, including biopsy (Assist.) (Anaes.) | \$552.40 |
| 49703 | Ankle, arthroscopic surgery of, not being a service associated with any other arthroscopic procedure of the ankle (Assist.) (Anaes.) | \$1332.20 |
| 49706 | Ankle, arthrotomy of, involving 1 or more of: lavage, removal of loose body or division of contracture (Assist.) (Anaes.) | \$700.40 |
| 49709 | Ankle, ligamentous stabilisation of (Assist.) (Anaes.) | \$1514.10 |
| 49712 | Ankle, arthrodesis of, with synovectomy if performed (Assist.) (Anaes.) | \$1600.00 |
| 49715 | Ankle, total joint replacement of (Assist.) (Anaes.) | \$2268.30 |
| 49716 | Ankle, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Assist.) (Anaes.) | \$2766.20 |
| 49717 | Ankle, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Assist.) (Anaes.) | \$3811.90 |
| 49718 | Ankle, Achilles' tendon or other major tendon, repair of (Assist.) (Anaes.) | \$828.90 |
| 49721 | Ankle, Achilles' tendon rupture managed by non-operative treatment | \$453.90 |
| 49724 | Ankle, Achilles' tendon, secondary repair or reconstruction of (Assist.) (Anaes.) | \$1655.00 |
| 49727 | Ankle, Achilles' tendon, operation for lengthening (Assist.) (Anaes.) | \$630.80 |
| 49728 | Ankle, lengthening of the gastrocnemius aponeurosis and soleus fascia, for the correction of equinus deformity in children with cerebral palsy (Assist.) (Anaes.) | \$1102.70 |
| 49800 | Foot, flexor or extensor tendon, primary repair of (Anaes.) | \$268.80 |
| 49803 | Foot, flexor or extensor tendon, secondary repair of (Anaes.) | \$356.00 |
| 49806 | Foot, subcutaneous tenotomy of, 1 or more tendons (Anaes.) | \$269.60 |
| 49809 | Foot, open tenotomy of, with or without tenoplasty (Anaes.) | \$477.10 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 49812 | Foot, tendon or ligament transplantation of, not being a service to which another item in this Group applies (Assist.) (Anaes.) | \$897.00 |
| 49815 | Foot, triple arthrodesis of, with synovectomy if performed (Assist.) (Anaes.) | \$1664.00 |
| 49818 | Foot, excision of calcaneal spur (Assist.) (Anaes.) | \$654.70 |
| 49821 | Foot, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - unilateral (Assist.) (Anaes.) | \$856.90 |
| 49824 | Foot, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - bilateral (Assist.) (Anaes.) | \$1469.10 |
| 49827 | Foot, correction of hallux valgus by transfer of adductor hallucis tendon - unilateral (Assist.) (Anaes.) | \$948.50 |
| 49830 | Foot, correction of hallux valgus by transfer of adductor hallucis tendon - bilateral (Assist.) (Anaes.) | \$1809.00 |
| 49833 | Foot, correction of hallux valgus by osteotomy of first metatarsal with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - unilateral (Assist.) (Anaes.) | \$1083.60 |
| 49836 | Foot, correction of hallux valgus by osteotomy of first metatarsal with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - bilateral (Assist.) (Anaes.) | \$1992.30 |
| 49837 | Foot, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallucis tendon, with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - unilateral (Assist.) (Anaes.) | \$1272.70 |
| 49838 | Foot, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallucis tendon, with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - bilateral (Assist.) (Anaes.) | \$2174.00 |
| 49839 | Foot, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - unilateral (Assist.) (Anaes.) | \$1136.50 |
| 49842 | Foot, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - bilateral (Assist.) (Anaes.) | \$1981.00 |
| 49845 | Foot, arthrodesis of, first metatarso- phalangeal joint, with synovectomy if performed (Assist.) (Anaes.) | \$1039.90 |
| 49848 | Foot, correction of claw or hammer toe (Anaes.) | \$321.10 |
| 49851 | Foot, correction of claw or hammer toe with internal fixation (Anaes.) | \$467.50 |
| 49854 | Foot, radical plantar fasciotomy or fasciectomy of (Assist.) (Anaes.) | \$721.10 |
| 49857 | Foot, metatarso-phalangeal joint replacement (Assist.) (Anaes.) | \$838.40 |
| 49860 | Foot, synovectomy of metatarso- phalangeal joint, single joint (Assist.) (Anaes.) | \$581.90 |
| 49863 | Foot, synovectomy of metatarso- phalangeal joint, 2 or more joints (Assist.) (Anaes.) | \$824.90 |
| 49866 | Foot, neurectomy for plantar or digital neuritis (Morton's or Bett's syndrome) (Assist.) (Anaes.) | \$656.30 |
| 49878 | Talipes equinovarus, calcaneo valgus or metatarsus varus, treatment by cast, splint or manipulation - each attendance (Anaes.) | \$109.20 |
| 50100 | Joint, diagnostic arthroscopy of (including biopsy), not being a service to which another item in this Group applies and not being a service associated with any other arthroscopic procedure (Assist.) (Anaes.) | \$528.80 |
| 50102 | Joint, arthroscopic surgery of, not being a service to which another item in this Group applies (Assist.) (Anaes.) | \$1173.10 |
| 50103 | Joint, arthrotomy of, not being a service to which another item in this Group applies (Assist.) (Anaes.) | \$649.00 |
| 50104 | Joint, synovectomy of, not being a service to which another item in this Group applies (Assist.) (Anaes.) | \$635.10 |
| 50106 | Joint, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (Assist.) (Anaes.) | \$934.10 |
| 50109 | Joint, arthrodesis of, not being a service to which another item in this Group applies, with synovectomy if performed (Assist.) (Anaes.) | \$966.20 |
| 50112 | Cicatricial flexion or extension contraction of joint, correction of, involving tissues deeper than skin and subcutaneous tissue, not being a service to which another item in this Group applies (Assist.) (Anaes.) | \$696.90 |
| 50115 | Joint or joints, manipulation of, performed in the operating theatre of a hospital, not being a service associated with a service to which another item in this Group applies (Anaes.) | \$273.90 |
| 50118 | Subtalar joint, arthrodesis of, with synovectomy if performed (Assist.) (Anaes.) | \$932.30 |
| 50121 | Greater Trochanter, transplantation of ileopsoas tendon to (Assist.) (Anaes.) | \$1913.40 |
| 50127 | Joint or joints, arthroplasty of, by any technique not being a service to which another item applies (Assist.) (Anaes.) | \$1353.80 |
| 50130 | Joint or joints, application of external fixator to, other than for treatment of fractures (Assist.) (Anaes.) | \$731.10 |
| 50200 | Aggressive or potentially malignant bone or deep soft tissue tumour, biopsy of (not including aftercare) (Anaes.) | \$364.00 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 50201 | Aggressive or potentially malignant bone or deep soft tissue tumour, involving neurovascular structures, open biopsy of (not including aftercare) (Assist.) (Anaes.) | \$659.30 |
| 50203 | Bone or malignant deep soft tissue tumour, lesional or marginal excision of (Assist.) (Anaes.) | \$854.90 |
| 50206 | Bone tumour, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Assist.) (Anaes.) | \$1220.30 |
| 50209 | Bone tumour, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Assist.) (Anaes.) | \$1449.40 |
| 50212 | Malignant or aggressive soft tissue tumour affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, without reconstruction (Assist.) (Anaes.) | \$3158.90 |
| 50215 | Malignant or aggressive soft tissue tumour affecting the long bones of leg or an arm, enbloc resection of, with compartmental or wide excision of soft tissue, with intercalary reconstruction (prosthesis, allograft or autograft) (Assist.) (Anaes.) | \$3967.30 |
| 50218 | Malignant tumour of long bone, enbloc resection of, with replacement or arthrodesis of adjacent joint, with synovectomy if performed (Assist.) (Anaes.) | \$5271.70 |
| 50221 | Malignant or aggressive soft tissue tumour of pelvis, sacrum or spine; or scapula and shoulder, enbloc resection of (Assist.) (Anaes.) | \$4883.40 |
| 50224 | Malignant or aggressive soft tissue tumour of pelvis, sacrum or spine; or scapula and shoulder, enbloc resection of, with reconstruction by prosthesis, allograft or autograft (Assist.) (Anaes.) | \$5431.80 |
| 50227 | Malignant bone tumour, enbloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement (Assist.) (Anaes.) | \$5941.10 |
| 50230 | Benign tumour, resection of, requiring anatomic specific allograft, with or without internal fixation (Assist.) (Anaes.) | \$3148.50 |
| 50233 | Malignant tumour, amputation for, hemipelvectomy or interscapulo-thoracic (Assist.) (Anaes.) | \$4150.90 |
| 50236 | Malignant tumour, amputation for, hip disarticulation, shoulder disarticulation or proximal third femur (Assist.) (Anaes.) | \$3015.50 |
| 50239 | Malignant tumour, amputation for, not being a service to which another item in this Group applies (Assist.) (Anaes.) | \$2169.80 |
| 50300 | Joint deformity, slow correction of, using ring fixator or similar device, including all associated attendances - payable only once in any 12 month period (Assist.) (Anaes.) | \$2223.80 |
| 50303 | Limb lengthening, 5cm or less, by gradual distraction, with application of an external fixator or intra-medullary device, in the operating theatre of a hospital - payable only once per limb in any 12 month period (Assist.) (Anaes.) | \$3040.50 |
| 50306 | Limb lengthening, where the lengthening is bipolar, or bone transport is performed or where the fixator is extended to correct an adjacent joint deformity, or where the lengthening is greater than 5cm (Assist.) (Anaes.) | \$4744.00 |
| 50309 | Ring fixator or similar device, adjustment of, with or without insertion or removal of fixation pins, performed under general anaesthesia in the operating theatre of a hospital, not being a service to which item 50303 or 50306 applies (Assist.) (Anaes.) | \$584.20 |
| 50312 | Ankle, synovectomy of, by arthroscopic or open means - not associated with any other arthroscopic procedure of the ankle (Assist.) (Anaes.) | \$1347.50 |
| 50315 | Talipes equinovarus, posterior release of (Assist.) (Anaes.) | \$1332.20 |
| 50318 | Talipes equinovarus, medial release of (Assist.) (Anaes.) | \$1227.30 |
| 50321 | Talipes equinovarus, combined postero- medial release of (Assist.) (Anaes.) | \$1792.20 |
| 50324 | Talipes equinovarus, combined postero- medial release of, revision procedure (Assist.) (Anaes.) | \$2344.10 |
| 50327 | Talipes equinovarus, bilateral procedures (Assist.) (Anaes.) | \$2859.30 |
| 50330 | Talipes equinovarus, or talus, vertical congenital - post operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital, not being a service to which item 50315, 50318, 50321, 50324 or 50327 applies (Anaes.) | \$504.00 |
| 50333 | Tarsal coalition, excision of, with interposition of muscle, fat graft or similar graft (Assist.) (Anaes.) | \$1238.50 |
| 50336 | Talus, vertical, congenital, combined anterior and posterior reconstruction (Assist.) (Anaes.) | \$1632.30 |
| 50339 | Foot and ankle, tibialis anterior tendon (split or whole) transfer to lateral column (Assist.) (Anaes.) | \$1079.90 |
| 50342 | Foot and ankle, tibialis or tibialis posterior tendon transfer, through the interosseous membrane to anterior or posterior aspect of foot (Assist.) (Anaes.) | \$1252.50 |
| 50345 | Hyperextension deformity of toe, release incorporating V-Y plasty of skin, lengthening of extensor tendons and release of capsule contracture (Assist.) (Anaes.) | \$737.90 |
| 50348 | Knee, deformity of, post-operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital (Anaes.) | \$470.50 |
| 50349 | Hip, congenital dislocation of, treatment of, by closed reduction (Anaes.) | \$566.80 |
| 50351 | Hip, developmental dislocation of, open reduction of (Assist.) (Anaes.) | \$2827.70 |
| 50352 | Hip, congenital dislocation of, treatment of, involving supervision of splint, harness or cast - each attendance (Anaes.) | \$109.20 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 50353 | Hip spica, initial application of, for congenital dislocation of hip (excluding aftercare) (Assist.) (Anaes.) | \$628.00 |
| 50354 | Tibia, pseudarthrosis of, congenital, resection and internal fixation (Assist.) (Anaes.) | \$2319.30 |
| 50357 | Knee, leg or thigh, rectus femoris tendon transfer or medial or lateral hamstring tendon transfer (Assist.) (Anaes.) | \$1242.20 |
| 50360 | Knee, leg or thigh, combined medial and lateral hamstring tendon transfer (Assist.) (Anaes.) | \$1380.50 |
| 50363 | Knee, contracture of, posterior release involving multiple tendon lengthening or tenotomies, unilateral (Assist.) (Anaes.) | \$960.80 |
| 50366 | Knee, contracture of, posterior release involving multiple tendon lengthening or tenotomies, bilateral (Assist.) (Anaes.) | \$1676.10 |
| 50369 | Knee, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, unilateral (Assist.) (Anaes.) | \$1261.80 |
| 50372 | Knee, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, bilateral (Assist.) (Anaes.) | \$2025.10 |
| 50375 | Hip, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, unilateral (Assist.) (Anaes.) | \$1155.00 |
| 50378 | Hip, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, bilateral (Assist.) (Anaes.) | \$1940.40 |
| 50381 | Hip, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, unilateral (Assist.) (Anaes.) | \$1249.20 |
| 50384 | Hip, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, bilateral (Assist.) (Anaes.) | \$2212.50 |
| 50387 | Hip, iliopsoas tendon transfer to greater trochanter, or transfer of abdominal musculature to greater trochanter, or transfer or adductors to ischium (Assist.) (Anaes.) | \$1153.60 |
| 50390 | Perthes, cerebral palsy, or other neuromuscular conditions, affecting hips or knees, application of cast under general anaesthesia, performed in the operating theatre of a hospital (Anaes.) | \$443.70 |
| 50393 | Pelvis, bone graft or shelf procedures for acetabular dysplasia (Assist.) (Anaes.) | \$1625.40 |
| 50394 | Acetabular dysplasia, treatment of, by multiple peri-acetabular osteotomy, including internal fixation where performed (Assist.) (Anaes.) | \$5378.90 |
| 50396 | Hand, congenital abnormalities or duplication of digits, amputation or splitting of phalanx or phalanges, with ligament or joint reconstruction (Assist.) (Anaes.) | \$915.40 |
| 50399 | Forearm, radial aplasia or dysplasia (radial club hand), centralisation or radialisation of (Assist.) (Anaes.) | \$1632.30 |
| 50402 | Torticollis, bipolar release of sternocleidomastoid muscle and associated soft tissue (Assist.) (Anaes.) | \$816.60 |
| 50405 | Elbow, flexorplasty, or tendon transfer to restore elbow function (Assist.) (Anaes.) | \$1200.70 |
| 50408 | Shoulder, congenital or developmental dislocation, open reduction of (Assist.) (Anaes.) | \$1767.30 |
| 50411 | Lower limb deficiency, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion (Assist.) (Anaes.) | \$2319.30 |
| 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 (Assist.) (Anaes.) | \$3129.40 |
| 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 (Assist.) (Anaes.) | \$2319.30 |
| 50420 | Patella, congenital dislocation of, reconstruction of the quadriceps (Assist.) (Anaes.) | \$1914.60 |
| 50423 | Tibia, fibula or both, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (Assist.) (Anaes.) | \$2285.90 |
| 50426 | Diaphyseal aclasia, removal of lesion or lesions from bone - 1 approach (Assist.) (Anaes.) | \$986.70 |
| 50450 | Unilateral single event multilevel surgery for patients less than 18 years of age with hemiplegic cerebral palsy comprising three or more of the following: Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. Correction of muscle imbalance by tendon transfer/transfers. Correction of femoral torsion by rotational osteotomy of the femur. Correction of tibial torsion by rotational osteotomy of the tibia. 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 (Assist.) (Anaes.) | \$2161.10 |
| 50451 | Unilateral single event multilevel surgery for patients less than 18 years of age with hemiplegic cerebral palsy comprising three or more of the following: (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of femoral torsion by rotational osteotomy of the femur. (d) Correction of tibial torsion by rotational osteotomy of the tibia. (e) Correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis, with synovectomy if performed, or os calcis lengthening. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Assist.) (Anaes.) | \$2161.10 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 50455 | Bilateral single event multilevel surgery for patients less than 18 years of age with diplegic cerebral palsy that comprises: Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. Correction of muscle imbalance by tendon transfer/transfers. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Assist.) (Anaes.) | \$2447.40 |
| 50456 | Bilateral single event multilevel surgery for patients less than 18 years of age with diplegic cerebral palsy that comprises: (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Assist.) (Anaes.) | \$2447.40 |
| 50460 | Bilateral single event multilevel surgery for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral femoral osteotomies. Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. Correction of muscle imbalance by tendon transfer/transfers. Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Assist.) (Anaes.) | \$3653.60 |
| 50461 | Bilateral single event multilevel surgery for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral femoral osteotomies. (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Assist.) (Anaes.) | \$3653.60 |
| 50465 | Bilateral single event multilevel surgery for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies. Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. Correction of muscle imbalance by tendon transfer/transfers. Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation. Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Assist.) (Anaes.) | \$5146.40 |
| 50466 | Bilateral single event multilevel surgery for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies. (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation. (d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Assist.) (Anaes.) | \$5146.40 |
| 50470 | Bilateral single event multilevel surgery for patients less than 18 years of age with cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation. Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. Correction of muscle imbalance by tendon transfer/transfers. Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation. Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Assist.) (Anaes.) | \$6526.80 |
| 50471 | Bilateral single event multilevel surgery for patients less than 18 years of age with cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation. (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation. (d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. (e) Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Assist.) (Anaes.) | \$6526.80 |
| 50475 | Single event multilevel surgery for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including: Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. Correction of muscle imbalance by tendon transfer/transfers. Correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation. Correction of patella alta and quadriceps insufficiency by patella tendon shortening/reconstruction. Correction of tibial torsion by rotational osteotomy of the tibia with internal fixation. Correction of foot instability by os calcis lengthening or subtalar fusion. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Assist.) (Anaes.) | \$7531.30 |
| 50476 | Single event multilevel surgery for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including: (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation. (d) Correction of patella alta and quadriceps insufficiency by patella tendon shortening/reconstruction. (e) Correction of tibial torsion by rotational osteotomy of the tibia with internal fixation. (f) Correction of foot instability by os calcis lengthening or subtalar fusion. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Assist.) (Anaes.) | \$7531.30 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 50500 | Radius or ulna, distal end of, with open growth plate, treatment of fracture of, by closed reduction (Anaes.) | \$790.00 |
| 50504 | Radius or ulna, distal end of, with open growth plate, treatment of fracture of, by open reduction (Assist.) (Anaes.) | \$653.20 |
| 50508 | Radius, distal end of, with open growth plate, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.) | \$842.30 |
| 50512 | Radius, distal end of, with open growth plate, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Assist.) (Anaes.) | \$1013.10 |
| 50516 | Radius or ulna, shaft of, with open growth plate, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) | \$685.80 |
| 50520 | Radius or ulna, shaft of, with open growth plate, treatment of fracture of, by open reduction (Assist.) (Anaes.) | \$1169.80 |
| 50524 | Radius or ulna, shaft of, with open growth plate, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction undertaken in the operating theatre of a hospital (Assist.) (Anaes.) | \$723.10 |
| 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 (Assist.) (Anaes.) | \$1573.60 |
| 50532 | Radius and ulna, shafts of, with open growth plates, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) | \$1640.00 |
| 50536 | Radius and ulna, shafts of, with open growth plates, treatment of fracture of, by open reduction (Assist.) (Anaes.) | \$1482.30 |
| 50540 | Olecranon, with open growth plate, treatment of fracture of, by open reduction (Assist.) (Anaes.) | \$1015.50 |
| 50544 | Radius, with open growth plate, treatment of fracture of head or neck of, by closed reduction of (Anaes.) | \$466.70 |
| 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 (Assist.) (Anaes.) | \$933.60 |
| 50552 | Humerus, proximal, with open growth plate, treatment of fracture of, by closed reduction, undertaken in the operating theatre, neonatal unit or nursery of a hospital (Anaes.) | \$872.70 |
| 50556 | Humerus, proximal, with open growth plate, treatment of fracture of, by open reduction (Assist.) (Anaes.) | \$1161.40 |
| 50560 | Humerus, shaft of, with open growth plate, treatment of fracture of, by closed reduction, undertaken in the operating theatre, neonatal unit or nursery of a hospital (Anaes.) | \$839.90 |
| 50564 | Humerus, shaft of, with open growth plate, treatment of fracture of, by internal or external fixation (Assist.) (Anaes.) | \$1119.90 |
| 50568 | Hummerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) | \$1066.50 |
| 50572 | Humerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means, undertaken in the operating theatre of a hospital (Assist.) (Anaes.) | \$1417.40 |
| 50576 | Femur, with open growth plate, treatment of fracture of, by closed reduction or traction (Assist.) (Anaes.) | \$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 per cutaneous means (Assist.) (Anaes.) | \$1173.60 |
| 50584 | Tibia, distal, with open growth plate, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Assist.) (Anaes.) | \$1377.50 |
| 50588 | Tibia and fibula, with open growth plates, treatment of fracture of, by internal fixation (Assist.) (Anaes.) | \$1481.70 |
| 50600 | Scoliosis or kyphosis, in a growing child, manipulation of deformity and application of a localiser cast, under general anaesthesia, in a hospital (Assist.) (Anaes.) | \$765.60 |
| 50604 | Scoliosis or kyphosis, in a child or adolescent, spinal fusion for (without instrumentation) (Assist.) (Anaes.) | \$3249.90 |
| 50608 | Scoliosis or Kyphosis, in a child or adolescent, treatment by segmental instrumentation and fusion of the spine, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.) | \$6995.00 |
| 50612 | Scoliosis or Kyphosis, in a child or adolescent, with spinal deformity, treatment by segmental instrumentation, utilising separate anterior and posterior approaches, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.) | \$9338.80 |
| 50616 | Scoliosis, in a child or adolescent, re-exploration for adjustment or removal of segmental instrumentation used for correction of spine deformity (Assist.) (Anaes.) | \$1186.50 |
| 50620 | Scoliosis, in a child or adolescent, revision of failed scoliosis surgery, involving more than 1 of osteotomy, fusion, removal of instrumentation or instrumentation, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.) | \$6602.30 |
| 50624 | Scoliosis, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - not more than 4 levels (Assist.) (Anaes.) | \$6645.10 |

| Item No. | Description | Max fee (excl GST) |
|--|---|--------------------|
| 50628 | Scoliosis, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Assist.) (Anaes.) | \$8102.70 |
| 50632 | Scoliosis or Kyphosis, in a child or adolescent, requiring segmental instrumentation and fusion of the spine down to and including the pelvis or sacrum, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.) | \$6822.50 |
| 50636 | Scoliosis, in a child or adolescent, requiring anterior decompression of the spinal cord with vertebral resection and instrumentation in the presence of spinal cord involvement, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.) | \$6964.80 |
| 50640 | Scoliosis, in a child or adolescent, congenital, resection and fusion of abnormal vertebra via an anterior or posterior approach, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.) | \$3850.00 |
| 50644 | Spine, bone graft to, for a child or adolescent, associated with surgery for correction of scoliosis or kyphosis or both (Assist.) (Anaes.) | \$4242.10 |
| 50650 | Hip dysplasia or dislocation, in a child, examination, manipulation and arthrography of the hip under anaesthesia (Anaes.) | \$730.60 |
| 50654 | Hip dysplasia or dislocation, in a child, application or reapplication of a hip spica, including examination of the hip (Assist.) (Anaes.) | \$874.70 |
| 50658 | Hip dysplasia or dislocation, in a child, examination and manipulation of the hip under anaesthesia (Anaes.) | \$380.00 |
| Radiofrequency ablation | | |
| 50950 | Unresectable primary malignant tumour of the liver, destruction of, by percutaneous radiofrequency ablation or percutaneous microwave tissue ablation (including any associated imaging services), other than a service associated with a service to which item 30419 or 50952 applies (Anaes.) | \$1511.40 |
| 50952 | Unresectable primary malignant tumour of the liver, destruction of, by open or laparoscopic radiofrequency ablation or open or laparoscopic microwave tissue ablation (including any associated imaging services), if a multi-disciplinary team has assessed that percutaneous radiofrequency ablation or percutaneous microwave tissue ablation cannot be performed or is not practical because of one or more of the following clinical circumstances: (a) percutaneous access cannot be achieved; (b) vital organs or tissues are at risk of damage from the percutaneous radiofrequency ablation or percutaneous microwave tissue ablation procedure; (c) resection of one part of the liver is possible, however there is at least one primary liver tumour in a portion of the liver that is suitable for radiofrequency ablation or microwave tissue ablation; other than a service associated with a service to which item 30419 or 50950 applies. (Anaes.) | \$1573.00 |
| GROUP 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 \$1020.50 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 \$1020.50. | \$159.70 |
| 51303 | Assistance at any operation identified by the word Assist for which the fee exceeds \$1020.50 or at a series of operations identified by the word Assist for which the aggregate fee exceeds \$1020.50. 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 | \$484.50 |
| 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; o r - 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 | \$294.20 |
| GROUP O1 - CONSULTATIONS | | |
| 51700 | Professional attendance (other than a second or subsequent attendance in a single course of treatment) by an approved dental practitioner in the practice of oral and maxillofacial surgery, at consulting rooms, hospital or residential aged care facility if the patient is referred to him or her | \$154.40 |
| 51703 | Professional attendance by an approved dental practitioner in the practice of oral and Maxillofacial Surgery, each attendance subsequent to the first in a single course of treatment at consulting rooms, hospital or residential aged care facility if the patient is referred to him or her | \$77.60 |
| GROUP O2 - ASSISTANCE OF OPERATIONS | | |
| 51800 | Assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery at any | \$159.70 |

| Item No. | Description | Max fee (excl GST) |
|-----------------------------------|---|--------------------|
| | operation identified by the word Assist. For which the fee does not exceed \$1020.50 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 \$1020.50. | |
| 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 \$1020.50 or at a series of combination of operations identified by the word Assist where the aggregate fee exceeds \$1020.50. 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 in the oral and maxillofacial region, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Assist.) (Anaes.) | \$588.10 |
| 51902 | Wounds of the oral and maxillofacial region, dressing of, under general anaesthesia, with or without removal of sutures, not being a service associated with a service to which another item in groups O3 to O9 applies (Anaes.) | \$133.30 |
| 51904 | Lipectomy - wedge excision of skin or fat - 1 excision (Assist.) (Anaes.) | \$871.50 |
| 51906 | Lipectomy - wedge excision of skin or fat - 2 or more excisions (Assist.) (Anaes.) | \$1224.60 |
| 52000 | Lipectomy - wedge excision of skin or fat - 2 or more excisions (Anaes.) | \$148.80 |
| 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.) | \$212.10 |
| 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.) | \$212.10 |
| 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.) | \$367.50 |
| 52010 | Full thickness laceration of ear, eyelid, nose or lip, repair of, with accurate apposition of each layer of tissue (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$499.10 |
| 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.) | \$325.40 |
| 52027 | Biopsy of lymph gland, muscle or other deep tissue or organ, as an independent procedure and not being a service to which item 52025 applies (Anaes.) | \$286.90 |
| 52030 | Sinus, excision of, involving superficial tissue only (Anaes.) | \$162.40 |
| 52033 | Sinus, excision of, involving muscle and deep tissue (Anaes.) | \$325.40 |
| 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, if the removal is by surgical excision and suture, not being a service to which item 52039 applies (Anaes.) | \$252.90 |
| 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, if the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Assist.) (Anaes.) | \$588.10 |
| 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.) | \$336.10 |
| 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 5 mm separation between the cyst lining and tooth structure or if 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.) | \$445.50 |
| 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 5 mm separation between the cyst lining and tooth structure or if 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 (Assist.) (Anaes.) | \$719.10 |
| 52051 | Tumour, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Assist.) (Anaes.) | \$907.70 |
| 52054 | Tumour, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Assist.) (Anaes.) | \$1088.90 |

| Item No. | Description | Max fee (excl GST) |
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| 52055 | Haematoma, small abscess or cellulitis in the oral and maxillofacial region, not requiring admission to a hospital, incision with drainage of (excluding after - care) | \$49.40 |
| 52056 | Haematoma in the oral and maxillofacial region, aspiration of (Anaes.) | \$49.40 |
| 52057 | Large haematoma, large abscess, carbuncle, cellulitis or similar lesion in the oral and maxillofacial region, incision with drainage of (excluding after-care) (Anaes.) | \$293.90 |
| 52058 | Percutaneous drainage of deep abscess in the oral and maxillofacial region, using interventional imaging techniques - but not including imaging (Anaes.) | \$428.80 |
| 52059 | Abscess in the oral and maxillofacial region drainage tube, exchange of using interventional imaging techniques - but not including imaging (Anaes.) | \$1137.80 |
| 52060 | Muscle in the oral and maxillofacial region, excision of (Anaes.) | \$364.40 |
| 52061 | Muscle, in the oral and maxillofacial region, ruptured, repair of (limited), not associated with external wound (Anaes.) | \$396.00 |
| 52062 | Muscle, in the oral and maxillofacial region, ruptured, repair of (extensive), not associated with external wound (Assist.) (Anaes.) | \$523.50 |
| 52063 | Bone tumour in the oral and maxillofacial region, innocent, excision of, not being a service to which another item in groups O3 to O9 applies (Assist.) (Anaes.) | \$696.50 |
| 52064 | Bone cyst in the oral and maxillofacial region, injection into or aspiration of (Anaes.) | \$321.60 |
| 52066 | Submandibular gland, extirpation of (Assist.) (Anaes.) | \$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.) | \$264.90 |
| 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 (Assist.) (Anaes.) | \$573.70 |
| 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 person aged not less than 2 years (Anaes.) | \$240.70 |
| 52087 | Ranula or mucous cyst of mouth, removal of (Anaes.) | \$393.60 |
| 52090 | Operation on mandible or maxilla (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Assist.) (Anaes.) | \$642.80 |
| 52092 | Operation on skull for osteomyelitis (Assist.) (Anaes.) | \$822.40 |
| 52094 | Operation on any combination of adjoining bones in the oral and maxillofacial region, being bones referred to in item 52092 (Assist.) (Anaes.) | \$1224.40 |
| 52095 | Bone growth stimulator in the oral and maxillofacial region, insertion of ((Assist.) (Anaes.) | \$868.10 |
| 52096 | Orthopaedic pin or wire, insertion of, into maxilla or mandible or zygoma, as an n independent procedure (Anaes.) | \$346.60 |
| 52097 | External fixation in the oral and maxillofacial region, removal of, in the operating theatre of a hospital (Anaes.) | \$308.30 |
| 52098 | External fixation in the oral and maxillofacial region, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.) | \$360.60 |
| 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.) | \$254.70 |
| 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, if undertaken in the operating theatre of a hospital, per bone (Anaes.) | \$276.20 |
| 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 (Assist.) (Anaes.) | \$506.40 |
| 52106 | Arch bars, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia if undertaken in the operating theatre of a hospital (Anaes.) | \$336.20 |
| 52108 | Lip, full thickness wedge excision of, with repair by direct sutures (Assist.) (Anaes.) | \$588.10 |
| 52111 | Vermilionectomy (Assist.) (Anaes.) | \$752.70 |
| 52114 | Mandible or maxilla, segmental resection of, for tumours or cysts (Assist.) (Anaes.) | \$1133.20 |
| 52117 | Mandible, including lower border, or maxilla, sub-total resection of (Assist.) (Anaes.) | \$1299.00 |
| 52120 | Mandible, hemimandiblectomy of, including condylectomy where performed (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$3517.20 |
| 52123 | Mandible, total resection of both sides, including condylectomies where performed (Assist.) (Anaes.) | \$1657.90 |

| Item No. | Description | Max fee (excl GST) |
|--|--|--------------------|
| 52126 | Maxilla, total resection of (Assist.) (Anaes.) | \$1594.20 |
| 52129 | Maxilla, total resection of both maxillae (Assist.) (Anaes.) | \$2133.90 |
| 52130 | Bone graft in the oral and maxillofacial region, not being a service to which another item in groups O3 to O9 applies (Assist.) (Anaes.) | \$798.30 |
| 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 (Assist.) (Anaes.) | \$1638.40 |
| 52132 | Tracheostomy (Anaes.) | \$1058.20 |
| 52133 | Cricothyrostomy by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.) | \$161.20 |
| 52135 | Post-operative or post-nasal haemorrhage, or both, control of, where undertaken in the operating theatre of a hospital (Anaes.) | \$260.50 |
| 52138 | Maxillary artery, ligation of (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$855.30 |
| 52144 | Foreign body, deep, removal of using interventional imaging techniques (Assist.) (Anaes.) | \$746.20 |
| 52147 | Duct of major salivary gland, transposition of (Assist.) (Anaes.) | \$748.20 |
| 52148 | Parotid duct, repair of, using micro- surgical techniques (Assist.) (Anaes.) | \$1221.20 |
| 52158 | Submandibular ducts, relocation of, for surgical control of drooling (Assist.) (Anaes.) | \$2135.40 |
| 52180 | Aggressive or potentially malignant bone or deep soft tissue tumour in the oral and maxillofacial region, biopsy of (not including after-care) (Anaes.) | \$431.40 |
| 52182 | Bone or malignant deep soft tissue tumour in the oral and maxillofacial region, lesional or marginal excision of (Assist.) (Anaes.) | \$785.50 |
| 52184 | Bone tumour in the oral and maxillofacial region, lesional or marginal excision of, combined with any 1 of liquid nitrogen freezing, autograft, allograft or cementation (Assist.) (Anaes.) | \$1185.80 |
| 52186 | Bone tumour in the oral and maxillofacial region, lesional or marginal excision of, combined with any 2 or more of liquid nitrogen freezing, autograft, allograft or cementation (Assist.) (Anaes.) | \$1359.00 |
| GROUP O4 - PLASTIC AND RECONSTRUCTIVE | | |
| 52300 | Single-stage local flap, where indicated, repair to 1 defect, with skin or mucosa (Assist.) (Anaes.) | \$513.10 |
| 52303 | Single-stage local flap, where indicated, repair to 1 defect, with buccal pad of fat (Assist.) (Anaes.) | \$732.40 |
| 52306 | Single-stage local flap, where indicated, repair to 1 defect, using temporalis muscle (Assist.) (Anaes.) | \$1086.90 |
| 52309 | Free grafting (mucosa or split skin) of a granulating area (Anaes.) | \$362.40 |
| 52312 | Free grafting (mucosa, split skin or connective tissue) to 1 defect, including elective dissection (Assist.) (Anaes.) | \$546.70 |
| 52315 | Free grafting, full thickness, to 1 defect (mucosa or skin) (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$991.10 |
| 52324 | Direct flap repair, using tongue, first stage (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$1531.20 |
| 52333 | Cleft palate, primary repair (Assist.) (Anaes.) | \$1384.40 |
| 52336 | Cleft palate, secondary repair, closure of fistula using local flaps (Assist.) (Anaes.) | \$955.00 |
| 52337 | Alveolar cleft (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Assist.) (Anaes.) | \$2114.10 |
| 52339 | Cleft palate, secondary repair, lengthening procedure (Assist.) (Anaes.) | \$985.40 |
| 52342 | Mandible or maxilla, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Assist.) (Anaes.) | \$1806.30 |
| 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 (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$2409.20 |
| 52351 | Mandible or maxilla, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$2692.00 |

| Item No. | Description | Max fee (excl GST) |
|---------------------------------|--|--------------------|
| 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 (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$3042.30 |
| 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 (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$3197.90 |
| 52369 | Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$3488.60 |
| 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) (Assist.) (Anaes.) | \$5932.30 |
| 52378 | Genioplasty including transposition of nerves and vessels and bone grafts taken from the same site (Assist.) (Anaes.) | \$2549.00 |
| 52379 | Face, contour reconstruction of 1 region, using autogenous bone or cartilage graft (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$4045.20 |
| 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 (Assist.) (Anaes.) | \$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) in the oral and maxillofacial region (Assist.) (Anaes.) | \$1461.70 |
| 52430 | Microvascular repair of the oral and maxillofacial region using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Assist.) (Anaes.) | \$1930.20 |
| 52440 | Cleft lip, unilateral - primary repair, 1 stage, without anterior palate repair (Assist.) (Anaes.) | \$958.60 |
| 52442 | Cleft lip, unilateral - primary repair, 1 stage, with anterior palate repair (Assist.) (Anaes.) | \$1198.30 |
| 52444 | Cleft lip, bilateral - primary repair, 1 stage, without anterior palate repair (Assist.) (Anaes.) | \$1331.30 |
| 52446 | Cleft lip, bilateral - primary repair, 1 stage, with anterior palate repair (Assist.) (Anaes.) | \$1571.10 |
| 52450 | Cleft lip, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.) | \$532.40 |
| 52452 | Cleft lip, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Assist.) (Anaes.) | \$881.80 |
| 52456 | Cleft lip reconstruction using full thickness flap (Abbe or similar), first stage (Assist.) (Anaes.) | \$1464.60 |
| 52458 | Cleft lip reconstruction using full thickness flap (Abbe or similar), second stage (Anaes.) | \$532.40 |
| 52460 | Velo-pharyngeal incompetence, pharyngeal flap for, orpharyngoplasty for (Anaes.) | \$1384.40 |
| 52480 | Composite graft (Chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (Assist.) (Anaes.) | \$889.20 |
| 52482 | Macrocheilia or macroglossia, operation for (Assist.) (Anaes.) | \$855.50 |
| 52484 | Macrostomia, operation for (Assist.) (Anaes.) | \$1018.50 |
| GROUP O5 - PREPROSTHETIC | | |
| 52600 | Mandibular or palatal exostosis, excision of (Assist.) (Anaes.) | \$655.20 |
| 52603 | Mylohyoid ridge, reduction of (Assist.) (Anaes.) | \$583.50 |
| 52606 | Maxillary tuberosity, reduction of (Anaes.) | \$445.00 |
| 52609 | Papillary hyperplasia of the palate, removal of - less than 5 lesions (Assist.) (Anaes.) | \$583.50 |
| 52612 | Papillary hyperplasia of the palate, removal of - 5 to 20 lesions (Assist.) (Anaes.) | \$732.40 |
| 52615 | Papillary hyperplasia of the palate, removal of - more than 20 lesions (Assist.) (Anaes.) | \$909.20 |
| 52618 | Vestibuloplasty, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Assist.) (Anaes.) | \$1058.30 |
| 52621 | Floor of mouth lowering (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Assist.) (Anaes.) | \$1989.20 |

| Item No. | Description | Max fee (excl GST) |
|--|--|--------------------|
| 52624 | Alveolar ridge augmentation with bone or alloplast or both - unilateral (Assist.) (Anaes.) | \$918.20 |
| 52626 | Alveolar ridge augmentation - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Assist.) (Anaes.) | \$645.30 |
| 52627 | Osseo-integration procedure - extra oral implantation of titanium fixture (Assist.) (Anaes.) | \$986.30 |
| 52630 | Osseo-integration procedure - 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 (Assist.) (Anaes.) | \$534.20 |
| 52803 | Nerve trunk, internal (interfascicular), neurolysis of, using microsurgical techniques (Assist.) (Anaes.) | \$719.00 |
| 52806 | Neurectomy, neurotomy or removal of tumour from superficial peripheral nerve (Assist.) (Anaes.) | \$490.00 |
| 52809 | Neurectomy, neurotomy or removal of tumour from deep peripheral nerve (Assist.) (Anaes.) | \$838.70 |
| 52812 | Nerve trunk, primary repair of, using microsurgical techniques (Assist.) (Anaes.) | \$1221.30 |
| 52815 | Nerve trunk, secondary repair of, using microsurgical techniques (Assist.) (Anaes.) | \$2935.60 |
| 52818 | Nerve, transposition of (Assist.) (Anaes.) | \$957.60 |
| 52821 | Nerve graft to nerve trunk (cable graft) including harvesting of nerve graft using microsurgical techniques (Assist.) (Anaes.) | \$1824.00 |
| 52824 | Peripheral branches of the trigeminal nerve, cryosurgery of, for pain relief (Assist.) (Anaes.) | \$800.30 |
| 52826 | Injection of primary branch of trigeminal nerve with alcohol, cortisone, phenol, or similar substance (Anaes.) | \$420.70 |
| 52828 | Cutaneous nerve, primary repair of, using microsurgical techniques (Assist.) (Anaes.) | \$625.70 |
| 52830 | Cutaneous nerve, secondary repair of, using microsurgical techniques (Assist.) (Anaes.) | \$825.20 |
| 52832 | Cutaneous nerve, nerve graft to, using microsurgical techniques (Assist.) (Anaes.) | \$1131.70 |
| 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, not being a service associated with a service to which another item in groups O3 to O9 applies (Anaes.) | \$176.20 |
| 53004 | Maxillary antrum, lavage of - each attendance at which the procedure is performed, including any associated consultation (Anaes.) | \$116.00 |
| 53006 | Antrostomy (radical) (Assist.) (Anaes.) | \$940.50 |
| 53009 | Antrum, intranasal operation on or removal of foreign body from (Assist.) (Anaes.) | \$570.30 |
| 53012 | Antrum, drainage of, through tooth socket (Anaes.) | \$226.60 |
| 53015 | Oro-antral fistula, plastic closure of (Assist.) (Anaes.) | \$1060.30 |
| 53016 | Nasal septum, septoplasty, submucous resection or closure of septal perforation (Assist.) (Anaes.) | \$1225.60 |
| 53017 | Nasal septum, reconstruction of (Assist.) (Anaes.) | \$2336.00 |
| 53019 | Maxillary sinus, bone graft to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), unilateral (Assist.) (Anaes.) | \$1351.10 |
| 53052 | Post-nasal space, direct examination of, with or without biopsy (Anaes.) | \$217.30 |
| 53054 | Nasendoscopy or sinuscopy or fiberoptic examination of nasopharynx - 1 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.) | \$129.70 |
| 53058 | Nasal haemorrhage, posterior, arrest of, with posterior nasal packing with or without cauterisation and with or without anterior pack (Anaes.) | \$217.30 |
| 53060 | Cauterisation (other than by chemical means) or cauterisation by chemical means when performed under general anaesthesia or diathermy of septum or 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.) | \$177.90 |
| 53062 | Post-surgical nasal haemorrhage, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) | \$159.30 |
| 53064 | Cryotherapy to nose in the treatment of nasal haemorrhage (Anaes.) | \$288.30 |
| 53068 | Turbinectomy or turbinectomies, partial or total, unilateral (Anaes.) | \$580.20 |
| 53070 | Turbinates, submucous resection of, unilateral (Anaes.) | \$516.70 |

| Item No. | Description | Max fee (excl GST) |
|---|---|--------------------|
| GROUP O8 - TEMPOROMANDIBULAR JOINT | | |
| 53200 | Mandible, treatment of a dislocation of, not requiring open reduction (Anaes.) | \$135.60 |
| 53203 | Mandible, treatment of a dislocation of, requiring open reduction (Anaes.) | \$210.20 |
| 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.) | \$277.30 |
| 53209 | Glenoid fossa, zygomatic arch and temporal bone, reconstruction of (Obwegeser technique) (Assist.) (Anaes.) | \$2919.50 |
| 53212 | Absent condyle and ascending ramus in hemifacial microsomia, construction of, not including harvesting of graft material (Assist.) (Anaes.) | \$1808.80 |
| 53215 | Temporomandibular joint, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Assist.) (Anaes.) | \$1737.60 |
| 53218 | Temporomandibular joint, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions -1 or more of such procedures (Assist.) (Anaes.) | \$1747.60 |
| 53220 | Temporomandibular joint, arthrotomy of, not being a service to which another item in this group applies (Assist.) (Anaes.) | \$583.50 |
| 53221 | Temporomandibular joint, open surgical exploration of, with or without microsurgical techniques (Assist.) (Anaes.) | \$1677.50 |
| 53224 | Temporomandibular joint, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Assist.) (Anaes.) | \$1712.00 |
| 53225 | Arthrocentesis, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space (Assist.) (Anaes.) | \$558.20 |
| 53226 | Temporomandibular joint, synovectomy of, not being a service to which another item in this group applies (Assist.) (Anaes.) | \$553.00 |
| 53227 | Temporomandibular joint, open surgical exploration of, with or without meniscus or capsular surgery, including meniscectomy when performed, with or without microsurgical techniques (Assist.) (Anaes.) | \$2103.60 |
| 53230 | Temporomandibular joint, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Assist.) (Anaes.) | \$4520.80 |
| 53233 | Temporomandibular joint, surgery of, involving procedures to which item 53224, 53226, 53227 or 53230 applies and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Assist.) (Anaes.) | \$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 (Assist.) (Anaes.) | \$833.20 |
| 53239 | Temporomandibular joint, arthrodesis of, not being a service to which another item in this group applies (Assist.) (Anaes.) | \$833.20 |
| 53242 | Temporomandibular joint or joints, application of external fixator to, other than for treatment of fractures (Assist.) (Anaes.) | \$601.80 |
| GROUP O9 - TREATMENT OF FRACTURES | | |
| 53400 | Maxilla, unilateral or bilateral, treatment of fracture of, not requiring splinting | \$228.60 |
| 53403 | Mandible, treatment of fracture of, not requiring splinting | \$284.70 |
| 53406 | Maxilla, treatment of fracture of, requiring splinting, wiring of teeth, circum osseous fixation or external fixation (Assist.) (Anaes.) | \$1139.70 |
| 53409 | Mandible, treatment of fracture of, requiring splinting, wiring of teeth, circum osseous fixation or external fixation (Assist.) (Anaes.) | \$779.10 |
| 53410 | Zygomatic bone, treatment of fracture of, not requiring surgical reduction | \$151.50 |
| 53411 | Zygomatic bone, treatment of fracture of, requiring surgical reduction, by 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 (Assist.) (Anaes.) | \$752.40 |
| 53413 | Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Assist.) (Anaes.) | \$928.30 |
| 53414 | Zygomatic bone, treatment of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Assist.) (Anaes.) | \$1539.10 |
| 53415 | Maxilla, treatment of fracture of, requiring open reduction (Assist.) (Anaes.) | \$838.50 |
| 53416 | Mandible, treatment of fracture of, requiring open reduction (Assist.) (Anaes.) | \$786.20 |
| 53418 | Maxilla, treatment of fracture of, requiring open reduction and internal fixation not involving a plate (Assist.) (Anaes.) | \$1002.90 |
| 53419 | Mandible, treatment of fracture of, requiring open reduction and internal fixation not involving a plate (Assist.) (Anaes.) | \$1086.30 |
| 53422 | Maxilla, treatment of fracture of, requiring open reduction and internal fixation involving a plate (Assist.) (Anaes.) | \$1797.50 |

| Item No. | Description | Max fee (excl GST) |
|---|---|--------------------|
| 53423 | Mandible, treatment of fracture of, requiring open reduction and internal fixation involving a plate (Assist.) (Anaes.) | \$1340.00 |
| 53424 | Maxilla, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving a plate (Assist.) (Anaes.) | \$2024.70 |
| 53425 | Mandible, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving a plate (Assist.) (Anaes.) | \$1293.60 |
| 53427 | Maxilla, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of a plate (Assist.) (Anaes.) | \$1732.90 |
| 53429 | Mandible, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of a plate (Assist.) (Anaes.) | \$1646.00 |
| 53439 | Mandible, treatment of a closed fracture of, involving a joint surface (Anaes.) | \$457.80 |
| 53453 | Orbital cavity, reconstruction of a wall or floor with or without foreign implant (Assist.) (Anaes.) | \$1162.20 |
| 53455 | Orbital cavity, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Assist.) (Anaes.) | \$1767.20 |
| 53458 | Nasal bones, treatment of fracture of, not being a service to which item 53459 or 53460 applies | \$77.40 |
| 53459 | Nasal bones, treatment of fracture of, by reduction (Anaes.) | \$532.60 |
| 53460 | Nasal bones, treatment of fractures of, by open reduction involving osteotomies (Assist.) (Anaes.) | \$1682.50 |
| GROUP O11 - REGIONAL OR FIELD NERVE BLOCKS | | |
| 53700 | Trigeminal nerve, primary division of, injection of an anaesthetic agent | \$221.10 |
| 53702 | Trigeminal nerve, peripheral branch of, injection of an anaesthetic agent | \$110.70 |
| 53704 | Facial nerve, injection of an anaesthetic agent | \$66.50 |
| 53706 | Nerve branch in the oral and maxillofacial region, destruction by a neurolytic agent, not being a service to which any other item in this group applies | \$530.80 |
| GROUP I1 - ULTRASOUND | | |
| General | | |
| 55005 | Head, ultrasound scan of, where:(a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk) | \$98.70 |
| 55007 | Head, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies (nr) (nk) | \$34.20 |
| 55008 | Orbital contents, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk) | \$98.70 |
| 55010 | Orbital contents, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies (nr) (nk) | \$34.20 |
| 55011 | Neck, 1 or more structures of, ultrasound scan of, where:(a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk) | \$98.70 |
| 55013 | Neck, 1 or more structures of, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies (nr) (nk) | \$34.20 |
| 55014 | Abdomen, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service to which an item in subgroup 4 applies, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies;(b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(c) the service is not performed with item 55017, 55020, 55038, 55044, 55731 or 55732 on the same patient within 24 hours (r) (nk) | \$100.70 |
| 55016 | Abdomen, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service to which an item in subgroup 4,applies where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies (nr) (nk) | \$34.20 |
| 55017 | Urinary tract, ultrasound scan of but not being a service associated with the service to which an item in subgroup 4,applies.,where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(c) the service is not performed with item 55041, 55020, 55036, 55044, 55731 or 55732 on the same patient within 24 hours (r) (nk) | \$98.70 |
| 55019 | Urinary tract, ultrasound scan of, but not being a service associated with the service to which an item in subgroup 4,applies, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies (nr) (nk) | \$34.20 |

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| 55023 | Scrotum, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk) | \$99.00 |
| 55025 | Scrotum, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies (nr) (nk) | \$34.20 |
| 55026 | Ultrasonic cross-sectional echography, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies (r) (nk) | \$98.70 |
| 55028 | Head, ultrasound scan of, if: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in subgroup 2 or 3 applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) | \$209.10 |
| 55029 | Head, ultrasound scan of, if the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in subgroup 2 or 3 applies (NR) | \$73.50 |
| 55030 | Orbital contents, ultrasound scan of, if: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) | \$249.30 |
| 55031 | Orbital contents, ultrasound scan of, if the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroup 2 or 3 applies (NR) | \$82.20 |
| 55032 | Neck, 1 or more structures of, ultrasound scan of, if: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) | \$209.10 |
| 55033 | Neck, 1 or more structures of, ultrasound scan of, if the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroup 2 or 3 applies (NR) | \$73.20 |
| 55036 | Abdomen, ultrasound scan of (including scan of urinary tract when performed), if: (a) the patient is referred by a medical practitioner or participating nurse practitioner for ultrasonic examination; and (b) if the patient is referred by a medical practitioner the medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) if the patient is referred by a participating nurse practitioner the nurse practitioner does not have a business or financial arrangement with the providing practitioner; and (d) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (e) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and (f) within 24 hours of the service, a service mentioned in item 55017, 55038, 55067 or 55065 is not performed on the same patient by the providing practitioner (r) (k) | \$215.70 |
| 55037 | Abdomen, ultrasound scan of (including scan of urinary tract when performed), if: (a) the patient is not referred by a medical practitioner; and (b) the service is not a service associated with a service to which an item in Subgroup 2 or 3 applies; and (c) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs (NR) | \$73.50 |
| 55038 | Urinary tract, ultrasound scan of, if: (a) the patient is referred by a medical practitioner for ultrasonic examination; and (b) the medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (d) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and (e) within 24 hours of the service, a service mentioned in item 55017, 55036, 55067 or 55065 is not performed on the same patient by the providing practitioner (r) (k) | \$211.20 |
| 55039 | Urinary tract, ultrasound scan of, if: (a) the patient is not referred by a medical practitioner; and (b) the service is not a service associated with a service to which an item in Subgroup 2 or 3 applies; and (c) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs (NR) | \$73.20 |
| 55048 | Scrotum, ultrasound scan of, if: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) | \$212.40 |
| 55049 | Scrotum, ultrasound scan of, if the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroup 2 or 3 applies (NR) | \$75.10 |
| 55054 | Ultrasonic cross-sectional echography, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies (R) | \$209.50 |
| 55059 | Breast, one, ultrasound scan of, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk) | \$89.10 |
| 55060 | Breast, one, ultrasound scan of, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies (nr) (nk) | \$31.00 |
| 55061 | Breasts, both, ultrasound scan of, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; | \$98.70 |

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| | and(c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk) | |
| 55062 | Breasts, both, ultrasound scan of, where:(a) the patient is not referred by a medical practitioner; and(b) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies (nr) (nk) | \$34.20 |
| 55063 | Urinary bladder, ultrasound scan of, by any or all approaches, if:(a) the patient is referred by a medical practitioner for ultrasonic examination; and(b) the medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and(d) within 24 hours of the service, a service mentioned in item 11917, 55014, 55017, 55036, 55038, 55600, 55601, 55603, 55604, 55067 or 55065 is not performed on the same patient by the providing practitioner (r) (nk) | \$89.10 |
| 55064 | Urinary bladder, ultrasound scan of, by any or all approaches, if:(a) the patient is not referred by a medical practitioner; and(b) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and(c) within 24 hours of the service, a service mentioned in item 11917, 55016, 55019, 55037, 55039, 55600, 55601, 55603, 55604, 55068 or 55069 is not performed on the same patient by the providing practitioner (nr) (nk) | \$31.00 |
| 55065 | Pelvis, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in subgroup 2, or 3, applies; and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and(e) the service is not performed with item 55014, 55017, 55036 or 55038 on the same patient within 24 hours (r)(k) | \$160.00 |
| 55067 | Pelvis, ultrasound scan of, by any or all approaches, where: a) the patient is referred by a medical practitioner; and b) the medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and c) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and d) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and e) within 24 hours of the service, a service mentioned in item 55014, 55017, 55036 or 55038 is not performed on the same patient by the providing practitioner (r) (nk) | \$81.80 |
| 55068 | Pelvis, ultrasound scan of, by any or all approaches, where:(a) the patient is not referred by a medical practitioner; and(b) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (c) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs (nr)(k) | \$57.00 |
| 55069 | Pelvis, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (c) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs (nr) (nk) | \$29.00 |
| 55070 | Breast, one, ultrasound scan of, if: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) | \$201.50 |
| 55073 | Breast, one, ultrasound scan of, if: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies (NR) | \$65.20 |
| 55076 | Breasts, both, ultrasound scan of, if: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) | \$236.60 |
| 55079 | Breasts, both, ultrasound scan of, if: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies (NR) | \$89.00 |
| 55084 | Urinary bladder, ultrasound scan of, by any or all approaches, if:(a) the patient is referred by a medical practitioner; and (b) the medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (d) within 24 hours of the service, a service mentioned in item 11917, 55014, 55017, 55036, 55038, 55600, 55601, 55603, 55604, 55067 or 55065 is not performed on the same patient by the providing practitioner (r) (k) | \$188.40 |
| 55085 | Urinary bladder, ultrasound scan of, by any or all approaches, if: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (c) within 24 hours of the service, a service mentioned in item 11917, 55016, 55019, 55037, 55039, 55600, 55601, 55603, 55604, 55068 or 55069 is not performed on the same patient by the providing practitioner (NR) (K) | \$65.20 |
| Cardiac | | |
| 55113 | M-mode and two-dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows for the investigation of symptoms or signs of cardiac failure, or suspected or known ventricular hypertrophy or dysfunction, or chest pain: (a) with: (i) measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave doppler techniques; and (ii) real time colour flow mapping from at least 2 acoustic windows; and (iii) recordings on video tape or digital media; and (b) not being a service associated with a service to which an item in Subgroup 1 (except item 55054) or 3, or another item in this subgroup (except items 55118 and 55130), applies (R) | \$444.70 |
| 55114 | M-mode and two-dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows for the investigation of suspected or known acquired valvular, aortic, pericardial, thrombotic or embolic disease or heart tumour: (a) with: (i) measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave doppler techniques; and (ii) real | \$447.30 |

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| 55115 | time colour flow mapping from at least 2 acoustic windows; and (iii) recordings on video tape or digital media; and (b) not being a service associated with a service to which an item in subgroup 1 (except item 55054) or 3, or another item in this subgroup (except items 55118 and 55130), applies (R) | \$441.70 |
| 55116 | M-mode and two-dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows for the investigation of symptoms or signs of congenital heart disease: (a) with: (i) measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave doppler techniques; and (ii) real time colour flow mapping from at least 2 acoustic windows; and (iii) recordings on video tape or digital media; and (b) not being a service associated with a service to which an item in subgroup 1 (except item 55054) or 3, or another item in this subgroup (except items 55118 and 55130), applies (r) | \$500.90 |
| 55117 | Exercise stress echocardiography performed in conjunction with item 11712: (a) with: (i) two-dimensional recordings before exercise (baseline) from at least 3 acoustic windows; and (ii) matching recordings from the same windows at, or immediately after, peak exercise; and (iii) recordings on digital media with equipment permitting display of baseline and matching peak images on the same screen; and (b) not being a service associated with a service to which an item in Subgroup 1 (except item 55054) or 3, or another item in this subgroup (except items 55118 and 55130), applies (R) | \$506.10 |
| 55118 | Pharmacological stress echocardiography performed in conjunction with item 1171 2: (a) with: (i) two-dimensional recordings before drug infusion (baseline) from at least 3 acoustic windows; and (ii) matching recordings from the same windows at least twice during drug infusion, including a recording at the peak drug dose; and (iii) recordings on digital media with equipment permitting display of baseline and matching peak images on the same screen; and (b) not being a service associated with a service to which an item in Subgroup 1 (except item 5505 4) or 3, or another item in this subgroup (except items 55118 and 55130), applies (R) | \$527.40 |
| 55119 | Heart, two-dimensional real time transoesophageal examination of, from at least 2 levels, and in more than 1 plane at each level: (a) with: (i) real time colour flow mapping and, if indicated, pulsed wave doppler examination; and (ii) recordings on video tape or digital medium; and (b) not being an intra-operative service or a service associated with a service to which an item in Subgroup 1 (except item 55054) or 3 applies (R (Anaes.)) | \$208.60 |
| 55120 | M-mode and 2 dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this subgroup (with the exception of items 55118, 55125, 55130 and 55131), applies, for the investigation of symptoms or signs of cardiac failure, or suspected or known ventricular hypertrophy or dysfunction, or chest pain (r) (nk) | \$208.60 |
| 55121 | M-mode and 2 dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this subgroup (with the exception of items 55118, 55125, 55130 and 55131), applies, for the investigation of symptoms or signs of congenital heart disease (r) (nk) | \$208.60 |
| 55122 | M-mode and 2 dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this subgroup applies (with the exception of items 55118, 55125, 55130 and 55131). recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (r) (nk) | \$236.80 |
| 55123 | Exercise stress echocardiography performed in conjunction with item 11712, with two-dimensional recordings before exercise (baseline) from at least three acoustic windows and matching recordings from the same windows at, or immediately after, peak exercise, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this subgroup applies (with the exception of items 55118, 55125, 55130 and 55131). recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (r) (nk) | \$236.80 |
| 55125 | Pharmacological stress echocardiography performed in conjunction with item 11712, with two-dimensional recordings before drug infusion (baseline) from at least three acoustic windows and matching recordings from the same windows at least twice during drug infusion, including a recording at the peak drug dose not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this subgroup, applies (with the exception of items 55118, 55125, 55130 and 55131). recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (r) (nk) | \$249.20 |
| 55130 | Heart, 2 dimensional real time transoesophageal examination of, from at least two levels, and in more than one plane at each level:(a) with: (i) real time colour flow mapping and, if indicated, pulsed wave doppler examination; and (ii) recordings on video tape or digital medium; and(b) not being an intra-operative service or a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 3, applies (r) (nk) (Anaes.) | \$325.90 |
| 55130 | Intra-operative 2 dimensional real time transoesophageal echocardiography incorporating doppler techniques with colour flow mapping and recording onto video t ape or digital medium, performed during cardiac surgery incorporating sequential assessment of cardiac function before and after the surgical procedure, not being a service associated with a service to which item 55135 applies (R (Anaes.)) | |

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| 55131 | Intra-operative 2 dimensional real time transoesophageal echocardiography incorporating doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac surgery incorporating sequential assessment of cardiac function before and after the surgical procedure - not associated with items 55135 and 55136 (r) (nk) (Anaes.) | \$153.90 |
| 55135 | Intra-operative 2 dimensional real time transoesophageal echocardiography incorporating doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac valve surgery (replacement or re pair) incorporating sequential assessment of cardiac function and valve competence before and after the surgical procedure, not being a service associated with a service to which item 55130 applies (R (Anaes.)) | \$678.10 |
| 55136 | Intra-operative 2 dimensional real time transoesophageal echocardiography incorporating doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac valve surgery (repair or replacement) incorporating sequential assessment of cardiac function and valve competence before and after the surgical procedure - not associated with items 55130 and 55131 (r) (nk) (Anaes.) | \$319.80 |
| Vascular | | |
| 55220 | Duplex scanning, unilateral, involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb or of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk) | \$153.50 |
| 55221 | Duplex scanning, unilateral, involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for acute venous thrombosis, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk) | \$153.50 |
| 55222 | Duplex scanning, unilateral, involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk) | \$153.50 |
| 55223 | Duplex scanning, unilateral, involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of arteries or bypass grafts in the upper limb or of arteries and bypass grafts in the upper limb, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk) | \$153.50 |
| 55224 | Duplex scanning, unilateral, involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of veins in the upper limb, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk) | \$153.50 |
| 55226 | Duplex scanning, bilateral, involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of extra-cranial bilateral carotid and vertebral vessels, with or without subclavian and innominate vessels, with or without oculoplethysmography or peri- orbital doppler examination, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this groups applies (r) (nk) | \$153.50 |
| 55227 | Duplex scanning involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of intra-abdominal, aorta and iliac arteries or inferior vena cava and iliac veins or of intra- abdominal, aorta and iliac arteries and inferior vena cava and iliac veins, excluding pregnancy related studies, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk) | \$153.50 |
| 55228 | Duplex scanning involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of renal or visceral vessels or of renal and visceral vessels, including aorta, inferior vena cava and iliac vessels as required excluding pregnancy related studies, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk) | \$153.50 |
| 55229 | Duplex scanning involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of intra-cranial vessels, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk) | \$153.50 |
| 55230 | Duplex scanning involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of cavernosal artery of the penis following intracavernosal administration of a vasoactive agent, performed during the period of pharmacological activity of the injected agent, to confirm a diagnosis of vascular aetiology for impotence, where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk) | \$153.50 |
| 55232 | Duplex scanning involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of cavernosal tissue of the penis to confirm a diagnosis and, where indicated, assess the progress and management of: (a) priapism; or (b) fibrosis of any type; or (c) fracture of the tunica; or (d) arteriovenous malformations; where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this groups applies (r) (nk) | \$153.50 |

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| 55233 | Duplex scanning, unilateral, involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of surgically created arteriovenous fistula or surgically created arteriovenous access graft in the upper or lower limb, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054) or 4 of this group applies (r) (nk) | \$153.50 |
| 55235 | Duplex scanning, involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of arteries or veins or arteries and veins, for mapping of bypass conduit prior to vascular surgery, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054), 3 or 4 of this group applies - including any associated skin marking (r) (nk) | \$153.50 |
| 55236 | Duplex scanning, unilateral, involving b mode ultrasound imaging and integrated doppler flow spectral analysis and marking of veins in the lower limb below the inguinal ligament prior to varicose vein surgery, not being a service associated with a service to which an item in subgroups 1 (with the exception of items 55026 and 55054), 3 or 4 of this group applies - including any associated skin marking (r) (nk) | \$100.40 |
| 55238 | Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb or of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R) | \$326.00 |
| 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 a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R) | \$326.70 |
| 55246 | Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R) | \$328.00 |
| 55248 | Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R) | \$326.50 |
| 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 1 (with the exception of item 55054) or 4 applies (R) | \$325.10 |
| 55274 | Duplex scanning, bilateral, involving B mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of extra-cranial bilateral carotid and vertebral vessels, with or without subclavian and innominate vessels, with or without oculoplethysmography or peri-orbital Doppler examination, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R) | \$324.90 |
| 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 with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R) | \$327.10 |
| 55278 | Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of renal or visceral vessels or of renal and visceral vessels, including aorta, inferior vena cava and iliac vessels as required excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R) | \$340.80 |
| 55280 | Duplex scanning involving B mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of intra-cranial vessels, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R) | \$328.40 |
| 55282 | Duplex scanning involving B mode ultrasound imaging and integrated doppler flow measurements: (a) by spectral analysis of cavernosal artery of the penis following intracavernosal administration of a vasoactive agent; and (b) performed during the period of pharmacological activity of the injected agent, to confirm a diagnosis of vascular aetiology for impotence; and (c) where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is performed, immediately before or for a period during the performance of the service; and (d) where that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R) | \$324.40 |
| 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) where 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) where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is performed, immediately before or for a period during the performance of the service; and (d) where that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R) | \$325.10 |
| 55292 | Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of surgically created arteriovenous fistula or surgically created | \$318.50 |

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| | arteriovenous access grafts in the upper or lower limbs, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R) | |
| 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 a service to which an item in Subgroup 1 (with the exception of item 55054), 3 or 4 applies (R) | \$324.50 |
| 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 a service to which an item in Subgroup 1 (with the exception of item 55054), 3 or 4 applies (R) | \$214.30 |
| Urological | | |
| 55600 | Prostate, bladder base and urethra, ultrasound scan of, if performed: (a) personally by a medical practitioner (not being the medical practitioner who assessed the patient as specified in paragraph (c)) using one or more transducer probes that can obtain both axial and sagittal scans in 2 planes at right angles; and (b) after a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by: (i) a specialist in urology, radiation oncology or medical oncology; or (ii) a consultant physician in medical oncology; who has: (iii) examined the patient in the 60 days before the scan; and (iv) recommended the scan for the management of the patient's current prostatic disease (R) (K) | \$211.50 |
| 55601 | Prostate, bladder base and urethra, ultrasound scan of, if performed: (a) personally by a medical practitioner (not being the medical practitioner who assessed the patient as specified in paragraph (c)) using one or more transducer probes that can obtain both axial and sagittal scans in 2 planes at right angles; and (b) after a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by: (i) a specialist in urology, radiation oncology or medical oncology; or (ii) a consultant physician in medical oncology; who has: (iii) examined the patient in the 60 days before the scan; and (iv) recommended the scan for the management of the patient's current prostatic disease (R) (NK) | \$98.70 |
| 55603 | Prostate, bladder base and urethra, ultrasound scan of, if performed: (a) personally by a medical practitioner who made the assessment mentioned in paragraph (c) using one or more transducer probes that can obtain both axial and sagittal scans in 2 planes at right angles; and (b) after a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by: (i) a specialist in urology, radiation oncology or medical oncology; or (ii) a consultant physician in medical oncology; who has: (iii) examined the patient in the 60 days before the scan; and (iv) recommended the scan for the management of the patient's current prostatic disease (R) (K) | \$225.30 |
| 55604 | Prostate, bladder base and urethra, ultrasound scan of, if performed: (a) personally by a medical practitioner who made the assessment mentioned in paragraph (c) using one or more transducer probes that can obtain both axial and sagittal scans in 2 planes at right angles; and (b) after a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by: (i) a specialist in urology, radiation oncology or medical oncology; or (ii) a consultant physician in medical oncology; who has: (iii) examined the patient in the 60 days before the scan; and (iv) recommended the scan for the management of the patient's current prostatic disease (R) (NK) | \$98.70 |
| Obstetric and gynaecological | | |
| 55700 | Pelvis or abdomen, pregnancy-related or pregnancy complication, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of foetal abnormality (R) | \$121.10 |
| 55701 | Pelvis or abdomen, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and (c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of foetal abnormality (r) footnote: for nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55707 or 55714 (r) (nk). fee is payable only for item 55700 or 55701, or, or item 55707 or 55714, not both items | \$54.30 |

| Item No. | Description | Max fee (excl GST) |
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| 55702 | Pelvis or abdomen, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where:(a) the patient is not referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxoemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of foetal abnormality (nr)footnote: for nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55708 or 55716 (r) (nk). fee is payable only for item 55702 or 55703, or item 55707 or 55714, not both items | \$31.70 |
| 55703 | Pelvis or abdomen, pregnancy-related or pregnancy complication, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxoemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of foetal abnormality (NR) | \$67.20 |
| 55704 | Pelvis or abdomen, pregnancy-related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxoemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of foetal abnormality (R) | \$135.10 |
| 55705 | Pelvis or abdomen, pregnancy-related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxoemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of foetal abnormality (NR) | \$67.20 |
| 55706 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of , by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner; and (b) the dating for the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) the service is not performed in the same pregnancy as item 55709 (R) | \$202.00 |
| 55707 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of , by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) one or more of the conditions mentioned in subparagraphs (e) (i) to (xxx) of item 55704 are present; and (f) nuchal translucency measurement is performed to assess the risk of foetal abnormality; and (g) the | \$216.70 |

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| | service is not performed with item 55700, 55703, 55704 or 55705 on the same patient within 24 hours (r) | |
| 55708 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of , by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) one or more of the conditions in subparagraphs (e) (i) to (xxx) of item 55704 are present; and (e) nuchal translucency measurement is performed to assess the risk of foetal abnormality; and (f) the service is not performed in conjunction with item 55700, 55703, 55704 or 55705 on the same patient within 24 hours (nr) | \$132.50 |
| 55709 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of , by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (d) the service is not performed in the same pregnancy as item 55706 (NR) | \$113.70 |
| 55710 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, where:(a) the patient is referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(e) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of foetal abnormality (r)footnote: for nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item 55704 or 55707 (r) (nk). fee is payable only for item 55704 or 55710, or, item 55707 or 55714, not both items | \$63.40 |
| 55711 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, where:(a) the patient is not referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) one or more of the following conditions are present: (i) hyperemesis gravidarum (ii) diabetes mellitus; (iii) hypertension; (iv) toxemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of foetal abnormality (nr)footnote: for nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item 55708 or 55716 (r) (nk). fee is payable only for item 55705 or 55711, or, item 55708 or 55716, not both items | \$31.70 |
| 55712 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and gynaecologists as being equivalent to a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55706 or 55709 applies (r) | \$220.60 |
| 55713 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where:(a) the patient is referred by a medical practitioner; and(b) the dating for the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(e) the service is not performed in the same pregnancy as item 55709 or 55717 (r) (nk) | \$90.50 |
| 55714 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where:(a) the patient is referred by a medical practitioner; and(b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(e) one or more of the conditions mentioned in subparagraphs (e) (i) to (xxx) of item 55704 or 55710 are present; | \$63.40 |

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| | and(f) nuchal translucency measurement is performed to assess the risk of foetal abnormality; and(g) the service is not performed with item 55700, 55701, 55702, 55703, 55704, 55705, 55710 or 55711 on the same patient within 24 hours (r) (nk) | |
| 55715 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where:(a) the patient is not referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies ; and(d) further examination is clinically indicated in the same pregnancy to which item 55706 or 55709 applies (nr) | \$76.70 |
| 55716 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where;(a) the patient is not referred by a medical practitioner; and(b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) one or more of the conditions in subparagraphs (e) (i) to (xxx) of item 55704 or 55710 are present; and(e) nuchal translucency measurement is performed to assess the risk of foetal abnormality; and(f) the service is not performed in conjunction with item 55700, 55701, 55702, 55703, 55704, 55705, 55710 or 55711 on the same patient within 24 hours (nr) (nk) | \$31.70 |
| 55717 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where:(a) the patient is not referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) the service is not performed in the same pregnancy as item 55706 or 55713 (nr) (nk) | \$34.40 |
| 55718 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of , by any or all approaches, where:(a) the patient is referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d)the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) the service is not performed in the same pregnancy as item 55723; and (f) one or more of the following conditions are present:(i) known or suspected foetal abnormality or foetal cardiac arrhythmia;(ii) foetal anatomy (late booking or incomplete mid-trimester scan); (iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery; (viii) uterine scar assessment; (ix) uterine fibroid;(x) previous foetal death in utero or neonatal death; (xi) antepartum haemorrhage; (xii) clinical suspicion of intrauterine growth retardation;(xiii) clinical suspicion of macrosomia; (xiv) reduced foetal movements; (xv) suspected foetal death; (xvi) abnormal cardiotocography; (xvii) prolonged pregnancy; (xviii) premature labour; (xix) foetal infection; (xx) pregnancy after assisted reproduction; (xxi) trauma; (xxii) diabetes mellitus; (xxiii) hypertension; (xxiv) toxemia of pregnancy; (xxv) liver or renal disease; (xxvi) autoimmune disease; (xxvii) cardiac disease; (xxviii) alloimmunisation; (xxix) maternal infection; (xxx) inflammatory bowel disease; (xxxi) bowel stoma; (xxxii) abdominal wall scarring; (xxxiii) previous spinal or pelvic trauma or disease;(xxxiv) drug dependency; (xxxv)thrombophilia; (xxxvi) significant maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (r) | \$194.20 |
| 55719 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where:(a) the patient is referred by a medical practitioner who is a member or a fellow of the royal Australian and New Zealand college of obstetricians and gynaecologists or who has a diploma of obstetrics or has a qualification recognised by the royal Australian and New Zealand college of obstetricians and gynaecologists as being equivalent to a diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(e) further examination is clinically indicated in the same pregnancy to which item 55706, 55709, 55713 or 55717 applies (r) (nk) | \$104.20 |
| 55720 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a member or a fellow of the royal Australian and New Zealand college of obstetricians and gynaecologists, where:(a) the patient is not referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and(c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) further examination is clinically indicated in the same pregnancy to which item 55706, 55709, 55713 or 55717 applies (nr) (nk) | \$36.20 |
| 55721 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan of by any or all approaches, where:(a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has qualifications recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of obstetrics or has obstetric privileges at a non- metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d)the referring practitioner is not a member of a group of practitioners of which the providing practitioner is | \$220.60 |

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| | a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (r) | |
| 55722 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) the service is not performed in the same pregnancy as item 55723 or 55726; and (f) one or more of the following conditions are present: (i) known or suspected foetal abnormality or foetal cardiac arrhythmia; (ii) foetal anatomy (late booking or incomplete mid-trimester scan); (iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery; (viii) uterine scar assessment; (ix) uterine fibroid; (x) previous foetal death in utero or neonatal death; (xi) antepartum haemorrhage; (xii) clinical suspicion of intrauterine growth retardation; (xiii) clinical suspicion of macrosomia; (xiv) reduced foetal movements; (xv) suspected foetal death; (xvi) abnormal cardiotocography; (xvii) prolonged pregnancy; (xviii) premature labour; (xix) foetal infection; (xx) pregnancy after assisted reproduction; (xxi) trauma; (xxii) diabetes mellitus; (xxiii) hypertension; (xxiv) toxemia of pregnancy; (xxv) liver or renal disease; (xxvi) autoimmune disease; (xxvii) cardiac disease; (xxviii) alloimmunisation; (xxix) maternal infection; (xxx) inflammatory bowel disease; (xxxii) abdominal wall scarring; (xxxiii) previous spinal or pelvic trauma or disease; (xxxiv) drug dependency; (xxxv) thrombophilia; (xxxvi) significant maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (r) (nk) | \$90.50 |
| 55723 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the service is not performed in the same pregnancy as item 55718; and (e) one or more of the following conditions are present (i) known or suspected foetal abnormality or foetal cardiac arrhythmia; (ii) foetal anatomy (late booking or incomplete mid-trimester scan); (iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery; (viii) uterine scar assessment; (ix) uterine fibroid; (x) previous foetal death in utero or neonatal death; (xi) antepartum haemorrhage; (xii) clinical suspicion of intrauterine growth retardation; (xiii) clinical suspicion of macrosomia; (xiv) reduced foetal movements; (xv) suspected foetal death; (xvi) abnormal cardiotocography; (xvii) prolonged pregnancy; (xviii) premature labour; (xix) foetal infection; (xx) pregnancy after assisted reproduction; (xxi) trauma; (xxii) diabetes mellitus; (xxiii) hypertension; (xxiv) toxemia of pregnancy; (xxv) liver or renal disease; (xxvi) autoimmune disease; (xxvii) cardiac disease; (xxviii) alloimmunisation; (xxix) maternal infection; (xxx) inflammatory bowel disease; (xxxii) abdominal wall scarring; (xxxiii) previous spinal or pelvic trauma or disease; (xxxiv) drug dependency; (xxxv) thrombophilia; (xxxvi) significant maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (nr) | \$72.80 |
| 55724 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan of by any or all approaches, where: (a) the patient is referred by a medical practitioner who is a member or a fellow of the royal Australian and New Zealand college of obstetricians and gynaecologists or who has a diploma of obstetrics or has qualifications recognised by the royal Australian and New Zealand college of obstetricians and gynaecologists as being equivalent to a diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55718, 55722, 55723 or 55726 applies (r) (nk) | \$104.20 |
| 55725 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (nr) | \$76.70 |
| 55726 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (d) the service is not performed in the same pregnancy as item 55718 or 55722; and (e) one or more of the following conditions are present: (i) known or suspected foetal abnormality or foetal cardiac arrhythmia; (ii) foetal anatomy (late booking or incomplete mid-trimester scan); (iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery; (viii) uterine scar assessment; (ix) uterine fibroid; (x) previous foetal death in utero or neonatal death; (xi) antepartum haemorrhage; (xii) clinical suspicion of intrauterine growth retardation; (xiii) clinical suspicion of macrosomia; (xiv) reduced foetal movements; (xv) suspected foetal death; (xvi) abnormal cardiotocography; (xvii) prolonged pregnancy; (xviii) premature labour; (xix) foetal infection; (xx) pregnancy after assisted reproduction; (xxi) trauma; (xxii) diabetes mellitus; (xxiii) hypertension; (xxiv) toxemia of pregnancy; (xxv) liver or renal disease; (xxvi) autoimmune disease; (xxvii) cardiac disease; (xxviii) alloimmunisation; (xxix) maternal infection; (xxx) inflammatory bowel disease; (xxxii) abdominal wall | \$34.40 |

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| | scarring; (xxxiii) previous spinal or pelvic trauma or disease; (xxxiv) drug dependency; (xxxv) thrombophilia; (xxxvi) significant maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (nr) (nk) | |
| 55727 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a member or a fellow of the royal Australian and New Zealand college of obstetricians and gynaecologists, where:(a) the patient is not referred by a medical practitioner; and(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(d) further examination is clinically indicated in the same pregnancy to which item 55718, 55722, 55723 or 55726 applies (nr) (nk) | \$36.20 |
| 55729 | Duplex scanning involving b mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of the umbilical artery, and measured assessment of amniotic fluid volume after the 24th week of gestation where the patient is referred by a medical practitioner for this procedure and where there is reason to suspect intrauterine growth retardation or a significant risk of foetal death, not being a service associated with a service to which an item in this Group applies - (r) | \$52.30 |
| 55730 | Duplex scanning involving b mode ultrasound imaging and integrated doppler flow measurements by spectral analysis of the umbilical artery, and measured assessment of amniotic fluid volume after the 24th week of gestation where the patient is referred by a medical practitioner for this procedure and where there is reason to suspect intrauterine growth retardation or a significant risk of foetal death, not being a service associated with a service to which an item in this group applies (r) (nk) | \$24.70 |
| 55735 | Pelvis, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where:(a) the patient is referred by a medical practitioner; and(b) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(c) the referring medical practitioner is not a member of a group of medical practitioners of which the providing practitioner is a member; and(d) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (r) (nk) | \$114.90 |
| 55736 | Pelvis, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (c) the referring medical practitioner is not a member of a group of medical practitioners of which the providing practitioner is a member; and (d) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (r) | \$305.00 |
| 55737 | Pelvis, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where:(a) the patient is not referred by a medical practitioner; and(b) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(c) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (nr) (nk) | \$51.50 |
| 55739 | Pelvis, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (c) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (nr) | \$126.00 |
| 55759 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of , by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and (f) the service is not performed in conjunction with item 55706, 55709, 5571 2, 55715 or 55762 during the same pregnancy (r) | \$287.40 |
| 55760 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where:(a) the patient is referred by a medical practitioner; and(b) ultrasound of the same pregnancy confirms a multiple pregnancy; and(c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and(d) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and(f) the service is not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717, 55719, 57721, 55762 or 55763 during the same pregnancy (r) (nk) | \$135.80 |
| 55762 | pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of , by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not performed in conjunction with item 55706, 55709, 557 12, 55715 or 55759 during the same pregnancy; and (e)the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies (nr) | \$162.10 |
| 55763 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where:(a) the patient is not referred by a medical practitioner; and(b) ultrasound of the same pregnancy confirms a multiple pregnancy; and(c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and(d) the service is not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717, 55719, 55720, 55759 or 55760 during the same pregnancy; and(e) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies (nr) (nk) | \$54.30 |

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| 55764 | pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of obstetrics or has obstetric privileges at a non- metropolitan hospital; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and (f) further examination is clinically indicated in the same pregnancy to which item 55759 or 55762 has been performed; and (g) not performed in conjunction with item 55706, 55709, 55712 or 55715 during the same pregnancy (r) | \$306.80 |
| 55765 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where:(a) the patient is referred by a medical practitioner who is a member or fellow of the royal Australian and New Zealand college of obstetricians and gynaecologists or who has a diploma of obstetrics or has a qualification recognised by the royal Australian and New Zealand college of obstetricians and gynaecologists as equivalent to a diploma of obstetrics or has obstetric privileges at a non- metropolitan hospital; and(b) ultrasound of the same pregnancy confirms a multiple pregnancy; and(c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and(d) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and(e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and(f) further examination is clinically indicated in the same pregnancy to which item 55759, 55760, 55762 or 55763 has been performed; and(g) not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717, 55719 during the same pregnancy (r) (nk) | \$144.80 |
| 55766 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c)the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; (e) further examination is clinically indicated in the same pregnancy to which item 55759, or 55762 has been performed; and (f) not performed in conjunction with item 55706, 55709, 55712 or 55715 during the same pregnancy (nr) | \$124.80 |
| 55767 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a member or fellow of the royal Australian and New Zealand college of obstetricians and gynaecologists, where:(a) the patient is not referred by a medical practitioner; and(b) ultrasound of the same pregnancy confirms a multiple pregnancy; and(c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and(d) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; (e) further examination is clinically indicated in the same pregnancy to which item 55759, 55760, 55762 or 55763 has been performed; and(f) not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717, 55719 or 55720 during the same pregnancy (nr) (nk) | \$58.80 |
| 55768 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of , by any or all approaches, where: (a) dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (b) the ultrasound confirms a multiple pregnancy; and (c) the patient is referred by a medical practitioner; and (d) the service is not performed in the same pregnancy as item 55770; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55723 or 55725 during the same pregnancy (r) | \$287.70 |
| 55769 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where:(a) dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and(b) the ultrasound confirms a multiple pregnancy; and(c) the patient is referred by a medical practitioner; and(d) the service is not performed in the same pregnancy as item 55770 or 55771; and (e) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(g) the service is not performed in conjunction with item 55718, 55721, 55722, 55723, 55724, 55725, 55726 or 55727 during the same pregnancy (r) (nk) | \$135.80 |
| 55770 | pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy), by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) the service is not performed in the same pregnancy as item 55768; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies and (f) the service is not performed in conjunction with item 55718, 55721, 55723 or 55725 during the same pregnancy (nr) | \$115.00 |
| 55771 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy), by any or all approaches, where:(a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and(b) the patient is not referred by a medical practitioner; and(c) the service is not performed in the same pregnancy as item 55768 or 55759; and(d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and(e) | \$54.30 |

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| | the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(f) the service is not performed in conjunction with item 55718, 55721, 55723, 55724,,55725, 55726 or 55727 during the same pregnancy (nr) (nk) | |
| 55772 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of obstetrics or has obstetric privileges at a non- metropolitan hospital; and (c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55723 or 55725 during the same pregnancy (r) | \$306.80 |
| 55773 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, where:(a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and(b) the patient is referred by a medical practitioner who is a member or fellow of the royal Australian and New Zealand college of obstetricians and gynaecologists or who has a diploma of obstetrics or has a qualification recognised by the royal Australian and New Zealand college of obstetricians and gynaecologists as equivalent to a diploma of obstetrics or has obstetric privileges at a non- metropolitan hospital; and(c) further examination is clinically indicated in the same pregnancy to which item 55768, 55769, 55770 or 55771 has been performed; and(d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and(e) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and(g) the service is not performed in conjunction with item 55718, 55721, 55722, 55723, 55724, 55725, 55726 or 55727 during the same pregnancy (r) (nk) | \$144.80 |
| 55774 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) further examination is clinically indicated in the same pregnancy to which item 557 68 or 55770 has been performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the service is not performed in conjunction with item 55718, 55721 55723 or 55725 during the same pregnancy (nr) | \$124.80 |
| 55775 | Pelvis or abdomen, pregnancy related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a member or a fellow of the royal Australian and New Zealand college of obstetricians and gynaecologists, where:(a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and(b) the patient is not referred by a medical practitioner; and(c) further examination is clinically indicated in the same pregnancy to which item 55768, 55769, 55770 or 5571 has been performed; and(d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and(e) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(f) the service is not performed in conjunction with item 55718, 55721, 55722, 55723, 55724, 55725, 55726 or 55727 during the same pregnancy (nr) (nk) | \$58.80 |
| Musculoskeletal | | |
| 55800 | Hand or wrist, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) | \$210.70 |
| 55801 | Hand or wrist, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk) | \$98.70 |
| 55802 | Hand or wrist, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (nr) | \$73.20 |
| 55803 | Hand or wrist, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner (nr) (nk) | \$34.20 |
| 55804 | Forearm or elbow, 1 or both sides, ultrasound scan of, where: (a) the service i s not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) | \$208.80 |
| 55805 | Forearm or elbow, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk) | \$98.70 |
| 55806 | Forearm or elbow, 1 or both sides, ultrasound scan of, where: (a) the service i s not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (nr) | \$72.90 |
| 55807 | Forearm or elbow, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner (nr) (nk) | \$34.20 |
| 55808 | Note: Benefits are only payable when referred based on the clinical indicators outlined in the item | \$210.80 |

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| | descriptions. Benefits are not payable when referred for non- specific shoulder pain alone. Shoulder or upper arm, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions:- evaluation of injury to tendon, muscle or muscle/tendon junction; or- rotator cuff tear/calcification/tendinosis (biceps, subscapular, suspraspinatus, infraspinatus); or- biceps subluxation; or- capsulitis and bursitis; or- evaluation of mass including ganglion; or- occult fracture; or- acromioclavicular joint pathology.(r) | |
| 55809 | Note: benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non- specific shoulder pain alone. Shoulder or upper arm, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions:- evaluation of injury to tendon, muscle or muscle/tendon junction; or- rotator cuff tear/calcification/tendinosis (biceps, subscapular, suspraspinatus, infraspinatus); or- biceps subluxation; or- capsulitis and bursitis; or- evaluation of mass including ganglion; or- occult fracture; or- acromioclavicular joint pathology (r) (nk) | \$98.70 |
| 55810 | Note: Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non- specific shoulder pain alone. Shoulder or upper arm, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which a n item in Subgroups 2 or 3 of this Group applies; and(b)the patient is not referred by a medical practitioner, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions:- evaluation of injury to tendon, muscle or muscle/tendon junction; or- rotator cuff tear/calcification/tendinosis (biceps, subscapular, suspraspinatus, infraspinatus); or- biceps subluxation; or- capsulitis and bursitis; or- evaluation of mass including ganglion; or- occult fracture; or- acromioclavicular joint pathology.(nr) | \$89.60 |
| 55811 | Note: benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non- specific shoulder pain alone. Shoulder or upper arm, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions:- evaluation of injury to tendon, muscle or muscle/tendon junction; or- rotator cuff tear/calcification/tendinosis (biceps, subscapular, suspraspinatus, infraspinatus); or- biceps subluxation; or- capsulitis and bursitis; or- evaluation of mass including ganglion; or- occult fracture; or- acromioclavicular joint pathology (nr) (nk) | \$34.20 |
| 55812 | Chest or abdominal wall, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) | \$210.80 |
| 55813 | Chest or abdominal wall, 1 or more areas, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk) | \$98.70 |
| 55814 | Chest or abdominal wall, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (nr) | \$73.20 |
| 55815 | Chest or abdominal wall, 1 or more areas, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner (nr) (nk) | \$34.20 |
| 55816 | Hip or groin, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) | \$210.50 |
| 55817 | Hip or groin, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk) | \$98.70 |
| 55818 | Hip or groin, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies: and (b) the patient is not referred by a medical practitioner (nr) | \$73.20 |
| 55819 | Hip or groin, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies: and(b) the patient is not referred by a medical practitioner (nr) (nk) | \$34.20 |
| 55820 | Paediatric hip examination for dysplasia, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in sub groups 2 or 3 of this group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) | \$209.30 |
| 55821 | Paediatric hip examination for dysplasia, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk) | \$98.70 |
| 55822 | Paediatric hip examination for dysplasia, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in sub groups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (nr) | \$70.90 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 55823 | Paediatric hip examination for dysplasia, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner (nr) (nk) | \$34.20 |
| 55824 | Buttock or thigh, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) | \$210.50 |
| 55825 | Buttock or thigh, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk) | \$98.70 |
| 55826 | Buttock or thigh, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (nr) | \$75.50 |
| 55827 | Buttock or thigh, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner (nr) (nk) | \$34.20 |
| 55828 | Note: Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non- specific knee pain alone or other knee condition including:- meniscal and cruciate ligament tears- assessment of chondral surfaces knee, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided for the assessment of one or more of the following conditions or suspected conditions:- abnormality of tendons or bursae about the knee; or- meniscal cyst, popliteal fossa cyst , mass or pseudomass; or- nerve entrapment, nerve or nerve sheath tumour; or-in jury of collateral ligaments.(r) | \$209.80 |
| 55829 | Note: benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. benefits are not payable when referred for non- specific knee pain alone or other knee condition including:- meniscal and cruciate ligament tears- assessment of chondral surfaces knee, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided for the assessment of one or more of the following conditions or suspected conditions:- abnormality of tendons or bursae about the knee; or- meniscal cyst, popliteal fossa cyst, mass or pseudomass; or- nerve entrapment, nerve or nerve sheath tumour; or- injury of collateral ligaments (r) (nk) | \$98.70 |
| 55830 | Note: Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non- specific knee pain alone or other knee condition including:- meniscal and cruciate ligament tears- assessment of chondral surfaces knee, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and(b) the patient is not referred by a medical practitioner and where the service is provided for the assessment of one or more of the following conditions or suspected conditions: - abnormality of tendons or bursae about the knee; or- meniscal cyst, popliteal fossa cyst, mass or pseudomass; or- nerve entrapment, nerve or nerve sheath tumour; or- injury of collateral ligaments.(nr) | \$73.20 |
| 55831 | Note: benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. benefits are not payable when referred for non- specific knee pain alone or other knee condition including:- meniscal and cruciate ligament tears- assessment of chondral surfaces knee, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner and where the service is provided for the assessment of one or more of the following conditions or suspected conditions:- abnormality of tendons or bursae about the knee; or- meniscal cyst, popliteal fossa cyst, mass or pseudomass; or- nerve entrapment, nerve or nerve sheath tumour; or- injury of collateral ligaments (nr) (nk) | \$34.20 |
| 55832 | Lower leg, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) | \$209.20 |
| 55833 | Lower leg, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk) | \$98.70 |
| 55834 | Lower leg, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (nr) | \$90.00 |
| 55835 | Lower leg, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner (nr) (nk) | \$34.20 |
| 55836 | Ankle or hind foot, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) | \$211.60 |
| 55837 | Ankle or hind foot, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk) | \$98.70 |
| 55838 | Ankle or hind foot, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (nr) | \$73.20 |

| Item No. | Description | Max fee (excl GST) |
|---------------------------------------|--|--------------------|
| 55839 | Ankle or hind foot, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner (nr) (nk) | \$34.20 |
| 55840 | Mid foot or fore foot, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) | \$214.20 |
| 55841 | Mid foot or fore foot, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk) | \$98.70 |
| 55842 | Mid foot or fore foot, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (nr) | \$85.60 |
| 55843 | Mid foot or fore foot, 1 or both sides, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner (nr) (nk) | \$34.20 |
| 55844 | Assessment of a mass associated with the skin or subcutaneous structures, not being a part of the musculoskeletal system, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) | \$168.10 |
| 55845 | Assessment of a mass associated with the skin or subcutaneous structures, not being a part of the musculoskeletal system, 1 or more areas, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk) | \$79.10 |
| 55846 | Assessment of a mass associated with the skin or subcutaneous structures, not being a part of the musculoskeletal system, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (nr) | \$72.70 |
| 55847 | Assessment of a mass associated with the skin or subcutaneous structures, not being a part of the musculoskeletal system, 1 or more areas, ultrasound scan of, where:(a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and(b) the patient is not referred by a medical practitioner (nr) (nk) | \$34.20 |
| 55848 | Musculoskeletal cross-sectional echography, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies, and not performed in conjunction with item 55054 (r) | \$248.80 |
| 55849 | Musculoskeletal cross-sectional echography, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies, and not performed in conjunction with item 55054 or 55026 (r) (nk) | \$98.70 |
| 55850 | Musculoskeletal cross-sectional echography, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, where: (a) the referring practitioner has indicated on a referral for a musculoskeletal ultrasound that a ultrasound guided intervention be performed if clinically indicated; (b) the service is not performed in conjunction with items 55054, or 55800 to 55848, and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) | \$315.20 |
| 55851 | Musculoskeletal cross-sectional echography, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, where:(a) the referring practitioner has indicated on a referral for a musculoskeletal ultrasound that a ultrasound guided intervention be performed if clinically indicated;(b) the service is not performed in conjunction with items 55026, 55054, or 55800 to 55849, and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk) | \$138.20 |
| 55852 | Paediatric spine, spinal cord and overlying subcutaneous tissues, ultrasound scan of, where: a) the patient is referred by a medical practitioner b) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) | \$204.20 |
| 55853 | Paediatric spine, spinal cord and overlying subcutaneous tissues, ultrasound scan of, where: a) the patient is referred by a medical practitioner b) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r) (nk) | \$98.70 |
| 55854 | Paediatric spine, spinal cord and overlying subcutaneous tissues, Ultrasound scan of, where: a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and b) the patient is not referred by a medical practitioner (nr) | \$70.90 |
| 55855 | Paediatric spine, spinal cord and overlying subcutaneous tissues, ultrasound scan of, where: a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and b) the patient is not referred by a medical practitioner (nr) (nk) | \$34.20 |
| GROUP I2 - COMPUTED TOMOGRAPHY | | |
| 56001 | Computed Tomography - scan of brain without intravenous contrast medium, not being a service to which item 57001 applies (R) (K) (Anaes.) | \$381.50 |
| 56007 | computed tomography - scan of brain with intravenous contrast medium and with any scans of the brain prior to intravenous contrast injection, when undertaken, not being a service to which item 57007 applies (r) (k) | \$483.50 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 56010 | Computed tomography - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (r) (k) | \$487.60 |
| 56013 | Computed tomography - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (K) | \$478.90 |
| 56016 | Computed tomography - scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (K) | \$565.30 |
| 56022 | Computed tomography - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (K) | \$431.10 |
| 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 sin uses or both prior to intravenous contrast injection, when undertaken (R) (K) | \$647.00 |
| 56030 | Computed tomography - scan of facial bones, paranasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (K) | \$435.20 |
| 56036 | Computed tomography - scan of facial bones, paranasal sinuses or both, with scan of brain, with intravenous contrast medium, where: (a) a scan without intravenous contrast medium has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (K) | \$650.60 |
| 56041 | Computed tomography - scan of brain without intravenous contrast medium, not being a service to which item 57041 applies (R) (NK) | \$185.00 |
| 56047 | Computed tomography - scan of brain with intravenous contrast medium and with any scans of the brain prior to intravenous contrast injection, when undertaken, not being a service to which item 57047 applies (R) (NK) | \$243.20 |
| 56050 | Computed tomography - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) | \$243.30 |
| 56053 | Computed tomography - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) | \$240.30 |
| 56056 | Computed tomography - scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (NK) | \$298.60 |
| 56062 | Computed tomography - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (NK) | \$212.10 |
| 56068 | Computed tomography - scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sin uses or both prior to intravenous contrast injection, when undertaken (R) (NK) | \$337.60 |
| 56070 | Computed tomography - scan of facial bones, paranasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (NK) | \$212.10 |
| 56076 | Computed tomography - scan of facial bones, paranasal sinuses or both, with scan of brain, with intravenous contrast medium, where: (a) a scan without intravenous contrast medium has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (NK) | \$323.90 |
| 56101 | Computed Tomography - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56801 applies (R) (K) (Anaes.) | \$441.50 |
| 56107 | Computed tomography - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) - with intravenous contrast medium and with any scans of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) prior to intravenous contrast injection, when undertaken, not being a service associated with a service associated with a service to which item 56807 applies (R) (K) | \$650.80 |
| 56141 | Computed tomography - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56841 applies (R) (NK) | \$225.70 |
| 56147 | Computed tomography - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) - with intravenous contrast medium and with any scans of soft tissues of neck including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) prior to intravenous contrast injection, when undertaken, not being a service associated with a service to which item 56847 applies (r) (nk) | \$321.60 |
| 56219 | Computed Tomography - scan of spine, 1 or more regions with intrathecal contrast medium, including the preparation for intrathecal injection of contrast medium and any associated plain X-rays, not being a service to which item 59724 applies (R) (K) (Anaes.) | \$633.30 |
| 56220 | Computed tomography - scan of spine, cervical region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (k) | \$460.90 |
| 56221 | Computed tomography - scan of spine, thoracic region, without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (r) (k) | \$468.10 |
| 56223 | Computed tomography - scan of spine, lumbosacral region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (k) | \$465.00 |
| 56224 | Computed tomography - scan of spine, cervical region, with intravenous contrast medium and with any scans of the cervical region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (k) | \$658.00 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 56225 | Computed tomography - scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (k) | \$667.10 |
| 56226 | Computed tomography - scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (k) | \$661.90 |
| 56227 | Computed tomography - scan of spine, cervical region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (nk) | \$236.70 |
| 56228 | Computed tomography - scan of spine, thoracic region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (nk) | \$229.40 |
| 56229 | Computed tomography - scan of spine, lumbosacral region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (nk) | \$229.40 |
| 56230 | Computed tomography - scan of spine, cervical region, with intravenous contrast medium, and with any scans of the cervical region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (nk) | \$332.30 |
| 56231 | Computed tomography - scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (nk) | \$332.30 |
| 56232 | Computed tomography - scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (nk) | \$332.30 |
| 56233 | Note: An account issued or a patient assignment form must show the item number s of the examinations performed under this item computed tomography - scan of s pine, two examinations of the kind referred to in items 56220, 56221 and 56223 without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (r) (k) | \$460.50 |
| 56234 | Note: An account issued or a patient assignment form must show the item number s of the examinations performed under this item computed tomography - scan of s pine, two examinations of the kind referred to in items 56224, 56225 and 56226 with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (k) | \$675.40 |
| 56235 | Note: An account issued or a patient assignment form must show the item number s of the examinations performed under this item computed tomography - scan of s pine, two examinations of the kind referred to in items 56227, 56228 and 56229 without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (r) (nk) | \$234.70 |
| 56236 | Note: An account issued or a patient assignment form must show the item number s of the examinations performed under this item computed tomography - scan of s pine, two examinations of the kind referred to in items 56230, 56231 and 56232 with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (nk) | \$332.30 |
| 56237 | Computed tomography - scan of spine, three regions cervical, thoracic and lumbo sacral, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (k) | \$460.90 |
| 56238 | Computed tomography - scan of spine, three regions cervical, thoracic and lumbo sacral, with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 bene fit, payable whether 1 or more attendances are required to complete the service (r) (k) | \$679.70 |
| 56239 | Computed tomography - scan of spine, three regions cervical, thoracic and lumbo sacral, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (nk) | \$229.30 |
| 56240 | computed tomography - scan of spine, three regions cervical, thoracic and lumbo sacral, with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 bene fit, payable whether 1 or more attendances are required to complete the service (r) (nk) | \$332.30 |
| 56259 | Computed tomography - scan of spine, 1 or more regions with intrathecal contras t medium, including the preparation for intrathecal injection of contrast medium and any associated plain X-rays, not being a service to which item 59724 applies (R) (NK) | \$308.70 |
| 56301 | Computed Tomography - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56801 or 57001 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) | \$568.20 |
| 56307 | Computed tomography - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contras t medium and with any scans of the chest including lungs, mediastinum, chest wall or pleura and upper abdomen prior to intravenous contrast injection, when undertaken, not being a service to which item 56807 or 57007 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) | \$761.70 |
| 56341 | Computed tomography - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56841 or 57041 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) | \$286.90 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 56347 | Computed tomography - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest including lungs, mediastinum, chest wall or pleura and upper abdomen prior to intravenous contrast injection, when undertaken, not being a service to which item 56847 or 57047 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) | \$387.00 |
| 56401 | Computed Tomography - scan of upper abdomen only (diaphragm to iliac crest) without intravenous contrast medium, not being a service to which item 56301, 56501, 56801 or 57001 applies (R) (K) (Anaes.) | \$407.80 |
| 56407 | Computed tomography - scan of upper abdomen only (diaphragm to iliac crest) with intravenous contrast medium, and with any scans of upper abdomen (diaphragm to iliac crest) prior to intravenous contrast injection, when undertaken, not being a service to which item 56307, 56507, 56807 or 57007 applies (R) (K) | \$690.20 |
| 56409 | Computed tomography - scan of pelvis only (iliac crest to pubic symphysis) without intravenous contrast medium not being a service associated with a service to which item 56401 applies (R) (K) | \$393.90 |
| 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) prior to intravenous contrast injection, when undertaken, not being a service to which item 56407 applies (R) (K) | \$696.20 |
| 56441 | Computed tomography - scan of upper abdomen only (diaphragm to iliac crest), without intravenous contrast medium, not being a service to which item 56341, 56541, 56841 or 57041 applies (R) (NK) | \$195.50 |
| 56447 | Computed tomography - scan of upper abdomen only (diaphragm to iliac crest), with intravenous contrast medium, and with any scans of upper abdomen (diaphragm to iliac crest) prior to intravenous contrast injection, when undertaken, not being a service to which item 56347, 56547, 56847 or 57047 applies (R) (NK) | \$339.90 |
| 56449 | Computed tomography - scan of pelvis only (iliac crest to pubic symphysis) without intravenous contrast medium, not being a service to which item 56441 applies (R) (NK) | \$209.50 |
| 56452 | Computed tomography - scan of pelvis only (iliac crest to pubic symphysis) with intravenous contrast medium, and with any scans of pelvis (iliac crest to pubic symphysis) prior to intravenous contrast injection, when undertaken, not being a service to which item 56447 applies (R) (NK) | \$339.90 |
| 56501 | Computed Tomography - scan of upper abdomen and pelvis without intravenous contrast medium, not for the purposes of virtual colonoscopy, not being a service to which item 56801 or 57001 applies (R) (K) (Anaes.) | \$589.40 |
| 56507 | Computed tomography - scan of upper abdomen and pelvis with intravenous contrast medium and with any scans of upper abdomen and pelvis prior to intravenous contrast injection, when undertaken, not for the purposes of virtual colonoscopy, not being a service to which item 56807 or 57007 applies (R) (K) | \$924.20 |
| 56541 | Computed tomography - scan of upper abdomen and pelvis without intravenous contrast medium, not for the purposes of virtual colonoscopy, not being a service to which item 56841 or 57041 applies (R) (NK) | \$293.40 |
| 56547 | Computed tomography - scan of upper abdomen and pelvis with intravenous contrast medium, and with any scans of upper abdomen and pelvis prior to intravenous contrast injection, when undertaken, not for the purposes of virtual colonoscopy, not being a service to which item 56847 or 57047 applies (R) (NK) | \$463.20 |
| 56553 | Computed tomography-scan of colon for exclusion or diagnosis of colorectal neoplasia in a symptomatic or high risk patient if:(a) one [or more] of the following applies: (i) the patient has had an incomplete colonoscopy in the 3 months before the scan; (ii) there is a high-grade colonic obstruction; (iii) the patient is referred by a specialist or consultant physician who performs colonoscopies [in the practice of his or her speciality]; and (b) the service is not a service to which item 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies; and(c) the service has not been performed on the patient in the 36 months before the scan (R) (K) (Anaes.) | \$827.30 |
| 56555 | Computed tomography-scan of colon for exclusion or diagnosis of colorectal neoplasia in a symptomatic or high risk patient if: (a) one [or more] of the following applies: (i) the patient has had an incomplete colonoscopy in the 3 months before the scan; (ii) there is a high-grade colonic obstruction; (iii) the patient is referred by a specialist or consultant physician who performs colonoscopies [in the practice of his or her speciality]; and (b) the service is not a service to which item 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies; and (c) the service has not been performed on the patient in the 36 months before the scan (R) (NK) (Anaes.) | \$413.70 |
| 56619 | Computed Tomography - scan of extremities, one region (other than knee), or more than one region (which may include knee), without intravenous contrast medium. Payable once only whether one or more attendances are required to complete the service, not being a service to which any of items 56620, 56626, 56660 or 56666 apply(R) (K) (Anaes.) | \$423.00 |
| 56625 | Computed Tomography - scan of extremities, one region (other than knee), or more than one region (which may include knee), with intravenous contrast medium and with any scans of extremities before intravenous contrast injection, when performed. Payable once only whether one or more attendances are required to complete the service, not being a service to which any of items 56620, 56626, 56660 or 56666 apply. (R) (K) (Anaes.) | \$629.70 |
| 56659 | Computed Tomography - scan of extremities, one region (other than knee), or more than one region (which may include knee), without intravenous contrast medium. Payable once only whether one or more attendances are required to complete the service, not being a service to which any of items 56620, 56626, 56660 or 56666 apply(R) (NK) (Anaes.). | \$215.90 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 56665 | Computed Tomography - scan of extremities, one region (other than knee), or more than one region (which may include knee), with intravenous contrast medium and with any scans of extremities before intravenous contrast injection, when performed. Payable once only whether one or more attendances are required to complete the service, not being a service to which any of items 56620, 56626, 56660 or 56666 apply(R) (NK) (Anaes.). | \$313.50 |
| 56801 | Computed Tomography - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) | \$878.40 |
| 56807 | Computed tomography - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) | \$1063.50 |
| 56841 | Computed tomography - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) | \$437.20 |
| 56847 | Computed tomography - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) | \$544.10 |
| 57001 | Computed Tomography - scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) | \$887.10 |
| 57007 | Computed tomography- scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) | \$1065.60 |
| 57041 | Computed tomography- scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) | \$437.30 |
| 57047 | Computed tomography- scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) | \$531.80 |
| 57201 | Computed Tomography - Pelvimetry (R) (K) (Anaes.) | \$316.10 |
| 57247 | Computed tomography - pelvimetry (R) (NK) | \$145.30 |
| 57341 | Computed Tomography, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (K) (Anaes.) | \$701.10 |
| 57345 | Computed tomography, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (NK) | \$452.80 |
| 57350 | Computed Tomography - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (c) the service has not been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (K) (Anaes.) | \$997.40 |
| 57351 | Computed tomography - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of acute or recurrent pulmonary embolism; acute symptomatic arterial occlusion; post operative complication of arterial surgery; acute ruptured aneurysm; or acute dissection of the aorta, carotid or vertebral artery; and (c) the services to which 57350 or 57355 apply have been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (r) (k) | \$985.50 |
| 57355 | Computed tomography - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (c) the service has not been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (r) (nk) | \$495.80 |
| 57356 | Computed tomography - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: a) the service is not a service to which another item in this group applies; and b) the service is performed for the exclusion of acute or recurrent pulmonary embolism; acute symptomatic arterial occlusion; post operative complication of arterial surgery; or acute ruptured aneurysm; acute dissection of the aorta, carotid or vertebral artery; and c) the services | \$494.80 |

| Item No. | Description | Max fee (excl GST) |
|---|---|--------------------|
| | to which 57350 or 57355 apply have been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (r) (nk) | |
| 57360 | Computed tomography of the coronary arteries performed on a minimum of a 64 slice (or equivalent) scanner, where the request is made by a specialist or consultant physician, and: the patient has stable symptoms consistent with coronary ischaemia, is at low to intermediate risk of coronary artery disease and would have been considered for coronary angiography; or the patient requires exclusion of coronary artery anomaly or fistula; or the patient will be undergoing non-coronary cardiac surgery (r) (k) (Anaes.) | \$1266.60 |
| 57361 | Computed tomography of the coronary arteries performed on a minimum of a 64 slice (or equivalent) scanner, where the request is made by a specialist or consultant physician, and: the patient has stable symptoms consistent with coronary ischaemia, is at low to intermediate risk of coronary artery disease and would have been considered for coronary angiography; or the patient requires exclusion of coronary artery anomaly or fistula; or the patient will be undergoing non-coronary cardiac surgery (r) (nk) (Anaes.) | \$633.20 |
| 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; and (f) temporo- mandibular joint conditions. Payable once per patient per day, not being for a service to which any of items 57959 to 57969 apply, and not being a service associated with another service in group I2 (R) (K) (Anaes.) | \$184.10 |
| 57363 | Cone beam computed tomography, dental and temporo-mandibular joint imaging (without contrast medium) for diagnosis and management of any of the following: (g) mandibular and dento- alveolar fractures;(h) dental implant planning; (i) orthodontics; (j) endodontic conditions; (k) periodontal conditions; and (l) temporo- mandibular joint conditions. Payable once per patient per day, not being for a service to which any of items 57959 to 57969 apply, and not being a service associated with another service in group I2 (R) (NK) (Anaes.) | \$92.10 |
| GROUP I3 - DIAGNOSTIC RADIOLOGY | | |
| Radiographic examination of extremities | | |
| 57506 | Hand, wrist, forearm, elbow or humerus (NR) | \$63.90 |
| 57509 | Hand, wrist, forearm, elbow or humerus (R) | \$76.30 |
| 57512 | Hand and wrist or hand, wrist and forearm or forearm and elbow or elbow and humerus (nr) | \$81.80 |
| 57515 | Hand and wrist or hand, wrist and forearm or forearm and elbow or elbow and humerus (R) | \$105.60 |
| 57518 | Foot, Ankle, Leg or Femur (NR)(K) | \$68.30 |
| 57521 | Foot, Ankle, Leg or Femur (R)(K) | \$83.30 |
| 57524 | Foot and ankle, or ankle and leg, or leg and knee, or knee or femur (NR) | \$95.70 |
| 57527 | Foot and ankle, or ankle and leg, or leg and knee, or knee and femur (R) | \$126.50 |
| 57529 | Hand, wrist, forearm, elbow or humerus (nr) (nk) | \$26.90 |
| 57530 | Hand, wrist, forearm, elbow or humerus (r) (nk) | \$36.10 |
| 57532 | Hand and wrist or hand, wrist and forearm or forearm and elbow or elbow and humerus (nr) (nk) | \$36.60 |
| 57533 | Hand and wrist or hand, wrist and forearm or forearm and elbow or elbow and humerus (r) (nk) | \$49.00 |
| 57535 | Foot, Ankle, Leg or Femur (NR) (NK) | \$29.40 |
| 57536 | Foot, Ankle, Leg or Femur (R) (NK) | \$39.40 |
| 57538 | Foot and ankle, or ankle and leg, or leg and knee, or knee and femur (nr) (nk) | \$44.70 |
| 57539 | Foot and ankle, or ankle and leg, or leg and knee, or knee and femur (r) (nk) | \$59.70 |
| Radiographic examination of shoulder or pelvis | | |
| 57700 | Shoulder or scapula (NR) | \$79.50 |
| 57702 | Shoulder or scapula (nr) (nk) | \$36.60 |
| 57703 | Shoulder or scapula (R) | \$104.50 |
| 57705 | Shoulder or scapula (r) (nk) | \$49.00 |
| 57706 | Clavicle (NR) | \$76.10 |
| 57708 | Clavicle (nr) (nk) | \$29.40 |
| 57709 | Clavicle (R) | \$83.10 |
| 57711 | Clavicle (r) (nk) | \$39.40 |
| 57712 | Hip joint (R) | \$91.10 |
| 57714 | Hip joint (r) (nk) | \$42.70 |
| 57715 | Pelvic girdle (R) | \$116.20 |
| 57717 | Pelvic girdle (r) (nk) | \$55.10 |
| 57721 | Femur, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R) | \$190.00 |
| 57723 | Femur, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (r) (nk) | \$89.90 |
| Radiographic examination of head | | |
| 57901 | Skull, not in association with item 57902 (R) | \$124.80 |

| Item No. | Description | Max fee (excl GST) |
|--|--|--------------------|
| 57902 | Cephalometry, not in association with item 57901 (R) | \$120.90 |
| 57903 | Sinuses (R) | \$90.80 |
| 57906 | Mastoids (R) | \$120.90 |
| 57909 | Petrous temporal bones (R) | \$120.90 |
| 57911 | Skull, not in association with item 57902 or 57914 (r) (nk) | \$58.40 |
| 57912 | Facial bones orbit, maxilla or malar, any or all (R) | \$90.70 |
| 57914 | Cephalometry, not in association with item 57901 or 57911 (r) (nk) | \$58.40 |
| 57915 | Mandible, not by orthopantomography technique (R) | \$91.50 |
| 57917 | Sinuses (r) (nk) | \$42.80 |
| 57918 | Salivary calculus (R) | \$91.90 |
| 57920 | Mastoids (r) (nk) | \$58.40 |
| 57921 | Nose (R) | \$91.50 |
| 57923 | Petrous temporal bones (r) (nk) | \$58.40 |
| 57924 | Eye (R) | \$89.60 |
| 57926 | Facial bones orbit, maxilla or malar, any or all (r) (nk) | \$42.70 |
| 57927 | Temporomandibular joints (R) | \$95.60 |
| 57929 | Mandible, not by orthopantomography technique (r) (nk) | \$42.70 |
| 57930 | Teeth single area (R) | \$68.60 |
| 57932 | Salivary calculus (r) (nk) | \$42.70 |
| 57933 | Teeth full mouth (R) | \$147.60 |
| 57935 | Nose (r) (nk) | \$42.70 |
| 57938 | Eye (r) (nk) | \$42.70 |
| 57939 | Palatopharyngeal studies with fluoroscopic screening (R) | \$121.40 |
| 57941 | Temporomandibular joints (r) (nk) | \$45.00 |
| 57942 | Palatopharyngeal studies without fluoroscopic screening (R) | \$95.20 |
| 57944 | Teeth single area (r) (nk) | \$29.80 |
| 57945 | Larynx, lateral airways and soft tissues of the neck, not being a service associated with a service to which item 57939 or 57942 applies (R) | \$83.30 |
| 57947 | Teeth full mouth (r) (nk) | \$70.90 |
| 57950 | Palatopharyngeal studies with fluoroscopic screening (r) (nk) | \$58.40 |
| 57953 | Palatopharyngeal studies without fluoroscopic screening (r) (nk) | \$45.00 |
| 57956 | Larynx, lateral airways and soft tissues of the neck, not being a service associated with a service to which item 57939, 57942, 57950 or 57953 applies (r) (nk) | \$39.40 |
| 57959 | Orthopantomography, for diagnosis and/or management of trauma, infection, tumours, congenital conditions or surgical conditions of the teeth or maxillofacial region (r) (nk) | \$43.00 |
| 57960 | Orthopantomography, for diagnosis and/or management of trauma, infection, tumours, congenital conditions or surgical conditions of the teeth or maxillofacial region (r) | \$90.20 |
| 57962 | Orthopantomography, for diagnosis and/or management of impacted teeth, caries, periodontal or peripical pathology where signs or symptoms of those conditions are evident (r) (nk) | \$43.00 |
| 57963 | Orthopantomography, for diagnosis and/or management of impacted teeth, caries, periodontal or peripical pathology where signs or symptoms of those conditions are evident (r) | \$90.10 |
| 57965 | Orthopantomography, for diagnosis and/or management of missing or crowded teeth, or developmental anomalies of the teeth or jaws (r) (nk) | \$43.00 |
| 57966 | Orthopantomography, for diagnosis and/or management of missing or crowded teeth, or developmental anomalies of the teeth or jaws (r) | \$89.60 |
| 57968 | Orthopantomography, for diagnosis and/or management of temporomandibular joint arthroses or dysfunction (r) (nk) | \$43.00 |
| 57969 | Orthopantomography, for diagnosis and/or management of temporomandibular joint arthroses or dysfunction (r) | \$91.90 |
| Radiographic examination of spine | | |
| 58100 | Spine cervical (R) | \$129.20 |
| 58102 | Spine cervical (r) (nk) | \$60.70 |
| 58103 | Spine thoracic (R) | \$106.30 |
| 58105 | Spine thoracic (r) (nk) | \$49.90 |
| 58106 | Spine lumbosacral (R) | \$148.10 |
| 58108 | Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal (r) | \$206.00 |
| 58109 | Spine sacrococcygeal (R) | \$90.40 |

| Item No. | Description | Max fee (excl GST) |
|--|--|--------------------|
| 58111 | Spine lumbosacral (r) (nk) | \$69.70 |
| 58112 | Note: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item Spine, two examinations of the kind referred to in items 58100, 58103, 58106 and 58109 (r) | \$189.30 |
| 58114 | Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal (r) (nk) | \$99.60 |
| 58115 | Spine, three examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (r) | \$206.00 |
| 58117 | Spine sacrococcygeal (r) (nk) | \$42.60 |
| 58120 | Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal (r), if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year | \$206.00 |
| 58121 | Note: an account issued or a patient assignment form must show the item numbers of the examinations performed under this item spine, three examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (r), if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year | \$206.00 |
| 58123 | Spine, two examinations of the kind referred to in items 58100, 58102, 58103, 58105, 58106, 58109, 58111 and 58117 (r) (nk) | \$88.00 |
| 58124 | Spine, three examinations of the kind mentioned in items 58100, 58102, 58103, 58105, 58106, 58109, 58111 and 58117 (r) (nk) | \$99.60 |
| 58126 | Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal, if the service to which item 58120, 58121, 58126 or 58127 applies has not been performed on the same patient within the same calendar year (r) (nk) | \$99.60 |
| 58127 | Spine, three examinations of the kind mentioned in items 58100, 58102, 58103, 58105, 58106 and 58109, 58111 and 58117 if the service to which item 58120, 58121, 58126 or 58127 applies has not been performed on the same patient within the same calendar year (r) (nk) | \$99.60 |
| Bone age study and skeletal surveys | | |
| 58300 | Bone age study (R) | \$81.80 |
| 58302 | Bone age study (r) (nk) | \$36.30 |
| 58306 | Skeletal survey (R) | \$173.20 |
| 58308 | Skeletal survey (r) (nk) | \$80.80 |
| Radiographic examination of thoracic region | | |
| 58500 | Chest (lung fields) by direct radiography (NR) | \$58.80 |
| 58502 | Chest (lung fields) by direct radiography (nr) (nk) chest (lung fields) by direct radiography (nr) (nk) | \$32.00 |
| 58503 | Chest (lung fields) by direct radiography (R) | \$90.40 |
| 58505 | Chest (lung fields) by direct radiography (r) (nk) | \$42.70 |
| 58506 | Chest (lung fields) by direct radiography with fluoroscopic screening (R) | \$134.30 |
| 58508 | Chest (lung fields) by direct radiography with fluoroscopic screening (r) (nk) | \$55.00 |
| 58509 | Thoracic inlet or trachea (R) | \$89.30 |
| 58511 | Thoracic inlet or trachea (r) (nk) | \$36.10 |
| 58521 | Left ribs, right ribs or sternum (R) | \$83.70 |
| 58523 | Left ribs, right ribs or sternum (r) (nk) | \$39.40 |
| 58524 | Left and right ribs, left ribs and sternum, or right ribs and sternum (R) | \$108.50 |
| 58526 | Left and right ribs, left ribs and sternum, or right ribs and sternum (r) (nk) | \$51.10 |
| 58527 | Left ribs, right ribs and sternum (R) | \$131.00 |
| 58529 | Left ribs, right ribs and sternum (r) (nk) | \$62.80 |
| Radiographic examination of urinary tract | | |
| 58700 | Plain renal only (R) | \$92.70 |
| 58702 | Plain renal only (r) (nk) | \$41.70 |
| 58706 | Intravenous pyelography, with or without preliminary plain films and with or without tomography - (r) | \$304.30 |
| 58708 | Intravenous pyelography, with or without preliminary plain films and with or without tomography - (r) (nk) | \$142.80 |
| 58715 | antegrade or retrograde pyelography, with or without preliminary plain films and with preparation and contrast injection - 1 side - (r) | \$257.50 |
| 58717 | Antegrade or retrograde pyelography, with or without preliminary plain films and with preparation and contrast injection - 1 side - (r) (nk) | \$137.10 |
| 58718 | Retrograde cystography or retrograde urethrography with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) | \$243.60 |
| 58720 | Retrograde cystography or retrograde urethrography with or without preliminary plain films and with preparation and contrast injection - (r) (nk) (Anaes.) | \$114.20 |
| 58721 | Retrograde micturating cysto- urethrography, with preparation and contrast injection - (R) (Anaes.) | \$239.20 |
| 58723 | Retrograde micturating cystourethrography, with preparation and contrast injection - (r) (nk) (Anaes.) | \$125.20 |

| Item No. | Description | Max fee (excl GST) |
|--|---|--------------------|
| 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) | \$55.30 |
| 58902 | Plain abdominal only, not being a service associated with a service to which item 58909, 58911, 58912, 58914, 58915 or 58917 applies (nr) (nk) | \$32.20 |
| 58903 | Plain abdominal only, not being a service associated with a service to which item 58909, 58912 or 58915 applies (R) | \$91.40 |
| 58905 | Plain abdominal only, not being a service associated with a service to which item 58909, 58911, 58912, 58914, 58915 or 58917 applies (r) (nk) | \$43.10 |
| 58909 | Barium or other opaque meal of 1 or more of pharynx, oesophagus, stomach or duodenum, with or without preliminary plain films of pharynx, chest or duodenum, not being a service associated with a service to which item 57939 or 57942 or 57 945 applies - (R) | \$202.80 |
| 58911 | Barium or other opaque meal of 1 or more of pharynx, oesophagus, stomach or duodenum, with or without preliminary plain films of pharynx, chest or duodenum, not being a service associated with a service to which item 57939, 57942, 57945, 57950, 57953 or 57956 applies - (r) (nk) | \$81.40 |
| 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) | \$236.80 |
| 58914 | Barium or other opaque meal of oesophagus, stomach, duodenum and follow through to colon, with or without screening of chest, with or without preliminary plain film (r) (nk) | \$99.80 |
| 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.) | \$268.80 |
| 58917 | Barium or other opaque meal, small bowel series only, with or without preliminary plain film (r) (nk) | \$71.50 |
| 58920 | Small bowel enema, barium or other opaque study of the small bowel, including duodenal intubation, with or without preliminary plain films, not being a service associated with a service to which item 30488 applies - (r) (nk) (Anaes.) | \$125.40 |
| 58921 | Opaque enema, with or without air contrast study and with or without preliminary plain films - (R) | \$259.40 |
| 58923 | Opaque enema, with or without air contrast study and with or without preliminary plain films - (r) (nk) | \$122.50 |
| 58927 | Cholecography 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) | \$148.40 |
| 58929 | Cholecography direct, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 30439 applies - (r) (nk) | \$69.30 |
| 58933 | Cholecography, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection - (R) | \$402.00 |
| 58935 | Cholecography, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection - (r) (nk) | \$186.00 |
| 58936 | Cholecography, drip infusion, with or without preliminary plain films, with preparation and contrast injection and with or without tomography - (R) | \$350.00 |
| 58938 | Cholecography, drip infusion, with or without preliminary plain films, with preparation and contrast injection and with or without tomography - (r) (nk) | \$177.30 |
| 58939 | Defaecogram (R) | \$266.70 |
| 58941 | Defaecogram (r) (nk) | \$126.00 |
| 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) | \$39.90 |
| 59104 | Localisation of foreign body, if provided in conjunction with a service described in subgroups 1 to 12 of group i3 (r) (nk) | \$19.30 |
| Radiographic examination of breasts | | |
| 59300 | Mammography of both breasts, if there is a reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner. Unless otherwise indicated, mammography includes both breasts (r) | \$171.70 |
| 59301 | Mammography of both breasts, if there is a reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patients family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner. Unless otherwise indicated, mammography includes both breasts (r) (nk) | \$80.80 |
| 59303 | Mammography of one breast, if: (a) the patient is referred with a specific request for a unilateral mammogram; and (b) there is reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner (r) | \$103.50 |
| 59304 | Mammography of one breast, if:(a) the patient is referred with a specific request for a unilateral mammogram; and(b) there is reason to suspect the presence of malignancy because of: (i) the past | \$49.00 |

| Item No. | Description | Max fee (excl GST) |
|---|---|--------------------|
| | occurrence of breast malignancy in the patient or members of the patients family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner (r) (nk) | |
| 59306 | Mammary ductogram (galactography) - 1 breast (R) | \$194.60 |
| 59307 | Mammary ductogram (galactography) - 1 breast (r) (nk) | \$90.70 |
| 59309 | Mammary ductogram (galactography) - 2 breasts (R) | \$375.80 |
| 59310 | Mammary ductogram (galactography) - 2 breasts (r) (nk) | \$181.40 |
| 59312 | Radiographic examination of both breasts, in conjunction with a surgical procedure on each breast, using interventional techniques - (R) | \$171.10 |
| 59313 | Radiographic examination of both breasts, in conjunction with a surgical procedure on each breast, using interventional techniques - (r) (nk) | \$78.80 |
| 59314 | Radiographic examination of 1 breast, in conjunction with a surgical procedure using interventional techniques - (R) | \$123.90 |
| 59315 | Radiographic examination of 1 breast, in conjunction with a surgical procedure using interventional techniques - (r) (nk) | \$47.40 |
| 59318 | Radiographic examination of excised breast tissue to confirm satisfactory excision of 1 or more lesions in 1 breast or both following pre-operative localisation in conjunction with a service under item 31536 - (R) | \$92.50 |
| 59319 | Radiographic examination of excised breast tissue to confirm satisfactory excision of 1 or more lesions in 1 breast or both following pre-operative localisation in conjunction with a service under item 31536 - (r) (nk) | \$42.60 |
| 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.) | \$196.20 |
| 59701 | Discography, each disc, with or without preliminary plain films and with preparation and contrast injection - (r) (nk) (Anaes.) | \$87.40 |
| 59703 | Dacryocystography, 1 side, with or without preliminary plain film and with preparation and contrast injection - (R) | \$162.90 |
| 59704 | Dacryocystography, 1 side, with or without preliminary plain film and with preparation and contrast injection - (r) (nk) | \$68.80 |
| 59712 | Hysterosalpingography, with without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) | \$219.90 |
| 59713 | Hysterosalpingography, with or without preliminary plain films and with preparation and contrast injection - (r) (nk) (Anaes.) | \$103.00 |
| 59715 | Bronchography, one side, with or without preliminary plain films and with preparation and contrast injection, on a person under 16 years of age - (R) (K) (Anaes.) | \$256.70 |
| 59716 | Bronchography, 1 side, with or without preliminary plain films and with preparation and contrast injection, on a person under 16 years of age - (r) (nk) (Anaes.) | \$130.00 |
| 59718 | Phlebography, 1 side, with or without preliminary plain films and with preparation and contrast injection - (r) (Anaes.) | \$260.80 |
| 59719 | Phlebography, 1 side, with or without preliminary plain films and with preparation and contrast injection - (r) (nk) (Anaes.) | \$121.90 |
| 59724 | Myelography, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 56219 applies - (R) (Anaes.) | \$417.40 |
| 59725 | Myelography, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 56219 or 56259 applies - (r) (nk) (Anaes.) | \$205.00 |
| 59733 | Sialography, 1 side, with preparation and contrast injection, not being a service associated with a service to which item 57918 applies - (R) | \$207.20 |
| 59734 | Sialography, 1 side, with preparation and contrast injection, not being a service associated with a service to which item 57918 or 57932 applies - (r) (nk) | \$97.50 |
| 59739 | Sinogram or fistulogram, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection - (R) | \$143.60 |
| 59740 | Sinogram or fistulogram, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection - (r) (nk) | \$66.80 |
| 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) | \$257.60 |
| 59752 | Arthrography, each joint, excluding the facet (zygapophyseal) joints of the spine, single or double contrast study, with or without preliminary plain films and with preparation and contrast injection - (r) (nk) | \$125.90 |
| 59754 | Lymphangiography, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection - (R) | \$410.80 |

| Item No. | Description | Max fee (excl GST) |
|--------------------|---|--------------------|
| 59755 | Lymphangiography, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection - (r) (nk) | \$198.60 |
| 59763 | Air insufflation during video - fluoroscopic imaging including associated consultation (R) | \$255.80 |
| 59764 | Air insufflation during video - fluoroscopic imaging including associated consultation (r) (nk) | \$121.20 |
| Angiography | | |
| 59903 | Angiocardiology including the service described in item 59970, 59974 or 61109, not being a service to which item 59912 or 59925 applies (r) (k) (Anaes.) | \$231.10 |
| 59912 | Selective coronary arteriography (r) (k), including the services described in item 59970, 59974 or 61109, not being a service to which item 59903 or 59925 applies | \$611.60 |
| 59925 | Selective coronary arteriography and angiocardiology, including the services described in items 59903, 59912, 59970, 59974 or 61109 (r) (k) (Anaes.) | \$736.60 |
| 59970 | Angiography and/or digital subtraction angiography with fluoroscopy and image acquisition using a mobile image intensifier, one or more regions including any preliminary plain films, preparation and contrast injection (R) (K) | \$315.10 |
| 59971 | Angiocardiology including the service described in item 59970, 59974 or 61109, not being a service to which item 59972 or 59973 applies (r) (nk) (Anaes.) | \$107.50 |
| 59972 | Selective coronary arteriography (r) (nk), including the service described in item 59970, 59974 or 61109, not being a service to which item 59971 or 59973 applies | \$308.40 |
| 59973 | Selective coronary arteriography and angiocardiology, including the services described in items 59970, 59971, 59972, 59974 or 61109 (r) (nk) (Anaes.) | \$351.50 |
| 59974 | Angiography and/or digital subtraction angiography with fluoroscopy and image acquisition using a mobile image intensifier, 1 or more regions including any preliminary plain films, preparation and contrast injection (r) (nk) | \$161.70 |
| 60000 | Digital subtraction angiography, examination of head and neck with or without arch aortography - 1 to 3 data acquisition runs (R) (K) (Anaes.) | \$1080.50 |
| 60001 | Digital subtraction angiography, examination of head and neck with or without arch aortography - 1 to 3 data acquisition runs (R) (NK) (Anaes.) | \$459.00 |
| 60003 | Digital subtraction angiography, examination of head and neck with or without arch aortography - 4 to 6 data acquisition runs (R) (K) (Anaes.) | \$1563.60 |
| 60004 | Digital subtraction angiography, examination of head and neck with or without arch aortography - 4 to 6 data acquisition runs (R) (NK) (Anaes.) | \$673.10 |
| 60006 | Digital subtraction angiography, examination of head and neck with or without arch aortography - 7 to 9 data acquisition runs (R) (K) (Anaes.) | \$2244.40 |
| 60007 | Digital subtraction angiography, examination of head and neck with or without arch aortography - 7 to 9 data acquisition runs (R) (NK) (Anaes.) | \$957.20 |
| 60009 | Digital subtraction angiography, examination of head and neck with or without arch aortography - 10 or more data acquisition runs (R) (K) (Anaes.) | \$2670.00 |
| 60010 | Digital subtraction angiography, examination of head and neck with or without arch aortography - 10 or more data acquisition runs (R) (NK) (Anaes.) | \$1119.90 |
| 60012 | Digital subtraction angiography, examination of thorax - 1 to 3 data acquisition runs (R) (K) (Anaes.) | \$1103.40 |
| 60013 | Digital subtraction angiography, examination of thorax - 1 to 3 data acquisition runs (R) (NK) (Anaes.) | \$459.00 |
| 60015 | Digital subtraction angiography, examination of thorax - 4 to 6 data acquisition runs (R) (K) (Anaes.) | \$1549.30 |
| 60016 | Digital subtraction angiography, examination of thorax - 4 to 6 data acquisition runs (R) (NK) (Anaes.) | \$673.10 |
| 60018 | Digital subtraction angiography, examination of thorax - 7 to 9 data acquisition runs (R) (K) (Anaes.) | \$2300.40 |
| 60019 | Digital subtraction angiography, examination of thorax - 7 to 9 data acquisition runs (R) (NK) (Anaes.) | \$957.20 |
| 60021 | Digital subtraction angiography, examination of thorax - 10 or more data acquisition runs (R) (K) (Anaes.) | \$2620.60 |
| 60022 | Digital subtraction angiography, examination of thorax - 10 or more data acquisition runs (R) (NK) (Anaes.) | \$1119.90 |
| 60024 | Digital subtraction angiography, examination of abdomen - 1 to 3 data acquisition runs (R) (K) (Anaes.) | \$1082.10 |
| 60025 | Digital subtraction angiography, examination of abdomen - 1 to 3 data acquisition runs (R) (NK) (Anaes.) | \$459.00 |
| 60027 | Digital subtraction angiography, examination of abdomen - 4 to 6 data acquisition runs (R) (K) (Anaes.) | \$1603.80 |
| 60028 | Digital subtraction angiography, examination of abdomen - 4 to 6 data acquisition runs (R) (NK) (Anaes.) | \$673.10 |
| 60030 | Digital subtraction angiography, examination of abdomen - 7 to 9 data acquisition runs (R) (K) (Anaes.) | \$2279.50 |
| 60031 | Digital subtraction angiography, examination of abdomen - 7 to 9 data acquisition runs (R) (NK) (Anaes.) | \$957.20 |
| 60033 | Digital subtraction angiography, examination of abdomen - 10 or more data acquisition runs (R) (K) (Anaes.) | \$2635.20 |
| 60034 | Digital subtraction angiography, examination of abdomen - 10 or more data acquisition runs (R) (NK) (Anaes.) | \$1119.90 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 60036 | Digital subtraction angiography, examination of upper limb or limbs - 1 to 3 data acquisition runs (R) (K) (Anaes.) | \$1079.30 |
| 60037 | Digital subtraction angiography, examination of upper limb or limbs - 1 to 3 data acquisition runs (R) (NK) (Anaes.) | \$459.00 |
| 60039 | Digital subtraction angiography, examination of upper limb or limbs - 4 to 6 data acquisition runs (R) (K) (Anaes.) | \$1549.30 |
| 60040 | Digital subtraction angiography, examination of upper limb or limbs - 4 to 6 data acquisition runs (R) (NK) (Anaes.) | \$673.10 |
| 60042 | Digital subtraction angiography, examination of upper limb or limbs - 7 to 9 data acquisition runs (R) (K) (Anaes.) | \$2266.30 |
| 60043 | Digital subtraction angiography, examination of upper limb or limbs - 7 to 9 data acquisition runs (R) (NK) (Anaes.) | \$957.20 |
| 60045 | Digital subtraction angiography, examination of upper limb or limbs - 10 or more data acquisition runs (R) (K) (Anaes.) | \$2658.60 |
| 60046 | Digital subtraction angiography, examination of upper limb or limbs - 10 or more data acquisition runs (R) (NK) (Anaes.) | \$1119.90 |
| 60048 | Digital subtraction angiography, examination of lower limb or limbs - 1 to 3 data acquisition runs (R) (K) (Anaes.) | \$1080.10 |
| 60049 | Digital subtraction angiography, examination of lower limb or limbs - 1 to 3 data acquisition runs (R) (NK) (Anaes.) | \$459.00 |
| 60051 | Digital subtraction angiography, examination of lower limb or limbs - 4 to 6 data acquisition runs (R) (K) (Anaes.) | \$1609.50 |
| 60052 | Digital subtraction angiography, examination of lower limb or limbs - 4 to 6 data acquisition runs (R) (NK) (Anaes.) | \$673.10 |
| 60054 | Digital subtraction angiography, examination of lower limb or limbs - 7 to 9 data acquisition runs (R) (K) (Anaes.) | \$2279.50 |
| 60055 | Digital subtraction angiography, examination of lower limb or limbs - 7 to 9 data acquisition runs (R) (NK) (Anaes.) | \$957.20 |
| 60057 | Digital subtraction angiography, examination of lower limb or limbs - 10 or more data acquisition runs (R) (K) (Anaes.) | \$2692.10 |
| 60058 | Digital subtraction angiography, examination of lower limb or limbs - 10 or more data acquisition runs (R) (NK) (Anaes.) | \$1119.90 |
| 60060 | Digital subtraction angiography, examination of aorta and lower limb or limbs - 1 to 3 data acquisition runs (R) (K) (Anaes.) | \$1089.60 |
| 60061 | Digital subtraction angiography, examination of aorta and lower limb or limbs - 1 to 3 data acquisition runs (R) (NK) (Anaes.) | \$459.00 |
| 60063 | Digital subtraction angiography, examination of aorta and lower limb or limbs - 4 to 6 data acquisition runs (R) (K) (Anaes.) | \$1591.40 |
| 60064 | Digital subtraction angiography, examination of aorta and lower limb or limbs - 4 to 6 data acquisition runs (R) (NK) (Anaes.) | \$673.10 |
| 60066 | Digital subtraction angiography, examination of aorta and lower limb or limbs - 7 to 9 data acquisition runs (R) (K) (Anaes.) | \$2281.90 |
| 60067 | Digital subtraction angiography, examination of aorta and lower limb or limbs - 7 to 9 data acquisition runs (R) (NK) (Anaes.) | \$957.20 |
| 60069 | Digital subtraction angiography, examination of aorta and lower limb or limbs - 10 or more data acquisition runs (R) (K) (Anaes.) | \$2641.20 |
| 60070 | Digital subtraction angiography, examination of aorta and lower limb or limbs - 10 or more data acquisition runs (R) (NK) (Anaes.) | \$1119.90 |
| 60072 | Selective arteriography or selective venography by digital subtraction angiography technique - 1 vessel (NR) (K) (Anaes.) | \$92.50 |
| 60073 | Selective arteriography or selective venography by digital subtraction angiography technique - one vessel (NR) (NK) (Anaes.) | \$39.20 |
| 60075 | Selective arteriography or selective venography by digital subtraction angiography technique - 2 vessels (NR) (K) (Anaes.) | \$184.10 |
| 60076 | Selective arteriography or selective venography by digital subtraction angiography technique - 2 vessels (NR) (NK) (Anaes.) | \$78.20 |
| 60078 | Selective arteriography or selective venography by digital subtraction angiography technique - 3 or more vessels (NR) (K) (Anaes.) | \$279.90 |
| 60079 | Selective arteriography or selective venography by digital subtraction angiography technique - 3 or more vessels (NR) (NK) (Anaes.) | \$117.40 |

| Item No. | Description | Max fee (excl GST) |
|---|---|--------------------|
| Fluoroscopic examination | | |
| 60500 | Fluoroscopy, with general anaesthesia (not being a service associated with a radiographic examination) (R) (Anaes.) | \$85.30 |
| 60501 | Fluoroscopy, with general anaesthesia (not being a service associated with a radiographic examination) (r) (nk) (Anaes.) | \$39.40 |
| 60503 | Fluoroscopy, without general anaesthesia (not being a service associated with a radiographic examination)(R) | \$86.00 |
| 60504 | Fluoroscopy, without general anaesthesia (not being a service associated with a radiographic examination) (r) (nk) | \$26.90 |
| 60506 | Fluoroscopy using a mobile image intensifier, in conjunction with a surgical procedure lasting less than 1 hour, not being a service associated with a service to which another item in this table applies (R) | \$145.00 |
| 60507 | Fluoroscopy using a mobile image intensifier, in conjunction with a surgical procedure lasting less than 1 hour, not being a service associated with a service to which another item in this table applies (r) (nk) | \$57.80 |
| 60509 | Fluoroscopy using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this table applies (R) | \$221.00 |
| 60510 | Fluoroscopy using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this table applies (r) (nk) | \$89.60 |
| Preparation for radiological procedure | | |
| 60918 | Arteriography (peripheral) or phlebography 1 vessel, when used in association with a service to which items 59903, 59912, 59925, 59970, 59971 59972, 59973 or 59974 applies, not being a service associated with a service to which items 60000 to 60079 inclusive apply (NR) (Anaes.) (Anaes.) | \$88.30 |
| 60927 | Selective arteriogram or phlebogram, when used in association with a service to which items 59903, 59912, 59925, 59970, 59971 59972, 59973 or 59974 applies, not being a service associated with a service to which items 60000 to 60079 inclusive apply (NR) (Anaes.) | \$73.90 |
| Interventional techniques | | |
| 61109 | Fluoroscopy in an angiography suite with image intensification, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) | \$504.90 |
| 61110 | Fluoroscopy in an angiography suite with image intensification, in conjunction with a surgical procedure, using interventional techniques, not being a service associated with a service to which another item in this table applies (r) (nk) | \$234.30 |
| GROUP I4 - NUCLEAR MEDICINE IMAGING | | |
| 61302 | Single stress or rest myocardial perfusion study - planar imaging | \$713.50 |
| 61303 | Single stress or rest myocardial perfusion study - with single photon emission tomography and with planar imaging when undertaken (R) | \$925.10 |
| 61306 | Combined stress and rest, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - planar imaging (R) | \$1137.50 |
| 61307 | Combined stress and rest, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - with single photon emission tomography and with planar imaging when undertaken (R) | \$1389.00 |
| 61310 | Myocardial infarct-avid-study, with planar imaging and single photon emission tomography, or planar imaging or single photon emission tomography (R) | \$584.80 |
| 61313 | Gated cardiac blood pool study, (equilibrium), with planar imaging and single photon emission tomography, or planar imaging or single photon emission tomography (R) | \$484.50 |
| 61314 | Gated cardiac blood pool study, and first pass blood flow or cardiac shunt study, with planar imaging and single photon emission tomography, or planar imaging , or single photon emission tomography (R) | \$675.50 |
| 61316 | Gated cardiac blood pool study, with intervention, with planar imaging and single photon emission tomography, or planar imaging, or single photon emission tomography (R) | \$675.50 |
| 61317 | Gated cardiac blood pool study, with intervention and first pass blood flow study or cardiac shunt study, with planar imaging and single photon emission tomography or planar imaging, or single photon emission tomography (R) | \$793.10 |
| 61320 | Cardiac first pass blood flow study or cardiac shunt study, not being a service to which another item in this Group applies (R) | \$373.60 |
| 61328 | Lung perfusion study, with planar imaging and single photon emission tomography or planar imaging, or single photon emission tomography (R) | \$354.20 |
| 61340 | Lung ventilation study using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography or planar imaging or single photon emission tomography (R) | \$343.40 |
| 61348 | Lung perfusion study and lung ventilation study using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography, or planar imaging, or single photon emission tomography (R) | \$691.70 |
| 61352 | Liver and spleen study (colloid) - planar imaging (R) | \$421.20 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 61353 | Liver and spleen study (colloid), with single photon emission tomography and with planar imaging when undertaken (R) | \$640.00 |
| 61356 | Red blood cell spleen or liver study, including single photon emission tomography when undertaken (R) | \$622.80 |
| 61360 | Hepatobiliary study, including morphine administration or pre-treatment with cholecystokinin (CCK) when undertaken (R) | \$779.70 |
| 61361 | Hepatobiliary study with formal quantification following baseline imaging, using an infusion of cholecystokinin (CCK) (R) | \$900.60 |
| 61364 | Bowel haemorrhage study (R) | \$773.00 |
| 61368 | Meckel's diverticulum study (R) | \$365.10 |
| 61369 | Indium-labelled octreotide study - including single photon emission tomography when undertaken, where: (a) there is a suspected gastro-entero- pancreatic endocrine tumour, based on biochemical evidence, with negative or equivocal conventional imaging; or (b) a surgically amenable gastro-entero- pancreatic endocrine tumour has been identified based on conventional techniques, in order to exclude additional disease sites.(ministerial determination)(R) | \$3776.00 |
| 61372 | Salivary study (R) | \$375.20 |
| 61373 | Gastro-oesophageal reflux study, including delayed imaging on a separate occasion when undertaken (R) | \$747.30 |
| 61376 | Oesophageal clearance study (R) | \$241.40 |
| 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) | \$1047.40 |
| 61384 | Radionuclide colonic transit study (R) | \$1288.10 |
| 61386 | Renal study, including perfusion and renogram images and computer analysis or cortical study with planar imaging (R) | \$508.90 |
| 61387 | Renal cortical study, with single photon emission tomography and planar quantification (R) | \$724.30 |
| 61389 | Single renal study with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R) | \$589.80 |
| 61390 | Renal study with diuretic administration following a baseline study (R) | \$627.90 |
| 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) | \$987.10 |
| 61397 | Cystoureterogram (R) | \$419.80 |
| 61401 | Testicular study (R) | \$270.50 |
| 61402 | Cerebral perfusion study, with single photon emission tomography and with planar imaging when undertaken (R) | \$998.10 |
| 61405 | Brain study with blood brain barrier agent, with planar imaging and single photon emission tomography, or planar imaging, or single photon emission tomography (R) | \$648.60 |
| 61409 | Cerebro-spinal fluid transport study, with imaging on 2 or more separate occasions (R) | \$1294.10 |
| 61413 | Cerebro-spinal fluid shunt patency study (R) | \$373.60 |
| 61417 | Dynamic blood flow study or regional blood volume quantitative study, not being a service associated with a service to which another item in this Group applies (R) | \$203.20 |
| 61421 | Bone study - whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) | \$772.60 |
| 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) | \$972.50 |
| 61426 | Whole body study using iodine (R) | \$850.30 |
| 61429 | Whole body study using gallium (R) | \$901.90 |
| 61430 | Whole body study using gallium, with single photon emission tomography (R) | \$1184.20 |
| 61433 | Whole body study using cells labelled with technetium (R) | \$762.50 |
| 61434 | Whole body study using cells labelled with technetium, with single photon emission tomography (R) | \$1104.90 |
| 61437 | Whole body study using thallium (R) | \$909.20 |
| 61438 | Whole body study using thallium, with single photon emission tomography (R) | \$1250.90 |
| 61441 | Bone marrow study - whole body using technetium labelled bone marrow agents (R) | \$754.80 |
| 61442 | Whole body study, using gallium -- with single photon emission tomography of 2 or more body regions acquired separately (R) | \$1246.10 |
| 61445 | Bone marrow study - localised using technetium labelled agent (R) | \$428.00 |
| 61446 | Localised bone or joint study, including when undertaken, blood flow, blood pool and repeat imaging on a separate occasion (R) | \$524.10 |
| 61449 | Localised bone or joint study and single photon emission tomography, including when undertaken, blood flow, blood pool and imaging on a separate occasion (R) | \$866.50 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| 61450 | Localised study using gallium (R) | \$646.20 |
| 61453 | Localised study using gallium, with single photon emission tomography (R) | \$961.00 |
| 61454 | Localised study using cells labelled with technetium (R) | \$540.10 |
| 61457 | Localised study using cells labelled with technetium, with single photon emission tomography (R) | \$881.50 |
| 61458 | Localised study using thallium (R) | \$666.40 |
| 61461 | Localised study using thallium, with single photon emission tomography (R) | \$988.90 |
| 61462 | Repeat planar and single photon emission tomography imaging, or repeat planar imaging or single photon emission tomography imaging on an occasion subsequent to the performance of any one of items 61364, 61426, 61429, 61430, 61442, 61450, 61453, 61469, 61484 or 61485 where there is no additional administration of radiopharmaceutical and where the previous radionuclide scan was abnormal or equivocal. (R) | \$241.60 |
| 61469 | Lymphoscintigraphy (R) | \$651.70 |
| 61473 | Thyroid study including uptake measurement when undertaken (R) | \$338.90 |
| 61480 | Parathyroid study, planar imaging and single photon emission tomography when undertaken (R) | \$595.90 |
| 61484 | Adrenal study (R) | \$1310.90 |
| 61485 | Adrenal study, with single photon emission tomography (R) | \$1652.40 |
| 61495 | Tear duct study (R) | \$365.10 |
| 61499 | Particle perfusion study (infra- arterial) or Le Vein shunt study (R) | \$404.80 |
| 61505 | CT scan performed at the same time and covering the same body area as single photon emission tomography for the purpose of anatomic localisation or attenuation correction where no separate diagnostic CT report is issued and only in association with items 61302 - 61650 (r) | \$187.40 |
| 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) | \$1785.20 |
| 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) | \$1785.20 |
| 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) | \$1687.90 |
| 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 ® | \$1785.20 |
| 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 ® | \$1871.50 |
| 61559 | FDG PET study of the brain, performed for the evaluation of refractory epilepsy which is being evaluated for surgery (r) | \$1719.70 |
| 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. ® | \$1785.20 |
| 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) | \$1785.20 |
| 61575 | Whole body fdg pet study, performed 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) | \$1724.40 |
| 61577 | Whole body FDG PET study, performed for the staging of proven oesophageal carcinoma, where curative surgery or chemoradiation is planned | \$1785.20 |
| 61598 | Whole body fdg pet study for the primary staging of carcinoma of the head and neck | \$1785.20 |
| 61604 | Whole body fdg pet study for the further investigation of suspected residual or recurrent carcinoma of the head and neck | \$1785.20 |
| 61610 | Whole body fdg pet study for the evaluation of metastatic squamous cell carcinoma involving cervical nodes from an unknown primary site | \$1785.20 |
| 61620 | Whole body FDG PET study for the initial staging of newly diagnosed or previously untreated Hodgkin or non-Hodgkin lymphoma (R). | \$1724.40 |
| 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). | \$1785.20 |
| 61628 | Whole body FDG PET study for restaging following confirmation of recurrence of Hodgkin or non-Hodgkin lymphoma (R). | \$1785.20 |
| 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). | \$1724.40 |
| 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. ® | \$1871.50 |
| 61646 | Whole body fdg pet study for the evaluation of patients with suspected residual or recurrent sarcoma | \$1871.50 |

| Item No. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| | (excluding gastrointestinal stromal tumour) after the initial course of definitive therapy to determine suitability for subsequent therapy with curative intent. (r) | |
| 61650 | Leukoscan study, for use in diagnostic imaging of the long bones and feet in patients with suspected osteomyelitis, and where patients do not have access to e x-vivo wbc scanning. Note leukoscan is only indicated for diagnostic imaging in patients suspected of infection in the long bones and feet, including those with diabetic ulcers. the descriptor does not cover patients who are being investigated for other sites of infection | \$1664.70 |
| 61651 | Single stress or rest myocardial perfusion study - planar imaging (r) (nk) | \$406.20 |
| 61652 | Single stress or rest myocardial perfusion study - with single photon emission tomography and with planar imaging when undertaken (r) (nk) | \$511.50 |
| 61653 | Combined stress and rest, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - planar imaging (r) (nk) | \$642.00 |
| 61654 | Combined stress and rest, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - with single photon emission tomography and with planar imaging when undertaken (r) (nk) | \$755.30 |
| 61655 | Myocardial infarct-avid-study, with planar imaging and single photon emission tomography, or planar imaging or single photon emission tomography (r) (nk) | \$332.30 |
| 61656 | Gated cardiac blood pool study, (equilibrium), with planar imaging and single photon emission tomography or planar imaging or single photon emission tomography (r) (nk) | \$274.40 |
| 61657 | Gated cardiac blood pool study, and first pass blood flow or cardiac shunt study, with planar imaging and single photon emission tomography, or planar imaging, or single photon emission tomography (r) (nk) | \$380.00 |
| 61658 | Gated cardiac blood pool study, with intervention, with planar imaging and single photon emission tomography, or planar imaging, or single photon emission tomography (r) (nk) | \$344.80 |
| 61659 | Gated cardiac blood pool study, with intervention and first pass blood flow study or cardiac shunt study, with planar imaging and single photon emission tomography or planar imaging, or single photon emission tomography (r) (nk) | \$445.40 |
| 61660 | Cardiac first pass blood flow study or cardiac shunt study, not being a service to which another item in this group applies (r) (nk) | \$207.20 |
| 61661 | Lung perfusion study, with planar imaging and single photon emission tomography or planar imaging, or single photon emission tomography (r) (nk) | \$206.00 |
| 61662 | Lung ventilation study using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography or planar imaging or single photon emission tomography (r) (nk) | \$228.80 |
| 61663 | Lung perfusion study and lung ventilation study using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography, or planar imaging, or single photon emission tomography (r) (nk) | \$401.20 |
| 61664 | Liver and spleen study (colloid) - planar imaging (r) (nk) | \$234.70 |
| 61665 | Liver and spleen study (colloid), with single photon emission tomography and with planar imaging when undertaken (r) (nk) | \$349.80 |
| 61666 | Red blood cell spleen or liver study, including single photon emission tomography when undertaken (r) (nk) | \$355.20 |
| 61667 | Hepatobiliary study, including morphine administration or pre- treatment with cholecystokinin (cck) when undertaken (r) (nk) | \$364.80 |
| 61668 | Hepatobiliary study with formal quantification following baseline imaging, using an infusion of cholecystokinin (cck) (r) (nk) | \$417.60 |
| 61669 | Bowel haemorrhage study (r) (nk) | \$449.60 |
| 61670 | Meckels diverticulum study (r) (nk) | \$201.80 |
| 61671 | Indium-labelled octreotide study - including single photon emission tomography when undertaken, where :(a) there is a suspected gastro-entero- pancreatic endocrine tumour, based on biochemical evidence, with negative or equivocal conventional imaging; or(b) a surgically amenable gastro- entero-pancreatic endocrine tumour has been identified based on conventional techniques, in order to exclude additional disease sites. (ministerial determination) (r) (nk) | \$1823.70 |
| 61672 | Salivary study (r) (nk) | \$201.80 |
| 61673 | Gastro-oesophageal reflux study, including delayed imaging on a separate occasion when undertaken (r) (nk) | \$443.00 |
| 61674 | Oesophageal clearance study (r) (nk) | \$129.90 |
| 61675 | Gastric emptying study, using single tracer (r) (nk) | \$519.60 |
| 61676 | Combined solid and liquid gastric emptying study using dual isotope technique or the same isotope on separate days (r) (nk) | \$565.50 |
| 61677 | Radionuclide colonic transit study (r) (nk) | \$622.20 |
| 61678 | Renal study, including perfusion and renogram images and computer analysis or cortical study with planar imaging (r) (nk) | \$300.80 |
| 61679 | Renal cortical study, with single photon emission tomography and planar quantification (r) (nk) | \$389.70 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 61680 | Single renal study with pre- procedural administration of a diuretic or angiotensin converting enzyme (ace) inhibitor (r) (nk) | \$335.30 |
| 61681 | Renal study with diuretic administration following a baseline study (r) (nk) | \$371.00 |
| 61682 | Combined examination involving a renal study following angiotensin converting enzyme (ace) inhibitor provocation and a baseline study, in either order and related to a single referral episode (r) (nk) | \$547.70 |
| 61683 | Cystoureterogram (r) (nk) | \$223.30 |
| 61684 | Testicular study (r) (nk) | \$146.90 |
| 61685 | Cerebral perfusion study, with single photon emission tomography and with planar imaging when undertaken (r) (nk) | \$547.30 |
| 61686 | Brain study with blood brain barrier agent, with planar imaging and single photon emission tomography, or planar imaging, or single photon emission tomography (r) (nk) | \$313.00 |
| 61687 | Cerebro-spinal fluid transport study, with imaging on 2 or more separate occasions (r) (nk) | \$790.30 |
| 61688 | Cerebro-spinal fluid shunt patency study (r) (nk) | \$204.40 |
| 61689 | Dynamic blood flow study or regional blood volume quantitative study, not being a service associated with a service to which another item in this group applies (r) (nk) | \$107.70 |
| 61690 | Bone study - whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (r) (nk) | \$434.10 |
| 61691 | Bone study - whole body and single photon emission tomography, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (r) (nk) | \$543.50 |
| 61692 | Whole body study using iodine (r) (nk) | \$501.80 |
| 61693 | Whole body study using gallium (r) (nk) | \$491.30 |
| 61694 | Whole body study using gallium, with single photon emission tomography (r) (nk) | \$596.50 |
| 61695 | Whole body study using cells labelled with technetium (r) (nk) | \$449.60 |
| 61696 | Whole body study using cells labelled with technetium, with single photon emission tomography (r) (nk) | \$556.80 |
| 61697 | Whole body study using thallium (r) (nk) | \$491.10 |
| 61698 | Whole body study using thallium, with single photon emission tomography (r) (nk) | \$609.00 |
| 61699 | Bone marrow study - whole body using technetium labelled bone marrow agents (r) (nk) | \$443.00 |
| 61700 | Whole body study, using gallium - with single photon emission tomography of 2 or more body regions acquired separately (r) (nk) | \$680.80 |
| 61701 | Bone marrow study - localised using technetium labelled agent (r) (nk) | \$259.40 |
| 61702 | Localised bone or joint study, including when undertaken, blood flow, blood pool and repeat imaging on a separate occasion (r) (nk) | \$301.80 |
| 61703 | Localised bone or joint study and single photon emission tomography, including when undertaken, blood flow, blood pool and imaging on a separate occasion (r) (nk) | \$412.80 |
| 61704 | Localised study using gallium (r) (nk) | \$359.60 |
| 61705 | Localised study using gallium, with single photon emission tomography (r) (nk) | \$465.60 |
| 61706 | Localised study using cells labelled with technetium (r) (nk) | \$314.80 |
| 61707 | Localised study using cells labelled with technetium, with single photon emission tomography (r) (nk) | \$425.80 |
| 61708 | Localised study using thallium (r) (nk) | \$359.20 |
| 61709 | Localised study using thallium, with single photon emission tomography (r) (nk) | \$477.60 |
| 61710 | Repeat planar and single photon emission tomography imaging, or repeat planar imaging or single photon emission tomography imaging on an occasion subsequent to the performance of any one of items 61364, 61426, 61429, 61430, 61442, 61450, 61453, 61469, 61484, 61485, 61669, 61692, 61693, 61694, 61700, 61704, 61705, 61712, 61715 or 61716 where there is no additional administration of radiopharmaceutical and where the previous radionuclide scan was abnormal or equivocal. (r) (nk) | \$116.70 |
| 61712 | Lymphoscintigraphy (r) (nk) | \$314.80 |
| 61713 | Thyroid study including uptake measurement when undertaken (r) (nk) | \$158.70 |
| 61714 | Parathyroid study, planar imaging and single photon emission tomography when undertaken (r) (nk) | \$350.00 |
| 61715 | Adrenal study (r) (nk) | \$797.00 |
| 61716 | Adrenal study, with single photon emission tomography (r) (nk) | \$904.10 |
| 61717 | Tear duct study (r) (nk) | \$201.80 |
| 61718 | Particle perfusion study (intra- arterial) or leveen shunt study (r) (nk) | \$228.80 |
| 61719 | CT scan performed at the same time and covering the same body area as single photon emission tomography for the purpose of anatomic localisation or attenuation correction where no separate diagnostic ct report is issued and only in association with items 61302 - 61729 (r) (nk) | \$90.50 |
| 61729 | Leukoscan study, for use in diagnostic imaging of the long bones and feet in patients with suspected osteomyelitis, and where patients do not have access to ex-vivo wbc scanning. (ministerial determination) (nk) note leukoscan is only indicated for diagnostic imaging in patients suspected of infection in the long bones and feet, including those with diabetic ulcers. the descriptor does not cover patients who are being investigated for other sites of infection | \$794.80 |

| Item No. | Description | Max fee (excl GST) |
|---|--|--------------------|
| GROUP 15 - MAGNETIC RESONANCE IMAGING | | |
| Scan of head - for specified conditions | | |
| 63001 | Magnetic resonance imaging (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head for: - tumour of the brain or meninges (r) (Contrast) (Anaes.) | \$687.00 |
| 63004 | - Inflammation of the brain or meninges (r) (Contrast) (Anaes.) | \$687.00 |
| 63007 | - Skull base or orbital tumour (r) (Contrast) (Anaes.) | \$687.00 |
| 63010 | - Stereotactic scan of brain, with Fiducials in place, for the sole purpose to allow planning for stereotactic neurosurgery (r) (Contrast) (Anaes.) | \$601.80 |
| 63013 | Magnetic resonance imaging (including magnetic resonance angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head for:- tumour of the brain or meninges (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63014 | Inflammation of the brain or meninges (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63016 | Skull base or orbital tumour (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63017 | Stereotactic scan of brain, with fiducials in place, for the sole purpose to allow planning for stereotactic neurosurgery (r) (nk) (contrast) (Anaes.) | \$303.90 |
| 63040 | Magnetic resonance imaging (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head for: - acoustic neuroma (r) (Contrast) (Anaes.) | \$601.80 |
| 63043 | - Pituitary tumour (r) (Contrast) (Anaes.) | \$630.20 |
| 63046 | - Toxic or metabolic or ischaemic encephalopathy (r) (contrast) (Anaes.) | \$687.00 |
| 63049 | - demyelinating disease of the brain (r) (Contrast) (Anaes.) | \$687.00 |
| 63052 | - Congenital malformation of the brain or meninges (r) (Contrast) (Anaes.) | \$687.00 |
| 63055 | - Venous sinus thrombosis (r) (Contrast) (Anaes.) | \$687.00 |
| 63058 | - Head trauma (r) (Contrast) (Anaes.) | \$687.00 |
| 63061 | - Epilepsy (r) (Contrast) (Anaes.) | \$687.00 |
| 63064 | - Stroke (r) (Contrast) (Anaes.) | \$687.00 |
| 63067 | - Carotid or vertebral artery desection (r) (Contrast) (Anaes.) | \$687.00 |
| 63070 | - Intracranial aneurysm (r) (Contrast) (Anaes.) | \$687.00 |
| 63073 | - Intracranial arteriovenous malformation (r) (Contrast) (Anaes.) | \$687.00 |
| 63074 | Note: benefits are payable for each service included by subgroup 2 on three occasions only in any 12 month periodmagnetic resonance imaging (including magnetic resonance angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head for:- acoustic neuroma (r) (nk) (contrast) (Anaes.) | \$303.90 |
| 63075 | Pituitary tumour (r) (nk) (contrast) (Anaes.) | \$324.20 |
| 63076 | Toxic or metabolic or ischaemic encephalopathy (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63077 | Demyelinating disease of the brain (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63078 | Congenital malformation of the brain or meninges (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63079 | Venous sinus thrombosis (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63080 | Head trauma (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63081 | Epilepsy (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63082 | Stroke (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63083 | Carotid or vertebral artery desection (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63084 | Intracranial aneurysm (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63085 | Intracranial arteriovenous malformation (r) (nk) (contrast) (Anaes.) | \$364.60 |
| Scan of head and neck vessels - for specified conditions | | |
| 63101 | Magnetic resonance imaging and magnetic resonance angiography of extra and/or intracranial circulation, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head and neck vessels for:- stroke (r) (Contrast) (Anaes.) | \$820.00 |
| 63104 | Note: benefits are payable for each service included by subgroup 3 on three occasions only in any 12 month periodmagnetic resonance imaging and magnetic resonance angiography of extra and/or intracranial circulation, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head and neck vessels for:- stroke (r) (nk) (contrast) (Anaes.) | \$446.00 |
| 63117 | Magnetic resonance imaging (including magnetic resonance angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head and cervical spine for:- tumour of the central nervous system or meninges (r) (nk) (contrast) (Anaes.) | \$446.00 |

| Item No. | Description | Max fee (excl GST) |
|--|---|--------------------|
| 63119 | Inflammation of the central nervous system or meninges (r) (nk) (contrast) (Anaes.) | \$446.00 |
| Scan of head and cervical spine - for specified conditions | | |
| 63111 | Magnetic resonance imaging (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head and cervical spine for: - tumour of the central nervous system or meninges (r) (Contrast) (Anaes.) | \$820.00 |
| 63114 | - Inflammation of the central nervous system or meninges (r) (Contrast) (Anaes.) | \$820.00 |
| 63125 | Magnetic resonance imaging (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head and cervical spine for:- demyelinating disease of the central nervous system (r) (Contrast) (Anaes.) | \$820.00 |
| 63128 | - Congenital malformation of the central nervous system or meninges (r) (Contrast) (Anaes.) | \$820.00 |
| 63131 | - Syrinx (congenital or acquired) (r) (Contrast) (Anaes.) | \$820.00 |
| 63134 | Note: benefits are payable for each service included by subgroup 5 on three occasions only in any 12 month periodmagnetic resonance imaging (including magnetic resonance angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of head and cervical spine for:- demyelinating disease of the central nervous system (r) (nk) (contrast) (Anaes.) | \$446.00 |
| 63135 | Congenital malformation of the central nervous system or meninges (r) (nk) (contrast) (Anaes.) | \$446.00 |
| 63136 | Syrinx (congenital or acquired) (r) (nk) (contrast) (Anaes.) | \$446.00 |
| Scan of spine - one region or two contiguous regions - for specified conditions | | |
| 63151 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of one region or two contiguous regions of the spine for: - infection (r) (Contrast) (Anaes.) | \$630.20 |
| 63154 | - Tumour (r) (Contrast) (Anaes.) | \$630.20 |
| 63157 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of one region or two contiguous regions of the spine for:- infection (r) (nk) (contrast) (Anaes.) | \$324.20 |
| 63158 | Tumour (r) (nk) (contrast) (Anaes.) | \$324.20 |
| 63161 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of one region or two contiguous regions of the spine for: - demyelinating (r) (Contrast) (Anaes.) | \$630.20 |
| 63164 | - Congenital malformation of the spinal cord or the cauda equina or the meninges (r) (Contrast) (Anaes.) | \$630.20 |
| 63167 | Myelopathy (r) (Contrast) (Anaes.) | \$630.20 |
| 63170 | - Syrinx (congenital or acquired) (r) (Contrast) (Anaes.) | \$630.20 |
| 63173 | - Cervical radiculopathy (r) (Contrast) (Anaes.) | \$630.20 |
| 63176 | - Sciatica (r) (Contrast) (Anaes.) | \$630.20 |
| 63179 | - Spinal canal stenosis (r) (Contrast) (Anaes.) | \$630.20 |
| 63182 | - Previous spinal surgery (r) (Contrast) (Anaes.) | \$630.20 |
| 63185 | - Trauma (r) (Anaes.) | \$630.20 |
| 63186 | Note: benefits are payable for each service included by subgroup 7 on three occasions only in any 12 month periodmagnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of one region or two contiguous regions of the spine for:- demyelinating (r) (nk) (contrast) (Anaes.) | \$324.20 |
| 63187 | Congenital malformation of the spinal cord or the cauda equina or the meninges (r) (nk) (contrast) (Anaes.) | \$324.20 |
| 63188 | Myelopathy (r) (nk) (contrast) (Anaes.) | \$324.20 |
| 63189 | Syrinx (congenital or acquired) (r) (nk) (contrast) (Anaes.) | \$324.20 |
| 63190 | Cervical radiculopathy (r) (nk) (contrast) (Anaes.) | \$324.20 |
| 63191 | Sciatica (r) (nk) (contrast) (Anaes.) | \$324.20 |
| 63192 | Spinal canal stenosis (r) (nk) (contrast) (Anaes.) | \$324.20 |
| 63193 | Previous spinal surgery (r) (nk) (contrast) (Anaes.) | \$324.20 |
| 63194 | Trauma (r) (nk) (Anaes.) | \$324.20 |
| Scan of spine - three contiguous regions or two non-contiguous regions - for specified conditions | | |
| 63201 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of three contiguous regions or two non contiguous regions of the spine for:- infection (r) (Contrast) (Anaes.) | \$753.70 |
| 63204 | - Tumour (r) (Contrast) (Anaes.) | \$753.70 |
| 63207 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of | \$405.10 |

| Item No. | Description | Max fee (excl GST) |
|--|--|--------------------|
| | three contiguous regions or two non contiguous regions of the spine for:- infection (r) (nk) (contrast) (Anaes.) | |
| 63208 | Tumour (r) (nk) (contrast) (Anaes.) | \$405.10 |
| 63219 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of three contiguous regions or two non contiguous regions of the spine for:- demyelinating disease (r) (Contrast) (Anaes.) | \$753.70 |
| 63222 | - Congenital malformation of the spinal cord or the cauda equina or the meninges (r) (Contrast) (Anaes.) | \$753.70 |
| 63225 | - Myelopathy (r) (Contrast) (Anaes.) | \$753.70 |
| 63228 | - Syrinx (congenital or acquired) (r) (Contrast) (Anaes.) | \$753.70 |
| 63231 | - Cervical radiculopathy (r) (Contrast) (Anaes.) | \$753.70 |
| 63234 | - Sciatica (r) (Contrast) (Anaes.) | \$753.70 |
| 63237 | - Spinal canal stenosis (r) (Contrast) (Anaes.) | \$753.70 |
| 63240 | - Previous spinal surgery (r) (Contrast) (Anaes.) | \$753.70 |
| 63243 | - Trauma (r) (Anaes.) | \$753.70 |
| 63257 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of three contiguous regions or two non contiguous regions of the spine for:- demyelinating disease (r) (nk) (contrast) (Anaes.) | \$405.10 |
| 63258 | Congenital malformation of the spinal cord or the cauda equina or the meninges (r) (nk) (contrast) (Anaes.) | \$405.10 |
| 63259 | Myelopathy (r) (nk) (contrast) (Anaes.) | \$405.10 |
| 63260 | Syrinx (congenital or acquired) (r) (nk) (contrast) (Anaes.) | \$405.10 |
| 63261 | Cervical radiculopathy (r) (nk) (contrast) (Anaes.) | \$405.10 |
| 63262 | Sciatica (r) (nk) (contrast) (Anaes.) | \$405.10 |
| 63263 | Spinal canal stenosis (r) (nk) (contrast) (Anaes.) | \$405.10 |
| 63264 | Previous spinal surgery (r) (nk) (contrast) (Anaes.) | \$405.10 |
| 63265 | Trauma (r) (nk) (Anaes.) | \$405.10 |
| Scan of cervical spine and brachial plexus - for specified conditions | | |
| 63271 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of cervical spine and brachial plexus for: - tumour (r) (Contrast) (Anaes.) | \$820.00 |
| 63274 | - Trauma (r) (Contrast) (Anaes.) | \$820.00 |
| 63277 | - Cervical radiculopathy (r) (Contrast) (Anaes.) | \$820.00 |
| 63280 | - Previous surgery (r) (Contrast) (Anaes.) | \$820.00 |
| 63282 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of cervical spine and brachial plexus for:- tumour (r) (nk) (contrast) (Anaes.) | \$446.00 |
| 63283 | Trauma (r) (nk) (contrast) (Anaes.) | \$446.00 |
| 63284 | Cervical radiculopathy (r) (nk) (contrast) (Anaes.) | \$446.00 |
| 63285 | Previous surgery (r) (nk) (contrast) (Anaes.) | \$446.00 |
| Scan of musculoskeletal system - for specified conditions | | |
| 63301 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for: - tumour arising in bone or musculoskeletal system, this excludes tumours arising in breast, prostate or rectum (r) (Contrast) (Anaes.) | \$658.20 |
| 63304 | - Infection arising in bone or musculoskeletal system, this excludes infection arising in breast, prostate or rectum (r) (Contrast) (Anaes.) | \$658.20 |
| 63307 | - Osteonecrosis (r) (Contrast) (Anaes.) | \$658.20 |
| 63310 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for:- tumour arising in bone or musculoskeletal system, this excludes tumours arising in breast, prostate or rectum (r) (nk) (contrast) (Anaes.) | \$344.40 |
| 63311 | Infection arising in bone or musculoskeletal system, this excludes infection arising in breast, prostate or rectum (r) (nk) (contrast) (Anaes.) | \$344.40 |
| 63313 | Osteonecrosis (r) (nk) (contrast) (Anaes.) | \$344.40 |
| 63322 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for: - derangement of hip or its supporting structures (r) (Contrast) (Anaes.) | \$687.20 |
| 63325 | - Derangement of shoulder or its supporting structures (r) (Contrast) (Anaes.) | \$687.20 |

| Item No. | Description | Max fee (excl GST) |
|---|---|--------------------|
| 63328 | - Derangement of knee or its supporting structures (r) (Contrast) (Anaes.) | \$687.20 |
| 63331 | - Derangement of ankle and/or foot or its supporting structures (r) (Contrast) (Anaes.) | \$687.20 |
| 63334 | - Derangement of one or both temporomandibular joints or their supporting structures (r) (Contrast) (Anaes.) | \$601.80 |
| 63337 | - Derangement of wrist and/or hand or its supporting structures (r) (Contrast) (Anaes.) | \$753.70 |
| 63340 | - Derangement of elbow or its supporting structures (r) (Contrast) (Anaes.) | \$687.20 |
| 63341 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for:- derangement of hip or its supporting structures (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63342 | Derangement of shoulder or its supporting structures (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63343 | Derangement of knee or its supporting structures (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63345 | Derangement of ankle and/or foot or its supporting structures (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63346 | Derangement of one or both temporomandibular joints or their supporting structures (r) (nk) (contrast) (Anaes.) | \$303.90 |
| 63347 | Derangement of wrist and/or hand or its supporting structures (r) (nk) (contrast) (Anaes.) | \$405.10 |
| 63348 | Derangement of elbow or its supporting structures (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63361 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for:- Gaucher disease (r) (Anaes.) | \$687.20 |
| 63364 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of musculoskeletal system for:- gaucher disease (r) (nk) (Anaes.) | \$364.60 |
| Scan of cardiovascular system - for specified conditions | | |
| 63385 | Magnetic resonance imaging (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of cardiovascular system for:- congenital disease of the heart or a great vessel (r) (Contrast) (Anaes.) | \$753.70 |
| 63388 | - Tumour of the heart or a great vessel (r) (Contrast) (Anaes.) | \$753.70 |
| 63391 | - Abnormality of thoracic aorta (r) (Contrast) (Anaes.) | \$687.20 |
| 63392 | Note: benefits are payable for each service included by subgroup 14 on two occasions only in any 12 month period magnetic resonance imaging (including magnetic resonance angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of cardiovascular system for:- congenital disease of the heart or a great vessel (r) (nk) (contrast) (Anaes.) | \$405.10 |
| 63393 | Tumour of the heart or a great vessel (r) (nk) (contrast) (Anaes.) | \$405.10 |
| 63394 | Abnormality of thoracic aorta (r) (nk) (contrast) (Anaes.) | \$364.60 |
| Magnetic resonance angiography - scan of cardiovascular system - for specified conditions | | |
| 63401 | Magnetic resonance angiography performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - scan of cardiovascular system for:- vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (r) (Contrast) (Anaes.) | \$687.20 |
| 63404 | - Obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (r) (Contrast) (Anaes.) | \$687.20 |
| 63407 | Magnetic resonance angiography performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - scan of cardiovascular system for:- vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63408 | Obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (r) (nk) (contrast) (Anaes.) | \$364.60 |
| Magnetic resonance angiography - for specified conditions - person under the age of 16 years | | |
| 63416 | Magnetic resonance angiography performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of person under the age of 16 for:- the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (r) (Contrast) (Anaes.) | \$687.20 |
| 63419 | Magnetic resonance angiography performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of person under the age of 16 for:- the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (r) (nk) (contrast) (Anaes.) | \$364.60 |
| Magnetic resonance imaging - for specified conditions - person under the age of 16 years | | |
| 63425 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of person under the age of 16 for:- post- inflammatory or post-traumatic physseal fusion (r) (Anaes.) | \$687.20 |
| 63428 | - Gaucher disease (r) (Anaes.) | \$687.20 |

| Item No. | Description | Max fee (excl GST) |
|--|---|--------------------|
| 63432 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of person under the age of 16 for:- post- inflammatory or post-traumatic physéal fusion (r) (nk) (Anaes.) | \$364.60 |
| 63433 | Gaucher disease (r) (nk) (Anaes.) | \$364.60 |
| 63440 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of person under the age of 16 for: - pelvic or abdominal mass (r) (Contrast) (Anaes.) | \$687.20 |
| 63443 | - Mediastinal mass (r) (Contrast) (Anaes.) | \$687.20 |
| 63446 | - Congenital uterine or anorectal abnormality (r) (Contrast) (Anaes.) | \$687.20 |
| 63447 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of person under the age of 16 for:- pelvic or abdominal mass (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63448 | Mediastinal mass (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63449 | Congenital uterine or anorectal abnormality (r) (nk) (contrast) (Anaes.) | \$364.60 |
| Scan of body - for specified conditions | | |
| 63455 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of body for:- adrenal mass in a patient with malignancy which is otherwise resectable (r) (nk) (Anaes.) | \$324.20 |
| 63457 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a dedicated breast coil is used; and (b) the request for scan identifies that the person is asymptomatic and is less than 50 years of age; and (c) the request for scan identifies either: (i) that the patient is at high risk of developing breast cancer, due to 1 of the following: (a) 3 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer; (b) 2 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer, if any of the following applies to at least 1 of the relatives:- has been diagnosed with bilateral breast cancer; - had onset of breast cancer before the age of 40 years; - had onset of ovarian cancer before the age of 50 years; - has been diagnosed with breast and ovarian cancer, at the same time or at different times; - has ashkenazi Jewish ancestry; - is a male relative who has been diagnosed with breast cancer; (c) 1 first or second degree relative diagnosed with breast cancer at age 45 years or younger, plus another first or second degree relative on the same side of the family with bone or soft tissue sarcoma at age 45 years or younger; or (ii) that genetic testing has identified the presence of a high risk breast cancer gene mutation. Scan of both breasts for:- detection of cancer (r) note: benefits are payable on one occasion only in any 12 month period (nk) (Anaes.) | \$624.10 |
| 63458 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where:(a) a dedicated breast coil is used; and (b) the person has had an abnormality detected as a result of a service described in item 63464 or 63457 performed in the previous 12 months scan of both breasts for: - detection of cancer (r) note 1: benefits are payable on one occasion only in any 12 month period note 2: this item is intended for follow-up imaging of abnormalities diagnosed on a scan described by item 63464 or 63457(nk) (Anaes.) | \$624.10 |
| 63461 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of body for: - adrenal mass in a patient with malignancy which is otherwise resectable (r) (Anaes.) | \$630.20 |
| 63464 | Note: benefits are payable on one occasion only in any 12 month period Magnetic Resonance Imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a dedicated breast coil is used; and (b) the request for scan identifies that the person is asymptomatic and is less than 50 years of age; and (c) the request for scan identifies either: (i) that the patient is at high risk of developing breast cancer, due to 1 of the following: (a) 3 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer; (b) 2 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer, if any of the following applies to at least 1 of the relatives: - has been diagnosed with bilateral breast cancer; - had onset of breast cancer before the age of 40 years; - had onset of ovarian cancer before the age of 50 years; - has been diagnosed with breast and ovarian cancer, at the same time or at different times; - has ashkenazi jewish ancestry; - is a male relative who has been diagnosed with breast cancer; (c) 1 first or second degree relative diagnosed with breast cancer at age 45 years or younger, plus another first or second degree relative on the same side of the family with bone or soft tissue sarcoma at age 45 years or younger; or (ii) that genetic testing has identified the presence of a high risk breast cancer gene mutation. Scan of both breasts for: - detection of cancer (R) (Anaes.) | \$1313.60 |
| 63467 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where:(a) a dedicated breast coil is used; and (b) the person has had an abnormality detected as a result of a service described in item 63464 performed in the previous 12 months scan of both breasts for: - detection of cancer (r)note 1: benefits are payable on one occasion only in any 12 month period note 2: this item is intended for follow-up imaging of abnormalities diagnosed on a scan described by item 63464 (Anaes.) | \$1308.50 |
| 63487 | MRI performed under the professional supervision of an eligible provider at an eligible location, if: (a) the patient is referred by a specialist or a consultant physician; and (b) a dedicated breast coil is used; and (c) the request for the scan identifies that: (i) the patient has been diagnosed with metastatic cancer restricted to the regional lymph nodes; and (ii) clinical examination and conventional imaging have failed to identify the primary cancer (R) (K) (Anaes) | \$1075.30 |

| Item No. | Description | Max fee (excl GST) |
|--|---|--------------------|
| 63488 | MRI performed under the professional supervision of an eligible provider at an eligible location, if: (a) the patient is referred by a specialist or a consultant physician; and (b) a dedicated breast coil is used; and (c) the request for the scan identifies that: (i) the patient has been diagnosed with metastatic cancer restricted to the regional lymph nodes; and (ii) clinical examination and conventional imaging have failed to identify the primary cancer (R) (NK) (Anaes) | \$537.60 |
| 63489 | MRI-guided biopsy, performed under the professional supervision of an eligible provider at an eligible location, if: (a) the patient is referred by a specialist or a consultant physician; and (b) a dedicated breast coil is used; and (c) the request for the scan identifies that: (i) the patient has a suspicious lesion seen on mri but not on conventional imaging; and (ii) the lesion is not amenable to biopsy guided by conventional imaging; and (d) a repeat ultrasound scan of the affected breast is performed: (i) before the guided biopsy is performed; and (ii) as part of the service under this item (R) (K) (Anaes.) | \$2244.00 |
| 63490 | MRI-guided biopsy performed under the professional supervision of an eligible provider at an eligible location, if: (a) the patient is referred by a specialist or a consultant physician; and (b) a dedicated breast coil is used; and (c) the request for the scan identifies that: (i) the patient has a suspicious lesion seen on mri but not on conventional imaging; and (ii) the lesion is not amenable to biopsy guided by conventional imaging; and (d) a repeat ultrasound scan of the affected breast is performed: (i) before the guided biopsy is performed; and (ii) as part of the service under this item (R) (NK) (Anaes.) | \$1122.00 |
| Scan of pelvis and upper abdomen - for specified conditions | | |
| 63470 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where: (a) the patient is referred by a specialist or by a consultant physician and (b) the request for scan identifies that (i) a histological diagnosis of carcinoma of the cervix has been made and (ii) the patient has been diagnosed with cervical cancer at figo stage 1b or greater Scan of: - Pelvis for the staging of histologically diagnosed cervical cancer at figo stages 1b or greater (r) (Contrast) (Anaes.) | \$687.20 |
| 63473 | - Pelvis and upper abdomen, in a single examination, for the staging of histologically diagnosed cervical cancer at figo stages 1b or greater (r) (Contrast) (Anaes.) | \$1019.50 |
| 63476 | Note: benefits are payable for a service included by subgroup 20 on one occasion only. Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a phased array body coil is used, and (b) the request for scan identifies that the indication is for the initial staging of rectal cancer (including cancer of the rectosigmoid and anorectum).scan of:- pelvis for the initial staging of rectal cancer (r) (contrast) (Anaes.) | \$755.00 |
| 63479 | Note: benefits are payable for a service included by subgroup 20 on one occasion only. Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where:(a) the patient is referred by a specialist or by a consultant physician and(b) the request for scan identifies that (i) a histological diagnosis of carcinoma of the cervix has been made and (ii) the patient has been diagnosed with cervical cancer at figo stage 1b or greater scan of:- pelvis for the staging of histologically diagnosed cervical cancer at figo stages 1b or greater (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63481 | Pelvis and upper abdomen, in a single examination, for the staging of histologically diagnosed cervical cancer at figo stages 1b or greater (r) (nk) (contrast) (Anaes.) | \$567.30 |
| 63484 | Note: benefits are payable for a service included by subgroup 20 on one occasion only. Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a phased array body coil is used, and (b) the request for scan identifies that the indication is for the initial staging of rectal cancer (including cancer of the rectosigmoid and anorectum).scan of: - pelvis for the initial staging of rectal cancer (r) (nk) (contrast) (Anaes.) | \$364.60 |
| 63740 | MRI to evaluate small bowel Crohn's disease. Medicare benefits are only payable for this item if the service is provided to patients:(a) evaluation of disease extent at time of initial diagnosis of Crohn's disease (b) evaluation of exacerbation/suspected complications of known Crohn's disease (c) evaluation of known or suspected Crohn's disease in pregnancy (d) assessment of change to therapy in patients with small bowel Crohn's disease assessment of change to therapy can only be claimed once in a 12 month period. (R) (K) (Contrast) | \$744.20 |
| 63741 | MRI enteroclysis for Crohn's disease. Medicare benefits are only payable for this item if the service is related to item 63740. (R) (K) | \$431.70 |
| 63743 | MRI for fistulising perianal Crohn's disease. Medicare benefits are only payable for this item if the service is provided to patients for:- evaluation of pelvic sepsis and fistulas associated with established or suspected Crohn's disease- assessment of change to therapy of pelvis sepsis and fistulas from Crohn's disease assessment of change to therapy can only be claimed once in a 12 month period. (R) (K) (Contrast) | \$656.20 |
| 63744 | MRI to evaluate small bowel Crohn's disease. Medicare benefits are only payable for this item if the service is provided to patients:(a) evaluation of disease extent at time of initial diagnosis of Crohn's disease (b) evaluation of exacerbation/suspected complications of known Crohn's disease (c) evaluation of known or suspected Crohn's disease in pregnancy (d) assessment of change to therapy in patients with small bowel Crohn's disease assessment of change to therapy can only be claimed once in a 12 month period. (R) (NK) (Contrast) | \$372.10 |
| 63746 | MRI enteroclysis for Crohn's disease. Medicare benefits are only payable for this item if the service is related to item 63744. (R) (NK) | \$216.00 |
| 63747 | MRI for fistulising perianal Crohn's disease. Medicare benefits are only payable for this item if the service is provided to patients for:- evaluation of pelvic sepsis and fistulas associated with established or suspected Crohn's disease- assessment of change to therapy of pelvis sepsis and fistulas from Crohn's disease assessment of change to therapy can only be claimed once in a 12 month period. (R) (NK) (Contrast) | \$328.20 |

| Item No. | Description | Max fee (excl GST) |
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| Scan of body - for specified conditions | | |
| 63482 | Magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of pancreas and biliary tree for:- suspected biliary or pancreatic pathology (r) (Anaes.) | \$755.00 |
| 63486 | Note: benefits are only payable for each service included by subgroup 21 on three occasions only in any 12 month period magnetic resonance imaging performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of pancreas and biliary tree for:- suspected biliary or pancreatic pathology (r) (nk) (contrast) (Anaes.) | \$364.60 |
| Modifying items | | |
| 63491 | Modifying items for use with magnetic resonance imaging or magnetic resonance angiography performed under the professional supervision of an eligible provider at an eligible location where the service requested by a medical practitioner. scan performed:- involves the use of contrast agent for eligible magnetic resonance imaging items (note: (contrast) denotes an item eligible for use with this item) | \$84.00 |
| 63494 | - involves use of intravenous or intramuscular sedation on a patient | \$84.00 |
| 63497 | - on a patient under anaesthetic in the presence of a medical practitioner qualified to perform an anaesthetic | \$293.60 |
| 63498 | MRI service to which item 63501, 63502, 63504 or 63505 applies if:(a) the service is performed in accordance with the determination; and (b) the service is performed on a person using intravenous or intra muscular sedation | \$80.90 |
| 63499 | MRI service to which item 63501, 63502, 63504 or 63505 applies if :(a) the service is performed in accordance with the determination; and (b) the service is performed on a person under anaesthetic in the presence of a medical practitioner who is qualified to perform an anaesthetic. | \$283.70 |
| Magnetic resonance imaging - PIP breast implant | | |
| 63501 | MRI - scan of one or both breasts for the evaluation of implant integrity where:(a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient:(i) has or is suspected of having a silicone breast implant manufactured by poly implant prostheses (pip); and (ii) the result of the scan confirms a loss of integrity of the implant (R) note: benefits are payable on one occasion only in any 12 month period | \$904.70 |
| 63502 | MRI - scan of one or both breasts for the evaluation of implant integrity where:(a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient:(i) has or is suspected of having a silicone breast implant manufactured by poly implant prostheses (PIP); and (ii) the result of the scan does not demonstrate a loss of integrity of the implant (R) note: benefits are payable on one occasion only in any 12 month period | \$904.70 |
| 63504 | MRI - scan of one or both breasts for the evaluation of implant integrity where:(a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient:(i) has or is suspected of having a silicone breast implant manufactured by poly implant prostheses (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) | \$904.70 |
| 63505 | MRI - scan of one or both breasts for the evaluation of implant integrity where:(a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient: (i) has or is suspected of having a silicone breast implant manufactured by poly implant prostheses (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) | \$904.70 |
| For specified conditions - person under the age of 16 years | | |
| 63507 | Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of head for a patient under 16 years for any of the following: unexplained seizure(s) (r) (contrast) (anaes.); or unexplained headache where significant pathology is suspected (r) (contrast) (anaes.); or paranasal sinus pathology which has not responded to conservative therapy (r) (contrast) (anaes.) | \$687.00 |
| 63508 | Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of head for a patient under 16 years for any of the following: unexplained seizure(s) (r) (nk) (contrast) (anaes.); or unexplained headache where significant pathology is suspected (r) (nk) (contrast) (anaes.); or paranasal sinus pathology which has not responded to conservative therapy (r) (nk) (contrast) (anaes.) | \$364.60 |
| 63510 | Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine for a patient under 16 years following radiographic examination for: significant trauma (R) (Contrast) (Anaes.); or unexplained neck or back pain with associated neurological signs (R) (Contrast) (Anaes.); or unexplained back pain where significant pathology is suspected (R) (Contrast) (Anaes.) | \$753.70 |
| 63511 | Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine for a patient under 16 years following radiographic examination for: significant trauma (R) (NK) (Contrast) (Anaes.); or unexplained neck or back pain with associated neurological signs (R) (NK) (Contrast) (Anaes.); or unexplained back pain where significant pathology is suspected (R) (NK) (Contrast) | \$405.10 |
| 63513 | MRI - referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of knee for a patient aged under 16 years for internal joint derangement (R) (K)(Contrast) (Anaes.) | \$687.20 |
| 63514 | MRI - referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of knee for a patient aged under 16 years for internal joint derangement (R) (NK) (Contrast) (Anaes.) | \$364.60 |
| 63516 | Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of hip for a patient under 16 years following radiographic examination for: suspected septic arthritis (R) (Contrast) (Anaes.); or suspected slipped capital femoral epiphysis (R) Contrast) (Anaes.); or suspected Perthes disease (R) (Contrast) (Anaes.) | \$687.20 |

| Item No. | Description | Max fee (excl GST) |
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| 63517 | Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of hip for a patient under 16 years following radiographic examination for: suspected septic arthritis (R) (NK) (Contrast) (Anaes.); or suspected slipped capital femoral epiphysis (R) (NK) (Contrast) (Anaes.); or suspected Perthes disease (R) (NK) (Contrast) (Anaes.) | \$364.60 |
| 63519 | Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of elbow for a patient under 16 years following radiographic examination where a significant fracture or avulsion injury is suspected that will change management (R) (Contrast) | \$687.20 |
| 63520 | Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of elbow for a patient under 16 years following radiographic examination where a significant fracture or avulsion injury is suspected that will change management (R) (NK) (Contrast) (Anaes.) | \$364.60 |
| 63522 | Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of wrist for a patient under 16 years following radiographic examination where scaphoid fracture is suspected (R) (Contrast) (Anaes.) | \$753.70 |
| 63523 | Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of wrist for a patient under 16 years following radiographic examination where scaphoid fracture is suspected (R) (NK) (Contrast) (Anaes.) | \$405.10 |
| For specified conditions | | |
| 63551 | Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of head for a patient 16 years or older for any of the following: - unexplained seizure(s) (R) (Contrast) (Anaes.) - unexplained chronic headache with suspected intracranial pathology (R) (Contrast) (Anaes.) | \$676.50 |
| 63552 | Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of head for a patient 16 years or older for any of the following: - unexplained seizure(s) (R) (NK) (Contrast) (Anaes.) - unexplained chronic headache with suspected intracranial pathology (R) (NK) (Contrast) (Anaes.) | \$338.30 |
| 63554 | Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine for a patient 16 years or older for suspected: cervical radiculopathy (R) (Contrast) (Anaes.) | \$601.40 |
| 63555 | Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine for a patient 16 years or older for suspected:- cervical radiculopathy (R) (NK) (Contrast) (Anaes.) | \$300.70 |
| 63557 | Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine for a patient 16 years or older for suspected: cervical spine trauma (R) (Contrast) (Anaes.) | \$826.90 |
| 63558 | Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine for a patient 16 years or older for suspected:- cervical spine trauma (R) (NK) (Contrast) (Anaes.) | \$413.60 |
| 63560 | MRI - scan of knee following acute knee trauma, after referral by a medical practitioner (other than a specialist or consultant physician), for a patient aged 16 to 49 years with: inability to extend the knee suggesting the possibility of acute meniscal tear; or clinical findings suggesting acute anterior cruciate ligament tear. (R) (K) (Contrast) (Anaes.) | \$676.50 |
| 63561 | MRI - scan of knee following acute knee trauma, after referral by a medical practitioner (other than a specialist or consultant physician), for a patient aged 16 to 49 years with: inability to extend the knee suggesting the possibility of acute meniscal tear; or clinical findings suggesting acute anterior cruciate ligament tear. (R) (NK) (Contrast) (Anaes.) | \$338.30 |
| 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, alphanaphthyl acetate esterase or chloroacetate esterase; or (c) a blood film using any other special staining methods including periodic acid Schiff and Sudan Black; or (d) a urinary sediment for haemosiderin including a service described in item 65072 | \$14.20 |
| 65070 | erythrocyte count, haematocrit, haemoglobin, calculation or measurement of red cell index or indices, platelet count, leucocyte count and manual or instrument generated differential count - not being a service where haemoglobin only is requested - one or more instrument generated set of results from a single sample ; and (if performed) (a) a morphological assessment of a blood film; (b) any service in item 65060 or 65072 | \$31.90 |
| 65072 | Examination for reticulocytes including a reticulocyte count by any method - 1 or more tests | \$19.10 |
| 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 | \$87.80 |
| 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 | \$314.60 |

| Item No. | Description | Max fee (excl GST) |
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| | examination of aspirated material (including clot sections where necessary), including (if performed): any test described in item 65060, 65066 or 65070 | |
| 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) | \$20.90 |
| 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 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) | \$208.50 |
| 65102 | Compatibility tests by crossmatch - all tests performed on any one day in excess of 6 units, including: (a) all grouping checks of the patient and donor; and (b) examination for antibodies, and if necessary identification of any antibodies detected; and (c) (if performed) any tests described in item 65060, 65070, 65090, 65096, 65099 or 65105 (Item is subject 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) | \$270.50 |
| 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 | \$12.50 |
| 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 | \$47.60 |
| 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 | \$47.60 |
| 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 | \$71.10 |
| 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 foetal red blood cells (Kleihauer test) | \$20.10 |
| 65165 | Detection and quantitation of foetal red blood cells in the maternal circulation by detection of red cell | \$66.10 |

| Item No. | Description | Max fee (excl GST) |
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| | antigens using flow cytometric methods including (if performed) any test described in item 65070 or 65162 | |
| 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 | \$47.60 |
| 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) | \$47.60 |
| 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 rule 6 and 18) | \$47.60 |
| 65181 | Tests described in item 65175, other than that described in 65180, if rendered by a receiving APA - each test to a maximum of 4 tests (Item is subject to rule 6 and 18) | \$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 | \$13.30 |
| 66503 | 2 tests described in item 66500 | \$15.70 |
| 66506 | 3 tests described in item 66500 | \$18.60 |
| 66509 | 4 tests described in item 66500 | \$21.40 |
| 66512 | 5 or more tests described in item 66500 | \$24.30 |
| 66517 | Quantitation of bile acids in blood in pregnancy. To a maximum of 3 tests in a pregnancy. | \$37.00 |
| 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 | \$37.20 |
| 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 |
| 66536 | Quantitation of hdl cholesterol | \$15.00 |
| 66539 | Electrophoresis of serum for demonstration of lipoprotein subclasses, if the cholesterol is >6.5 mmol/l and triglyceride >4.0 mmol/l or in the diagnosis of ty pes iii and iv hyperlipidaemia - (Item is subject to rule 25) | \$43.60 |
| 66542 | Oral glucose tolerance test for the diagnosis of diabetes mellitus that includes: (a) administration of glucose; (b) at least 2 measurements of blood glucose; and if performed (c) any test described in item 66695 | \$31.40 |
| 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 (item is subject to rule 25) | \$31.60 |
| 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) | \$31.60 |
| 66557 | Quantitation of fructosamine performed in the management of established diabetes - each test to a maximum of 4 tests in a 12 month period | \$18.30 |
| 66560 | Microalbumin - quantitation in urine | \$38.10 |
| 66563 | Osmolality, estimation by osmometer, in serum or in urine - 1 or more tests | \$33.70 |
| 66566 | Quantitation of: (a) blood gases (including pO ₂ , oxygen saturation and pCO ₂); and (b) bicarbonate and pH; including any other measurement (e.g. haemoglobin, lactate, potassium or ionised calcium) or calculation performed on the same specimen - 1 or more tests on 1 specimen | \$53.40 |
| 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 | \$96.30 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 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 | \$129.90 |
| 66581 | Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 6 or more specimens performed within any 1 day | \$145.80 |
| 66584 | Quantitation of ionised calcium (except if performed as part of item 66566) - 1 test | \$18.30 |
| 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 | \$33.80 |
| 66596 | Iron studies, consisting of quantitation of: (a) serum iron; and (b)transferrin or iron binding capacity; and (c) ferritin | \$61.20 |
| 66605 | Vitamins - quantitation of vitamins b1, b2, b3, b6 or c in 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 | \$137.90 |
| 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 | \$56.60 |
| 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 | \$66.90 |
| 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 | \$27.50 |
| 66647 | C-1 esterase inhibitor - functional assay | \$61.50 |
| 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 - 1 of this item in a 12 month period (Item is subject to rule 25) | \$38.10 |
| 66656 | Prostate specific antigen - quantitation in the monitoring of previously diagnosed prostatic disease (including a test described in item 66655) | \$38.10 |
| 66659 | Prostate specific antigen - quantitation of 2 or more fractions of psa and any derived index including (if performed) a test described in item 66656, in the follow up of a psa result which lies above the age related median but below the age related, method specific 97.5% reference limit - 1 of this item in a 12 month period (Item is subject to rule 25) | \$70.00 |
| 66660 | Prostate specific antigen - quantitation of 2 or more fractions of psa and any derived index including | \$70.90 |

| Item No. | Description | Max fee (excl GST) |
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| | (if performed) a test described in item 66656, in the follow up of a psa result which lies above the age related, method specific 97.5 % reference limit, but below a value of 10 ug/l - 4 of this item in a 12 month period. | |
| 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 | \$41.80 |
| 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 | \$20.90 |
| 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-deoxy cortisol, 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) | \$41.60 |
| 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 | Test 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) | \$24.80 |
| 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) | \$56.70 |
| 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 | \$34.20 |
| 66719 | Thyroid function tests (comprising the service described in item 66716 and 1 or more of the following tests - free thyroxine, free t3, for a patient, if at least 1 of the following conditions is satisfied: (a) the patient has an abnormal level of tsh; (b) the tests are performed: (i) for the purpose of monitoring thyroid disease in the patient; or (ii) to investigate the sick euthyroid syndrome if the patient is an admitted patient; or (iii) to investigate dementia or psychiatric illness of the patient; or (iv) to investigate amenorrhoea or infertility of the patient; (c) the medical practitioner who requested the tests suspects the patient has a pituitary dysfunction; (d) the patient is on drugs that interfere with thyroid hormone metabolism or function (Item is subject to rule 9) | \$47.40 |
| 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 |

| Item No. | Description | Max fee (excl GST) |
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| 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 any two of the following - total human chorionic gonadotrophin (total hcg), free alpha human chorionic gonadotrophin (free alpha hcg), free beta human chorionic gonadotrophin (free beta hcg), pregnancy associated plasma protein a (papp-a), unconjugated oestriol (ue3), alpha- fetoprote in (afp) - to detect foetal abnormality, including a service described in 1 or more of items 73527 and 73529 (if performed) - (Item is subject to rule 25) | \$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 | \$46.50 |
| 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 | \$46.50 |
| 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 | \$33.50 |
| 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) | \$33.60 |
| 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 | \$33.60 |
| 66779 | Adrenaline, noradrenaline, dopamine, histamine, hydroxyindoleacetic acid (5HIAA), hydroxymethoxymandelic acid (HMMA), homovanillic acid (HVA), metanephrines, methoxyhydroxyphenylethylene glycol (MHPG), phenylacetic acid (PAA)or serotonin quantitation - 1 or more tests | \$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 | Porphyryns or porphyryns 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 | Porphyryns or porphyryns precursors - quantitation in plasma, red cells, urine or faeces - 1 test (Item is subject to rule 6) | \$75.50 |
| 66788 | Porphyryns or porphyryns 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 66786, if rendered by a receiving APP - to a maximum of 1 test(Item is subject to rule 6 and 18) | \$49.00 |
| 66791 | Porphyryn 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 |

| Item No. | Description | Max fee (excl GST) |
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| 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, netilmic in, 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) | \$34.00 |
| 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) | \$65.50 |
| 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) | \$65.50 |
| 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) | \$46.60 |
| 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) | \$41.00 |
| 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) | \$41.00 |
| 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 an 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 | \$49.00 |
| 66834 | A test described in item 66833 if rendered by a receiving APP (Item is subject to Rule 18) | \$49.00 |
| 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 | \$63.60 |
| 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 | \$63.60 |
| 66837 | A test described in item 66835 or 66836 if rendered by a receiving APP (Item is subject to Rule 18) | \$63.60 |
| 66838 | Serum vitamin B12 test (Item is subject to rule 25) | \$38.40 |
| 66839 | Quantification of vitamin B12 markers such as holoTranscobalamin or methylmalonic acid, where initial serum vitamin B12 result is low or equivocal | \$69.90 |
| 66840 | Serum folate test and, if required, red cell folate test for a patient at risk of folate deficiency, including | \$38.40 |

| Item No. | Description | Max fee (excl GST) |
|--------------------------------|---|--------------------|
| | patients with malabsorption conditions, macrocytic anaemia or coeliac disease | |
| 66841 | Quantitation of HbA1c (glycated haemoglobin) performed for the diagnosis of diabetes in asymptomatic patients at high risk. (item is subject to rule 25) | \$27.30 |
| 66900 | Carbon-labelled urea breath test using 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 | \$20.70 |
| 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, 69 303, 69312, 69318; 1 or more tests on 1 or more specimens | \$61.90 |
| 69309 | Microscopy and culture to detect dermatophytes and other fungi causing cutaneous disease from skin scrapings, skin biopsies, hair and nails (excluding swab specimens) and including (if performed): (a) the detection of antigens not elsewhere specified in this Table; or (b) a service described in items 69300, 69303, 69306, 69312, 69318; 1 or more tests on 1 or more specimens | \$89.90 |
| 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 | \$61.90 |
| 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 | \$61.90 |
| 69319 | 2 tests described in item 69494 and a test described in 69316. (Item is subject to rule 26) | \$80.80 |
| 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 69 300, 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 mentioned in item 69300 | \$80.30 |
| 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 | \$157.30 |
| 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 | \$238.50 |
| 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 examination) by any means other than simple culture by dip slide, including:(a) cell count; and(b) culture; and(c) colony count; and(d) (if performed) stained preparations; and(e) (if performed) identification of cultured pathogens; and(f) (if performed) antibiotic susceptibility testing; and(g) (if performed) examination for ph, specific gravity, blood, protein, urobilinogen, sugar, acetone or bile salts | \$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 mentioned in item 69300 - 1 of this item in any 7 day period | \$62.90 |
| 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 | \$26.10 |
| 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 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 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 | \$48.90 |
| 69357 | 2 sets of cultures described in item 69354 | \$97.40 |
| 69360 | 3 sets of cultures described in item 69354 | \$145.80 |
| 69363 | Detection of clostridium difficile or clostridium difficile toxin (except if a service described in item 69345 has been performed) - one or more tests | \$47.10 |
| 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 patients viral load is greater than 1,000 copies per ml at any of the following times: at presentation; or before antiretroviral therapy; or when treatment with combination antiretroviral agents fails; maximum of 2 tests in a 12 month period | \$1403.20 |
| 69381 | Quantitation of HIV viral RNA load in plasma or serum in the monitoring of anti retroviral 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 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 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) | \$79.40 |
| 69393 | 4 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 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) | \$100.10 |
| 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 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) | \$120.90 |
| 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, 6 9475, 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, 6 9475, 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 6938 4, 69475, 69478 and 69481 | \$120.90 |
| 69445 | Detection of Hepatitis c viral rna in a patient undertaking antiviral therapy f or 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 |

| Item No. | Description | Max fee (excl GST) |
|------------------------------|--|--------------------|
| 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) | \$65.60 |
| 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) | \$32.10 |
| 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) | \$81.00 |
| 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 sero conversion 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 |
| 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 | \$94.80 |
| 71059 | Electrophoresis and immunofixation or immunoelectrophoresis or isoelectric focussing of: (a) urine for detection of Bence Jones proteins; or (b) serum, plasma or other body fluid; and characterisation, if detected, of a paraprotein or cryoglobulin not previously characterised - examination of 1 specimen type (e.g. serum, urine or CSF) | \$55.00 |
| 71060 | Examination as described in item 71059 of 2 or more specimen types | \$82.40 |
| 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 | \$82.40 |
| 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 | \$31.10 |

| Item No. | Description | Max fee (excl GST) |
|----------|--|--------------------|
| 71071 | 3 or more tests described in items 71066, 71068, 71072 or 71074 | \$42.40 |
| 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 | \$144.90 |
| 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) | \$31.40 |
| 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 | \$76.30 |
| 71083 | Quantitation of complement components C3 and C4 or properdin factor B - 1 test | \$27.50 |
| 71085 | 2 tests described in item 71083 | \$39.60 |
| 71087 | 3 or more tests described in item 71083 | \$53.10 |
| 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) | \$39.80 |
| 71090 | A test described in item 71089, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18) | \$54.90 |
| 71091 | 2 tests described in item 71089 (Item is subject to rule 6) | \$72.20 |
| 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) | \$44.60 |
| 71093 | 3 or more tests described in item 71089 (Item is subject to rule 6) | \$104.40 |
| 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 | \$33.30 |
| 71099 | Double-stranded DNA antibodies - quantitation by 1 or more methods other than the Crithidia method | \$36.20 |
| 71101 | Antibodies to 1 or more extractable nuclear antigens - detection in serum or other body fluids | \$23.80 |
| 71103 | Characterisation of an antibody detected in a service described in item 71101 (including that service) | \$71.10 |
| 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 | \$23.80 |
| 71121 | Detection of 2 antibodies specified in item 71119 | \$28.40 |
| 71123 | Detection of 3 antibodies specified in item 71119 | \$33.10 |
| 71125 | Detection of 4 or more antibodies specified in item 71119 | \$37.70 |
| 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 | \$240.90 |
| 71129 | 2 tests described in item 71127 | \$297.40 |
| 71131 | 3 or more tests described in item 71127 | \$354.20 |
| 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 | \$19.50 |
| 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 | \$283.90 |
| 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 | \$142.10 |
| 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 | \$269.50 |
| 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 | \$354.90 |

| Item No. | Description | Max fee (excl GST) |
|------------------------------------|--|--------------------|
| | 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 | |
| 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 | \$608.30 |
| 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 pheresis 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 7 1147 | \$147.80 |
| 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 | \$162.30 |
| 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) | \$47.10 |
| 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) | \$64.80 |
| 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) | \$82.40 |
| 71159 | Detection of 4 or more antibodies described in item 71153 (Item is subject to rule 6 and 23) | \$99.90 |
| 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 | \$46.60 |
| 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 |
| 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. | \$29.10 |
| 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. | \$68.80 |
| 71203 | Determination of hlab5701 status by flow cytometry or cytotoxicity 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 |
| 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 | \$162.90 |

| Item No. | Description | Max fee (excl GST) |
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| | separately identified specimen (Item is subject to rule 13) | |
| 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) | \$225.40 |
| 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) | \$424.40 |
| 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) | \$692.10 |
| 72838 | Examination of complexity 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) | \$864.60 |
| 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 (Item is subject to rule 13) except those listed in 72848 | \$89.70 |
| 72847 | Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 4-6 or more antibodies (Item is subject to rule 13) | \$136.70 |
| 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) | \$122.90 |
| 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) | \$156.00 |
| 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) | \$177.70 |
| 72851 | Electron microscopic examination of biopsy material - 1 separately identified specimen (Item is subject to rule 13) | \$305.70 |
| 72852 | Electron microscopic examination of biopsy material - 2 or more separately identified specimens (Item is subject to rule 13) | \$420.10 |
| 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) | \$330.00 |
| 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) | \$437.80 |
| 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. | \$286.40 |
| 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. | \$588.80 |

| Item No. | Description | Max fee (excl GST) |
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| GROUP P6 – CYTOLOGY | | |
| 73043 | Cytology (including serial examinations) of nipple discharge or smears from skin, lip, mouth, nose or anus for detection of precancerous or cancerous changes 1 or more tests | \$40.50 |
| 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 | \$82.40 |
| 73047 | Cytology of a series of 3 sputum or urine specimens for malignant cells | \$171.90 |
| 73049 | Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues - 1 identified site | \$116.00 |
| 73051 | 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 (e.g. serum, urine or csf) | \$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) | \$80.90 |
| 73060 | Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 4 to 6 antibodies(item is subject to rule 13) | \$94.80 |
| 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 | \$403.50 |
| 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 | \$235.20 |
| 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 | \$53.70 |
| 73071 | A test, including partial genotyping, for oncogenic human papillomavirus that may be associated with cervical pre-cancer or cancer: (a) performed on a self-collected vaginal specimen; and (b) for an asymptomatic patient who is at least 30 years of age For any particular patient, once only in a 7 year period | \$53.70 |
| 73072 | A test, including partial genotyping, for oncogenic human papillomavirus, performed on a liquid based cervical specimen: (a) for the investigation of a patient in a specific population that appears to have a higher risk of cervical pre-cancer or cancer; or (b) for the follow-up management of a patient with a previously detected oncogenic human papillomavirus infection or cervical pre-cancer or cancer; or (c) for the investigation of a patient with symptoms suggestive of cervical cancer; or (d) for the follow-up management of a patient after treatment of high grade squamous intraepithelial lesions or adenocarcinoma in situ of the cervix; or (e) for the follow-up management of a patient with glandular abnormalities; or (f) for the follow-up management of a patient exposed to diethylstilboestrol in utero | \$53.70 |
| 73073 | A test, including partial genotyping, for oncogenic human papillomavirus: (a) performed on a self-collected vaginal specimen; and (b) for the follow-up management of a patient with oncogenic human papillomavirus infection or cervical pre-cancer or cancer that was detected by a test to which item73071 applies For any particular patient, once only in a 21 month period | \$53.70 |
| 73074 | A test, including partial genotyping, for oncogenic human papillomavirus: (a) performed on a liquid based vaginal vault specimen; and (b) for the investigation of a patient following a total hysterectomy | \$53.70 |
| 73075 | A test, including partial genotyping, for oncogenic human papillomavirus, if: (a) the test is a repeat of a test to which item73070, 73071, 73072, 73073, 73074 or this item applies; and (b) the specimen collected for the previous test is unsatisfactory | \$53.70 |
| 73076 | Cytology of a liquid-based cervical or vaginal vault specimen, where the stained cells are examined | \$70.60 |

| Item No. | Description | Max fee (excl GST) |
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| | 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, 73073, 73074 or 73075 applies; or (ii) a test to which item 73072 applies for a patient mentioned in paragraph(a) or (b) of that item; or (b) the cytology is associated with a test to which item 73072 applies for a patient mentioned in paragraph(c), (d), (e) or (f) of that item; or (c) the cytology is associated with a test to which item 73074 applies; or (d) the test is a repeat of a test to which this item applies, if the specimen collected for the previous test is unsatisfactory; or (e) the cytology is for the follow-up management of a patient treated for endometrial adenocarcinoma | |
| GROUP P7 - GENETICS | | |
| 73287 | Chromosome studies, (karyotype), by cytogenetic or other comparable techniques, of 1 or more of any tissue or fluid except blood - 1 or more tests | \$761.30 |
| 73289 | chromosome studies, (karyotype), by cytogenetic or other comparable techniques of blood - 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 monitoring of 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 gene mutations, in a patient with platinum-sensitive relapsed ovarian, fallopian tube or primary peritoneal cancer with high grade serous features or a high grade serous component, and who has responded to subsequent platinum-based chemotherapy, requested by a specialist or consultant physician, to determine whether the eligibility criteria for olaparib under the Pharmaceutical Benefits Scheme (PBS) are fulfilled. Maximum one test per lifetime | \$1869.90 |
| 73296 | Characterisation of germline gene mutations, requested by a specialist or consultant physician, including copy number variation in BRCA1 and BRCA2 genes and one or more of the following genes STK11, PTEN, CDH1, PALB2, or TP53 in a patient with breast or ovarian cancer for whom clinical and family history criteria, as assessed by the specialist or consultant physician who requests the service using a quantitative algorithm, place the patient at >10% risk of having a pathogenic mutation identified in one or more of the genes specified above. | \$1840.50 |
| 73297 | Characterisation of germline gene mutations, requested by a specialist or consultant physician, including copy number variation in BRCA1 and BRCA2 genes and one or more of the following genes STK11, PTEN, CDH1, PALB2, or TP53 in a patient who is a biological relative of a patient who has had a pathogenic mutation identified in one or more of the genes specified above, and has not previously received a service under item 73296. | \$613.50 |
| 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 fmri 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 test s(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 test s(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 test s(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 c28 2y genetic mutation, or with compound heterozygosity for recognised genetic mutations for haemochromatosis (Item is subject to rule 20) | \$68.90 |

| Item No. | Description | Max fee (excl GST) |
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| 73318 | A test described in item 73317, if rendered by a receiving APP - 1 or more test s(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 test s.(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 app1 or more tests(item is subject to rule 18) | \$77.30 |
| 73325 | Characterisation of mutations in:(a) the jak2 gene; or (b) the mpl gene; or(c) both genes; in the diagnostic work-up, by, or on behalf of, the specialist or consultant physician, of a patient with clinical and laboratory evidence of: a) polycythaemia vera; orb) essential thrombocythaemia;1 or more tests | \$135.80 |
| 73326 | Characterisation of the gene rearrangement fip111-pdgfra in the diagnostic work-up and management of a patient with laboratory evidence of: a) mast cell disease; orb) idiopathic hypereosinophilic syndrome; orc) chronic eosinophilic leukaemia; 1 or more tests | \$420.80 |
| 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 | \$94.70 |
| 73332 | An in situ hybridization (ish) test of tumour tissue from a patient with breast cancer (other than in the neoadjuvant setting) requested by, or on behalf of, a specialist or consultant physician to determine if the requirements relating to human epidermal growth factor receptor 2 (her2) gene mutation status for access to trastuzumab under the pharmaceutical benefits scheme (pbs) or the herceptin program are fulfilled. | \$574.40 |
| 73333 | Detection of germline mutations of the von hippel-lindau (vhl) gene: in a patient who has a clinical diagnosis of vhl syndrome and: a family history of vhl syndrome and one of the following: haemangioblastoma (retinal or central nervous system); phaeochromocytoma; renal cell carcinoma; or2 or more haemangioblastomas; or one haemangioblastoma and a tumour or a cyst of: the adrenal gland; or the kidney; or the pancreas; or the epididymis; or a broad ligament (other than epididymal and single renal cysts, which are common in the general population); or in a patient presenting with one or more of the following clinical features suggestive of vhl syndrome: (i) haemangioblastomas of the brain, spinal cord, or retina; (ii) phaeochromocytoma; (iii) functional extra-adrenal paraganglioma | \$1030.00 |
| 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 | \$583.70 |
| 73335 | Detection of somatic mutations of the von hippel-lindau (vhl) gene in a patient with: 2 or more tumours comprising: 2 or more haemangioblastomas, or one haemangioblastoma and a tumour of: the adrenal gland; orthe kidney; orthe pancreas; orthe epididymis; and no germline mutations of the vhl gene identified by genetic testing | \$806.90 |
| 73336 | A test of tumour tissue from a patient with unresectable stage iii or stage iv metastatic cutaneous melanoma, requested by, or on behalf of, a specialist or consultant physician, to determine if the requirements relating to braf v600 mutation status for access to dabrafenib or vemurafenib under the pharmaceutical benefits scheme are fulfilled. | \$387.50 |
| 73337 | A test of tumour tissue from a patient diagnosed with non-small cell lung cancer, shown to have non-squamous histology or histology not otherwise specified, requested by, or on behalf of, a specialist or consultant physician, to determine if the requirements relating to epidermal growth factor receptor (EGFR) gene status for access to erlotinib, gefitinib or afatinib under the Pharmaceutical Benefits Scheme (PBS) are fulfilled. | \$666.80 |
| 73338 | A test of tumour tissue from a patient with metastatic colorectal cancer requested by, or on behalf of, a specialist or consultant physician to determine if the requirements relating to kirsten ras (kras) gene mutation status for access to cetuximab or panitumumab under the pharmaceutical benefits scheme (pbs) are fulfilled. | \$387.50 |
| 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) | \$651.00 |
| 73340 | Detection of a known mutation in the RET gene in an asymptomatic relative of a patient with a documented pathogenic germline RET mutation requested by a specialist or consultant physician who manages the treatment of the patient.one test. (Item is subject to rule 25) | \$325.50 |
| 73341 | Fluorescence in situ hybridisation (FISH) test of tumour tissue from a patient with locally advanced or metastatic non-small cell lung cancer, which is of non-squamous histology or histology not otherwise specified, with documented evidence of anaplastic lymphoma kinase (ALK) immunoreactivity by immunohistochemical (IHC) examination giving a staining intensity score > 0, and with documented absence of activating mutations of the epidermal growth factor receptor (EGFR) gene, requested by a specialist or consultant physician to determine if requirements relating to ALK gene rearrangement status for access to crizotinib, ceritinib or alectinib under the Pharmaceutical Benefits Scheme (PBS) are fulfilled. | \$636.40 |
| 73343 | Detection of 17p chromosomal deletions by fluorescence in situ hybridisation, in a patient with relapsed or refractory chronic lymphocytic leukaemia or small lymphocytic lymphoma, on a peripheral blood or bone marrow sample, requested by a specialist or consultant physician, to determine if the requirements for access to idelalisib or ibrutinib on the Pharmaceutical Benefits Scheme are fulfilled. | \$354.20 |
| 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 |

| Item No. | Description | Max fee (excl GST) |
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| 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 | \$8.60 |
| 73803 | 2 tests described in item 73802 | \$12.00 |
| 73804 | 3 or more tests described in item 73802 | \$15.30 |
| 73805 | Microscopy of urine, excluding dipstick testing. | \$8.80 |
| 73806 | Pregnancy test by 1 or more immunochemical methods | \$19.10 |
| 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 |
| 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 | \$9.40 |
| 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. | \$3.90 |
| 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, 73073, 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, 73073, 73074, 73075 or 73076 if: (a) the person is a private patient in a recognised hospital; or (b) the person receives the service from a prescribed laboratory | \$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 in a of a recognised hospital; or (b) a private patient in 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 an in-patient of a private hospital. | \$15.30 |
| 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 private 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 73 929 applies | \$11.10 |
| 73929 | Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner for a prescribed laboratory or by an employee of an approved pathology authority, who conducts a prescribed laboratory, if the specimen is collected in an approved pathology collection centre | \$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 a n 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 | \$4.70 |

| Item No. | Description | Max fee (excl GST) |
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| | 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 | |
| 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 | \$19.30 |
| 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. | \$11.20 |
| 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 | \$15.00 |
| 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

| | | |
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| 73940 | Receipt of a specimen by an approved pathology practitioner of an approved pathology authority from another approved pathology practitioner of a different approved pathology authority or another approved pathology authority (Item is subject to rules 14, 15 and 16) | \$19.30 |
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GROUP A33 - SEXUAL HEALTH MEDICINE**Case Conferences**

| | | |
|-------|--|---------|
| 06080 | Coordination of a TAVI Case Conference by a TAVI Practitioner where the TAVI Case Conference has a duration of 10 minutes or more. (Not payable more than once per patient in a five year period.) | \$75.20 |
| 06081 | Attendance at a TAVI Case Conference by a specialist or consultant physician who does not also perform the service described in item 6080 for the same case conference where the TAVI Case Conference has a duration of 10 minutes or more. (Not payable more than twice per patient in a five year period.) | \$56.10 |

SCHEDULE 1B—SCALE OF CHARGES—OTHER MEDICAL SERVICES

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) |
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| 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. | \$66.20 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. Note 1: A recovery and return to work plan must be requested by: <ul style="list-style-type: none"> - a case manager or self-insured employer - a worker's employer (including the employer's return to work co-ordinator) - 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. | \$130.10 flat fee |

| Item no. | Description | Max fee (excl GST) |
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| | 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. | \$101.90 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. | \$130.10 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. Note 1: A short medical report must be requested in writing and may be requested by a: <ul style="list-style-type: none"> - case 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 case 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. | \$130.10 flat fee |
| 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. | \$265.20 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. | \$497.00 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. Note 1: A standard medical report must be requested in writing and may be requested by a: <ul style="list-style-type: none"> - case 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 case 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. | \$497.00 flat fee |
| 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. | \$331.50 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. | \$623.30 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. Note 1: A complex medical report must be requested in writing and may be requested by a: <ul style="list-style-type: none"> - case 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 case 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 | \$623.30 flat fee |

| Item no. | Description | Max fee (excl GST) |
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| | <p>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.</p> <p>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.</p> <p>Note 6: Payment will only be made following submission of the report.</p> | |
| STANDARD MEDICAL REPORT - TREATING PSYCHIATRIST | | |
| WMY43 | <p>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.</p> <p>Note 1: A standard medical report must be requested in writing and may be requested by a:</p> <ul style="list-style-type: none"> - case manager or self-insured employer, - worker, worker's representative or advocate. <p>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.</p> <p>Note 3: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the case manager and clarified.</p> <p>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.</p> <p>Note 5: Payment will only be made following submission of the report.</p> | \$623.30 flat fee |
| COMPLEX MEDICAL REPORT - TREATING PSYCHIATRIST | | |
| WMY46 | <p>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.</p> <p>Note 1: A complex medical report must be requested in writing and may be requested by a:</p> <ul style="list-style-type: none"> - case manager or self-insured employer, - worker, worker's representative or advocate. <p>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.</p> <p>Note 3: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the case manager and clarified.</p> <p>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.</p> <p>Note 5: Payment will only be made following submission of the report.</p> | \$775.60 flat fee |
| CONSULTATION, MEDICAL REVIEW FOR PREPARATION OF A REPORT - TREATING DOCTOR | | |
| WMG70 | General Practitioner: Consultation: medical review for the preparation of a treating doctor report. | \$60.70 flat fee |
| WMP70 | Consultant Physicians: Consultation: medical review for the preparation of a treating doctor report. | \$121.60 flat fee |
| WMS70 | Specialist in a surgical discipline: Consultation: medical review for the preparation of a treating doctor report. | \$121.60 flat fee |
| WMY73 | Psychiatrists: Consultation: medical review for the preparation of a treating doctor report. | \$337.50 flat fee |
| READING TIME TO PREPARE A REPORT - TREATING DOCTOR | | |
| WMG55 | 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 \$60.70 for reading time up to and including 12 pages, plus \$5.30 per page thereafter. | DF |
| WMP55 | 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 \$121.60 for reading time up to and including 12 pages, plus \$9.60 per page thereafter. | DF |
| WMS55 | 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 \$121.60 for reading time up to and including 12 pages, plus \$9.60 per page thereafter. | DF |
| WMY55 | <p>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 \$158.00 for reading time up to and including 12 pages, plus \$9.60 per page thereafter.</p> <p>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:</p> <ul style="list-style-type: none"> - case manager or self-insured employer - worker, worker's representative or advocate. <p>Note 2: A fee is not payable for the reading of case notes, clinical material or any other material that</p> | DF |

| Item no. | Description | Max fee (excl GST) |
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| | 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. | \$59.70 flat fee |
| WMP25 | Consultant physicians: Clarification of a medical report, re-examination not required. | \$108.50 flat fee |
| WMS25 | Specialists in a surgical discipline: Clarification of a medical report, re-examination not required. Note 1: Clarification of a medical report must be requested in writing and may be requested by a: <ul style="list-style-type: none"> - case 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. | \$108.50 flat fee |
| TELEPHONE CALL (EXCLUDING CALLS MADE TO OR RECEIVED FROM INJURED WORKERS) | | |
| WMG24 | General practitioners: Telephone call up to and including 60 minutes duration. | \$265.20 per hour |
| WMP24 | Consultant physicians: Telephone call up to and including 60 minutes duration. | \$519.80 per hour |
| WMS24 | Specialists in a surgical discipline: Telephone call up to and including 60 minutes duration. 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: <ul style="list-style-type: none"> - a case 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. | \$519.80 per hour |
| 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. | \$265.20 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. | \$519.80 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. Note 1: A case conference may be requested by: <ul style="list-style-type: none"> - a case 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 case manager or self-insured employer should attend the case conference if at all possible. If the case 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 case manager or self-insured employer. It is the responsibility of the case 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. | \$519.80 per hour |

| Item no. | Description | Max fee (excl GST) |
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| 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. | \$265.20 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. | \$519.80 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. Note 1: A worksite assessment may be requested by a: <ul style="list-style-type: none"> - case 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, case manager or self-insured employer representative should be present. Note 3: The case 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 case 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. | \$519.80 per hour |
| THIRD PARTY CONSULTATION | | |
| WMG14 | General practitioners: Third party consultation at the doctor's rooms where the worker is usually not present. | \$265.20 per hour |
| WMP14 | Consultant physicians: Third party consultation at the doctor's rooms where the worker is usually not present. | \$519.80 per hour |
| WMS14 | Specialists in a surgical discipline: Third party consultation at the doctor's rooms where the worker is usually not present. Note 1: A third party consultation must involve at least one of the following: <ul style="list-style-type: none"> - case 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 case 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. | \$519.80 per hour |
| ATTENDANCE AT A DISPUTE RESOLUTION | | |
| WMG15 | General practitioners: Attendance at a dispute resolution. | \$265.20 per hour |
| MP15 | Consultant physicians: Attendance at a dispute resolution. | \$519.80 per hour |
| WMS15 | Specialists in a surgical discipline: Attendance at a dispute resolution. Note 1: Attendance at a dispute resolution must be at the request of a: <ul style="list-style-type: none"> - case 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. | \$519.80 per hour |
| 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. | \$265.20 per hour |
| WMP10 | Consultant physicians: Travel time for the purpose of a worksite assessment, case conference, dispute resolution or third party consultation. | \$519.80 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. | \$519.80 per hour |

| Item no. | Description | Max fee (excl GST) |
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| | <p>Note 1: All accounts must include the total time spent travelling plus the distance travelled.</p> <p>Note 2: Where more than one worksite assessment, case conference or dispute resolution is conducted, the travel fee is to be apportioned accordingly.</p> <p>Note 3: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.</p> | |
| | 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. | \$265.20 per hour |
| WMP36 | Consultant physicians: Cancellation of case conference, worksite assessment, dispute resolution or third party consultation. | \$519.80 per hour |
| WMS36 | Specialists in a surgical discipline: Cancellation of case conference, worksite assessment, dispute resolution or third party consultation. | \$519.80 per hour |
| | <p>Note 1: Payment for cancellation will only be made when the attendance was at the request of a:</p> <ul style="list-style-type: none"> - case manager or self-insured employer - worker, worker's representative or advocate - employer or employer's representative. <p>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.</p> <p>Note 3: A cancellation fee is not payable if the doctor is responsible for the cancellation.</p> <p>Note 4: If the cancelled appointment is subsequently filled with any other earning activity, no cancellation fee will be payable.</p> <p>Note 5: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.</p> | |
| | 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. | \$101.90 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. | \$130.10 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. | \$130.10 flat fee |
| | <p>Note 1: A job analysis and/or job description statement must be requested in writing and may be requested by:</p> <ul style="list-style-type: none"> - a case manager or self-insured employer - a worker, worker's representative or advocate - an approved return to work service provider. <p>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.</p> | |
| | SPECIFIED DUTIES FORM | |
| WMG23 | General practitioners: Completion of a specified duties form. | \$23.40 flat fee |
| WMP23 | Consultant physicians: Completion of a specified duties form. | \$23.40 flat fee |
| WMS23 | Specialist in a surgical discipline: Completion of a specified duties form. | \$23.40 flat fee |
| | <p>Note 1: This form is to be completed at the request of a:</p> <ul style="list-style-type: none"> - case manager or self-insured employer - worker, worker's representative or advocate. <p>Note 2: A fee is not payable if the form is completed during a consultation with the worker.</p> <p>Note 3: Specified duties forms can be obtained by contacting ReturnToWorkSA on 13 18 55.</p> | |
| | 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. | \$70.70 flat fee |
| | <p>Note 1: A fee is only payable if the photocopying is at the request of a:</p> <ul style="list-style-type: none"> - case manager or self-insured employer - worker, worker's representative or advocate - investigator. <p>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.</p> <p>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.</p> | |
| 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. | \$0.28 flat fee |

| Item no. | Description | Max fee (excl GST) |
|--|---|--------------------|
| | <p>Note 1: A fee is only payable if the photocopying is at the request of a: - case manager or self-insured employer</p> <ul style="list-style-type: none"> - worker, worker's representative or advocate - investigator. <p>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.</p> <p>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.</p> | |
| TRAVEL TIME - EMERGENCY ATTENDANCE | | |
| WMG58 | <p>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.</p> <p>Note 1: Where more than one worker is treated at the site of the emergency, the travel fee is to be apportioned accordingly.</p> <p>Note 2: All invoices must include the distance travelled, the travel commencement location, place of emergency attendance and a brief reason for the attendance.</p> <p>Note 3: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.</p> | \$265.20 per hour |
| WMG59 | <p>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.</p> <p>Note 1: Where more than one worker is treated at the site of the emergency, the travel fee is to be apportioned accordingly.</p> <p>Note 2: All invoices must include the distance travelled, the travel commencement location, place of emergency attendance and a brief reason for the attendance.</p> <p>Note 3: Any part of an hour should be charged proportionately and rounded to the nearest six minutes.</p> | \$385.70 per hour |
| TRAVEL TIME - EMERGENCY RETRIEVAL TEAM | | |
| WMS51 | <p>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).</p> <p>Note 1: Where more than one worker is treated at the site of the emergency, the travel fee is to be apportioned accordingly.</p> <p>Note 2: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.</p> | \$519.80 per hour |
| WMS52 | <p>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.</p> <p>Note 1: Where more than one worker is treated at the site of the emergency, the travel fee is to be apportioned accordingly.</p> <p>Note 2: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.</p> | \$753.30 per hour |
| EXTRA-CORPOREAL SHOCK WAVE THERAPY | | |
| WMI11 | <p>Specialists: Initial treatment of Extra-Corporeal Shock Wave Therapy provided by a specialist radiology practice.</p> | \$148.50 flat fee |
| WMI12 | <p>Specialists: Subsequent treatments of Extra-Corporeal Shock Wave Therapy provided by a specialist radiology practice.</p> | \$121.60 flat fee |
| WMI13 | <p>Specialists: Double treatments (bilateral or multiple) of Extra-Corporeal Shock Wave Therapy provided by a specialist radiology practice.</p> <p>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:</p> <ul style="list-style-type: none"> - heel pain/plantar fasciitis - calcific tendonitis of shoulder - lateral epicondylitis (tennis elbow) - medial epicondylitis - non-united fractures - patellar tendinopathy. <p>Note 3: Where Extra-Corporeal Shock Wave Therapy is delivered outside of the approved conditions it is recommended to seek case manager authorisation prior to the provision of the service.</p> <p>Note 4: Epicondylitis treatment is NOT payable by ReturnToWorkSA for treatment provided within three months or after five years from date of injury.</p> | \$202.60 flat fee |
| SERVICES DELIVERED BY EAR, NOSE AND THROAT SURGEONS | | |
| WME24 | Otorhinolaryngologists: Cortical evoked response audiometry - verification. | \$346.20 flat fee |
| WME25 | Otorhinolaryngologists: Sonosmell identification test. | \$150.40 flat fee |
| WME2A | Otorhinolaryngologists: Cortical evoked response audiometry - quantification. | \$346.20 flat fee |
| SERVICES DELIVERED BY MEDICAL PRACTITIONERS | | |
| WMG26 | Medical practitioners: Fluids, intravenous drip infusion of - percutaneous. | \$59.50 flat fee |

| Item no. | Description | Max fee (excl GST) |
|--|---|--------------------|
| MG27 | Medical Practitioners: Fluids, intravenous drip infusion of - open exposure. Note 1: Item WMG26 is only payable where the service is not in association with a surgical procedure. | \$98.60 flat fee |
| SERVICES DELIVERED BY MEDICAL PRACTITIONERS IN THE PRACTICE OF HYPNOTHERAPY | | |
| WMG28 | Hypnotherapy at consulting rooms, 16 to 30 minutes. | \$88.60 flat fee |
| WMG29 | Hypnotherapy at consulting rooms, 31 to 45 minutes. | \$133.10 flat fee |
| WMG30 | Hypnotherapy at consulting rooms, more than 46 minutes. | \$181.30 flat fee |
| WMG31 | Hypnotherapy at consulting rooms, not more than 15 minutes. | \$51.20 flat fee |
| INDEPENDENT MEDICAL EXAMINER - SHORT MEDICAL REPORT | | |
| WMPA1 | Consultant physicians: Independent medical examiner short medical report, expected to be provided within 72 hours of receipt of the initial request or examination (where applicable), whichever is the later. | \$130.10 flat fee |
| WMSA1 | Specialists in a surgical discipline: Independent medical examiner short medical report, expected to be provided within 72 hours of receipt of the initial request or examination (where applicable), whichever is the later. Note 1: A short medical report must be requested in writing and may be requested by a: - case 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 case manager and clarified. Note 4: A short report should be concise and focused. The expected length of a short report is approximately half an A4 page. Note 5: A short report may be faxed to the requestor with the relevant account for services. Note 6: Payment will only be made following submission of the report. | \$130.10 flat fee |
| INDEPENDENT MEDICAL EXAMINER - MEDICAL REPORT (EXCLUDING PSYCHIATRISTS) | | |
| WMP29 | Consultant physicians: Independent medical examiner report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the later. | \$623.30 flat fee |
| WMS29 | Specialists in a surgical discipline: Independent medical examiner report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the later. Note 1: A medical report must be requested in writing and may be requested by a: - case 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 case manager and clarified. Note 4: There is an expectation that a consultation will be required for the preparation of a report and this should be billed in accordance with item number WMP80 or WMS80. Note 5: Payment will only be made following submission of the report. | \$623.30 flat fee |
| INDEPENDENT MEDICAL EXAMINER - PSYCHIATRISTS MEDICAL REPORT | | |
| WMY61 | Psychiatrists: Independent medical examiner 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. Note 1: A psychiatrists medical report must be requested in writing and may be requested by a: - case 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: There is an expectation that a consultation will be required for the preparation of a report and this should be billed in accordance with item number WMY83. Note 4: Occasionally a psychiatrist will require more than one consultation with a patient to write a report. We recommend that the psychiatrist contacts the case manager prior to providing a second consultation, to determine whether this is appropriate in the circumstances of the case (eg time constraints). Where an additional consultation is required it must be provided within 10 business days of the first consultation. Note 5: Payment will only be made following submission of the report. | \$775.60 flat fee |
| INDEPENDENT MEDICAL EXAMINER - CONSULTATION, MEDICAL REVIEW FOR PREPARATION OF A REPORT | | |
| WMP80 | Consultant physicians: Independent medical examiner consultation, medical review for the preparation of an independent medical examiner report. | \$236.30 flat fee |
| WMS80 | Specialists in a surgical discipline: Independent medical examiner consultation, medical review for the preparation of an independent medical examiner report. | \$236.30 flat fee |

| Item no. | Description | Max fee (excl GST) |
|--|--|--------------------|
| WMY83 | Psychiatrists: Independent medical examiner consultation, medical review for the preparation of an independent medical examiner report. | \$337.50 flat fee |
| INDEPENDENT MEDICAL EXAMINER - READING TIME | | |
| WMP32 | Consultant physicians: Independent medical examiner reading time payable to an independent medical examiner 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 WMP32 is \$121.60 for reading time up to and including 12 pages, plus \$9.60 per page thereafter. | DF |
| WMS32 | Specialists in a surgical discipline: Independent medical examiner reading time payable to an independent medical examiner 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 WMS32 is \$121.60 for reading time up to and including 12 pages, plus \$9.60 per page thereafter. | DF |
| WMY32 | Psychiatrists: Independent medical examiner reading time payable to an independent medical examiner 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 WMY32 is \$158.00 for reading time up to and including 12 pages, plus \$9.60 per page thereafter. | DF |
| <p>Note 1: Payment for the 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:</p> <ul style="list-style-type: none"> - case manager or self-insured employer - worker, worker's representative or advocate. <p>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.</p> <p>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.</p> <p>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.</p> <p>Note 4: The reading of material supplied by the requestor can only be billed once. No additional charge can be submitted for re-reading of material.</p> | | |
| INDEPENDENT MEDICAL EXAMINER - MEDICAL REPORT CLARIFICATION | | |
| WMP33 | Consultant physicians: Independent medical examiner clarification of a medical report, re-examination not required. | \$108.50 flat fee |
| WMS33 | Specialists in a surgical discipline: Independent medical examiner clarification of a medical report, re-examination not required. | \$108.50 flat fee |
| <p>Note 1: A clarification of a medical report must be requested in writing and may be requested by a:</p> <ul style="list-style-type: none"> - case manager or self-insured employer - worker, worker's representative or advocate. <p>Note 2: The requestor must specify that he or she is seeking a clarification of a previous medical report.</p> <p>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.</p> <p>Note 4: 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. The decision to undertake a further consultation is at the discretion of the doctor. If required, please refer to item numbers WMP80, WMS80 or WMY83.</p> <p>Note 5: Payment will only be made following submission of the report.</p> | | |
| 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. | \$514.70 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. | \$514.70 per hour |
| <p>Note 1: Travel will be approved for independent medical examiner services requested by a:</p> <ul style="list-style-type: none"> - case manager or self-insured employer - worker, worker's representative or advocate. <p>Note 2: All accounts must include the total time spent travelling as well as the distance travelled.</p> <p>Note 3: Where more than one service is conducted, the travel fee is to be apportioned accordingly.</p> <p>Note 4: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.</p> | | |
| INDEPENDENT MEDICAL EXAMINER - NON-ATTENDANCE OR CANCELLATION OF AN APPOINTMENT | | |
| WMP34 | Consultant physicians: Independent medical examiner non-attendance at, or cancellation less than 48 hours (excluding weekends and public hospitals in South Australia) before an appointment. | \$236.30 flat fee |
| WMS34 | Specialists in a surgical discipline: Independent medical examiner non-attendance at, or cancellation less than 48 hours (excluding weekends and public holidays in South Australia) before an appointment. | \$236.30 flat fee |
| WMY88 | Psychiatrists: Independent medical examiner non-attendance at, or cancellation less than 48 hours (excluding weekends and public holidays in South Australia) before an appointment. | \$337.50 flat fee |
| <p>Note 1: Fees apply only to the cancellation of medical appointments arranged by a:</p> | | |

| Item no. | Description | Max fee (excl GST) |
|---|---|--------------------|
| | - case 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. | \$152.00 flat fee |
| WMP65 | Consultant physicians: Independent medical examiner cancellation of an attendance at a venue more than 100 kilometres from the Adelaide GPO. | \$243.10 flat fee |
| WMP66 | Consultant physicians: Independent medical examiner overnight accommodation including meals and incidentals. | \$322.00 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. | \$152.00 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. | \$243.10 flat fee |
| WMS66 | Specialists in a surgical discipline: Independent medical examiner overnight accommodation including meals and incidentals. | \$322.00 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. | |

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 - reading, examination and report in accordance with the Impairment Assessment Guidelines. | \$1039.60 flat fee |
| PIA30 | Specialists (excluding psychiatrists): permanent impairment assessor standard report, simple assessment of one body system - reading, examination and report in accordance with the Impairment Assessment Guidelines. | \$1039.60 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, examination and report in accordance with the Impairment Assessment Guidelines and using the Guidelines for the Evaluation of Psychiatric Impairment by Clinicians (GEPIC). | \$1299.50 flat fee |
| | Note 1: Reports will be requested by a case 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: Payment will only be made following submission of the report which is prepared in accordance with, and conforms with, the requirements of the relevant guidelines stated above. Corrections and amendments to the report 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. | |

| Item no. | Description | Max fee (excl GST) |
|--|--|--------------------|
| PERMANENT IMPAIRMENT ASSESSOR - MODERATELY COMPLEX REPORT | | |
| PIA11 | General practitioners: permanent impairment assessor moderately complex report, simple assessment of two body systems or more than one injury to a single body system - reading, examination and report in accordance with the Impairment Assessment Guidelines. | \$1299.70 flat fee |
| PIA31 | Specialists: permanent impairment assessor moderately complex report, simple assessment of two body systems or more than one injury to a single body system - reading, examination and report in accordance with the Impairment Assessment Guidelines. Note 1: Reports will be requested by a case 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: Payment will only be made following submission of the report which is prepared in accordance with, and conforms with, the requirements of the Impairment assessment guidelines. Corrections and amendments to the report 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. | \$1299.70 flat fee |
| PERMANENT IMPAIRMENT ASSESSOR - COMPLEX REPORT | | |
| PIA12 | General practitioners: permanent impairment assessor complex report, complex assessment on a single body system or multiple injuries involving more than one body system or lead assessor report - reading, examination and report in accordance with the Impairment Assessment Guidelines. | \$1646.20 flat fee |
| PIA32 | Specialists (excluding psychiatrists): permanent impairment assessor complex report, complex assessment on a single body system or multiple injuries involving more than one body system or lead assessor report - reading, examination and report in accordance with the Impairment Assessment Guidelines. | \$1646.20 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, examination and report in accordance with the Impairment Assessment Guidelines and using the Guidelines for the Evaluation of Psychiatric Impairment by Clinicians (GEPIC). Note 1: Reports will be requested by a case 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: Payment will only be made following submission of the report which is prepared in accordance with, and conforms with, the requirements of the relevant guidelines stated above. Corrections and amendments to the report 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. | \$1818.80 flat fee |
| PERMANENT IMPAIRMENT ASSESSOR - ENT REPORT | | |
| PIA50 | ENT specialists: permanent impairment assessor ENT report - reading, examination of ear, nose and/or throat only, including audiometric testing and report in accordance with the Impairment Assessment Guidelines. Note 1: Reports will be requested by a case 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: Payment will only be made following submission of the report which is prepared in accordance with, and conforms with, the requirements of the Impairment Assessment Guidelines. Corrections and amendments to the report do not attract an additional fee. Note 5: 'Specialist' means a specialist in a surgical discipline or a consultant physician. | \$1039.60 flat fee |
| 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 - reading, examination conducted with the assistance of an interpreter and report in accordance with the Impairment Assessment Guidelines. | \$1299.70 flat fee |
| PIA33 | Specialists (excluding psychiatrists): permanent impairment assessor standard report with interpreter, simple assessment of one body system - reading, examination conducted with the assistance of an interpreter and report in accordance with the Impairment Assessment Guidelines. | \$1299.70 flat fee |

| Item no. | Description | Max fee (excl GST) |
|--|---|--------------------|
| PIA43 | <p>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, examination and report in accordance with the Impairment Assessment Guidelines and using the Guidelines for the Evaluation of Psychiatric Impairment by Clinicians (GEPIC).</p> <p>Note 1: Reports will be requested by a case manager or self-insured employer.</p> <p>Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex or supplementary report is required.</p> <p>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.</p> <p>Note 4: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.</p> <p>Note 5: Payment will only be made following submission of the report which is prepared in accordance with, and conforms with, the requirements of the relevant guidelines stated above. Corrections and amendments to the report do not attract an additional fee.</p> <p>Note 6: 'Specialist' means a specialist in a surgical discipline or a consultant physician.</p> <p>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.</p> | \$1624.30 flat fee |
| PERMANENT IMPAIRMENT ASSESSOR - MODERATELY COMPLEX REPORT WHERE AN EXAMINATION IS CONDUCTED WITH THE ASSISTANCE OF AN INTERPRETER | | |
| PIA14 | <p>General practitioners: permanent impairment assessor moderately complex report with interpreter, simple assessment of two body systems or more than one injury to a single body system - reading, examination conducted with the assistance of an interpreter and report in accordance with the Impairment Assessment Guidelines.</p> | \$1559.60 flat fee |
| PIA34 | <p>Specialists: permanent impairment assessor moderately complex report with interpreter, simple assessment of two body systems or more than one injury to a single body system - reading, examination conducted with the assistance of an interpreter and report in accordance with the Impairment Assessment Guidelines.</p> <p>Note 1: Reports will be requested by a case manager or self-insured employer.</p> <p>Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex or supplementary report is required.</p> <p>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.</p> <p>Note 4: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.</p> <p>Note 5: Payment will only be made following submission of the report which is prepared in accordance with, and conforms with, the requirements of the Impairment Assessment Guidelines. Corrections and amendments to the report do not attract an additional fee.</p> <p>Note 6: 'Specialist' means a specialist in a surgical discipline or a consultant physician.</p> <p>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.</p> | \$1559.60 flat fee |
| PERMANENT IMPAIRMENT ASSESSOR - COMPLEX REPORT WHERE AN EXAMINATION IS CONDUCTED WITH THE ASSISTANCE OF AN INTERPRETER | | |
| PIA15 | <p>General practitioners: permanent impairment assessor complex report with interpreter, complex assessment on a single body system or multiple injuries involving more than one body system or lead assessor report - reading, examination conducted with the assistance of an interpreter and report in accordance with the Impairment Assessment Guidelines.</p> | \$1906.10 flat fee |
| PIA35 | <p>Specialists (excluding psychiatrists): permanent impairment assessor complex report with interpreter, complex assessment on a single body system or multiple injuries involving more than one body system or lead assessor report - reading, examination conducted with the assistance of an interpreter and report in accordance with the Impairment Assessment Guidelines.</p> | \$1906.10 flat fee |
| PIA45 | <p>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, examination and report in accordance with the Impairment Assessment Guidelines and using the Guidelines for the Evaluation of Psychiatric Impairment by Clinicians (GEPIC).</p> <p>Note 1: Reports will be requested by a case manager or self-insured employer.</p> <p>Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex or supplementary report is required.</p> <p>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.</p> <p>Note 4: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.</p> <p>Note 5: Payment will only be made following submission of the report which is prepared in accordance with, and conforms with, the requirements of the relevant guidelines stated above. Corrections and amendments to the report do not attract an additional fee.</p> <p>Note 6: 'Specialist' means a specialist in a surgical discipline or a consultant physician.</p> <p>Note 7: The lead assessor may only bill for the final complete report including the sub-assessor's report(s).</p> | \$2273.50 flat fee |

| Item no. | Description | Max fee (excl GST) |
|---|---|--------------------|
| | 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, 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. Note 1: Reports will be requested by a case 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: If an interpreter is present at the examination, the medical fee payable is in accordance with the fee set out above. Note 5: Payment will only be made following submission of the report which is prepared in accordance with, and conforms with, the requirements of the Impairment Assessment Guidelines. Corrections and amendments to the report do not attract an additional fee. Note 6: 'Specialist' means a specialist in a surgical discipline or a consultant physician. | \$1299.70 flat fee |
| 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. | \$374.40 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 Note 1: A fee for a cancellation with more than 48 hours notice (excluding weekends and public holidays) is not payable. Note 2: A fee for a cancellation or non-attendance does not apply if the appointment is subsequently filled with another earning activity. | \$374.40 flat fee |
| PERMANENT IMPAIRMENT ASSESSOR - SUPPLEMENTARY REPORT | | |
| PIA17 | General practitioners: permanent impairment assessor supplementary report, where additional information is requested by the report requestor. | \$259.90 flat fee |
| PIA37 | Specialists (including psychiatrists): permanent impairment assessor supplementary report, where additional information is requested by the report requestor. Note 1: Supplementary report fees are not payable if additional work is required as a result of an error or omission on the part of the assessor. | \$259.90 flat fee |
| PERMANENT IMPAIRMENT ASSESSOR - ADDITIONAL READING TIME | | |
| PIA18 | General practitioners: permanent impairment assessor additional reading time in conjunction with a standard or moderately complex report. The fee is only to be charged if there are more than 25 pages of reading material supplied by the report requestor. The first 25 pages are included in the report fee and are therefore not chargeable under this item. Derived fee: \$9.60 per page over 25 pages. | DF |
| PIA19 | General practitioners: permanent impairment assessor additional reading time in conjunction with a complex report. This fee is only to be charged if there are more than 51 pages of reading material supplied by the report requestor. The first 51 pages are included in the report fee and are therefore not chargeable under this item. Derived fee: \$9.60 per page over 51 pages. | DF |
| PIA38 | Specialists (including psychiatrists): permanent impairment assessor additional reading time in conjunction with a standard or moderately complex report. This fee is only to be charged if there are more than 25 pages of reading material supplied by the report requestor. The first 25 pages are included in the report fee and are therefore not chargeable under this item. Derived fee: \$9.60 per page over 25 pages. | DF |
| PIA39 | Specialists (including psychiatrists): permanent impairment assessor additional reading time in conjunction with a complex report. This fee is only to be charged if there are more than 51 pages of reading material supplied by the report requestor. The first 51 pages are included in the report fee and are therefore not chargeable under this item. Derived fee: \$9.60 per page over 51 pages. Note 1: Reading fees are only payable where the material has been directly supplied by the report requestor. A fee is not payable for the reading of case notes, clinical material or any other material that is not directly supplied by the report requestor. Note 2: The reading of material supplied by the requestor can only be charged once. No additional charge can be submitted for re-reading of material. 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. | DF |
| 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. | \$152.00 flat fee |
| PIA62 | General practitioners or specialists (including psychiatrists): permanent impairment assessor - | \$243.10 flat fee |

| Item no. | Description | Max fee (excl GST) |
|----------|---|--------------------|
| | cancellation of an attendance at a venue more than 100 kilometres from the Adelaide GPO. | |
| PIA64 | General practitioners or specialists (including psychiatrists): permanent impairment assessor accommodation - overnight accommodation including meals and incidentals. | \$322.00 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 5 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. | |

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) |
|---|--|----------------------------------|
| 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. | \$66.50 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. | \$115.90 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. | \$52.60 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. | \$108.10 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 case manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer. | \$46.50 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 case manager, self-insured employer, worker or worker's representative. Maximum 4 hours. | \$185.40 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 case 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. | \$25.70 flat fee |
| | *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. | |
| 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 case manager, self-insured employer, worker or worker's representative. | \$185.40 flat fee |
| CASE CONFERENCE | | |
| CH870 | Case conference. Attendance at a case conference as requested in writing by the case manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an approved return to work service provider*. | \$185.40 per hour |
| | *An approved return to work service provider means a provider approved by RTWSA to deliver | |

| Item no. | Description | Max fee (excl GST) |
|---|---|--------------------|
| | 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. | |
| 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. | \$157.40 per hour |
| RADIOLOGICAL SERVICES (INCLUDING INTERPRETATION BY A CHIROPRACTOR) | | |
| CHT11 | Cervical spine - 2 views | \$143.90 flat fee |
| CHT13 | Thoracic spine - 2 views | \$122.30 flat fee |
| CHT15 | Lumbo-sacral spine - 3-6 views | \$168.80 flat fee |
| CHT16 | Sacro-coccygeal area - 2 views | \$101.90 flat fee |
| CHT27 | Hip joint | \$110.00 flat fee |
| CHT28 | Pelvic girdle | \$138.90 flat fee |

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. | \$147.00 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. Maximum of 10 sessions (inclusive of initial assessment and any group sessions). | \$147.00 per hour Max 1 hour |
| GROUP SESSION | | |
| EP103 | Group session. A session during which a maximum of 6 participants are constantly and directly supervised and assessed by the exercise physiologist. | \$24.50 per participant |
| 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 . For claims managed by ReturnToWorkSA or their claims agents, the exercise physiologist is expected to submit a plan: <ul style="list-style-type: none"> • prior to the 11th treatment if more than 10 treatments are likely to be required, or • prior to the expiry of an existing exercise physiology management plan if additional treatment is required, or • at the request of the case manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer. | \$36.80 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 case 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. | \$20.40 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 case manager, self-insured employer, worker or worker's representative. | \$147.00 flat fee |
| CASE CONFERENCE | | |
| EP870 | Case conference. Attendance at a case conference as requested in writing by the case manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an approved return to work service provider*. | \$147.00 per hour |
| TRAVEL TIME | | |
| EP905 | Travel time. Travel by an exercise physiologist for the purpose of a case conference or as otherwise discussed and approved with the case manager or self-insured employer. | \$124.80 per hour |

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. | \$185.40 per hour |
| OT205 | Subsequent consultation. Re-assessment planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. | \$185.40 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 case manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer. | \$46.50 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 case manager, supervisor/employer should also be present to facilitate a team approach. Maximum 1 hour. | \$185.40 per hour Max 1 hour |
| CORRECTIVE/SERIAL SPLINTING | | |
| OT300 | Fabrication/fitting/adjustment of splint | \$185.40 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 case manager, self-insured employer, worker or worker's representative. Maximum 4 hours. | \$185.40 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 case manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the case manager or self-insured employer. Maximum 5 hours. | \$185.40 per hour Max 5 hours |
| ACTIVITIES OF DAILY LIVING RE-ASSESSMENT | | |
| OT762 | Activities of daily living re-assessment. 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 case manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the case manager or self-insured employer. Maximum 2 hours. | \$185.40 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 case manager, self-insured employer or treating medical practitioner. Maximum 5 hours. | \$185.40 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 case manager, self-insured employer or treating medical practitioner. | \$185.40 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 case 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. | \$25.70 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 case manager, self-insured employer, worker or worker's representative. | \$185.40 flat fee |
| CASE CONFERENCE | | |
| OT870 | Case conference. Attendance at a case conference as requested in writing by the case manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an | \$185.40 per hour |

| Item no. | Description | Max fee (excl GST) |
|--|--|----------------------------------|
| | 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. | |
| 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. | \$157.40 per hour |
| 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. | \$122.00 flat fee |
| OS220 | Subsequent consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. | \$90.10 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 case manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer. | \$46.50 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 case manager, self-insured employer, worker or worker's representative. Maximum 4 hours. | \$185.40 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 case 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. | \$25.70 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 case manager, self-insured employer, worker or worker's representative. | \$185.40 flat fee |
| CASE CONFERENCE | | |
| OS870 | Case conference. Attendance at a case conference as requested in writing by the case 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. | \$185.40 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. | \$157.40 per hour |
| RADIOLOGICAL SERVICES (INCLUDING INTERPRETATION BY AN OSTEOPATH) | | |
| OST11 | Cervical spine - 2 views | \$143.90 flat fee |
| OST13 | Thoracic spine - 2 views | \$122.30 flat fee |
| OST15 | Lumbo-sacral spine 3 - 6 views | \$168.80 flat fee |
| OST16 | Sacro-coccygeal area - 2 views | \$101.90 flat fee |
| OST27 | Hip joint | \$110.00 flat fee |
| OST28 | Pelvic girdle | \$138.90 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. | \$83.50 flat fee |
| PT210 | Subsequent consultation. Re-assessment, planning education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. | \$68.00 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. | \$92.90 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 case manager on a case-by-case basis. Maximum 1 hour. | \$185.40 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 case manager, supervisor/employer should also be present to facilitate a team approach. Maximum 1 hour. | \$185.40 per hour Max 1 hour |
| CORRECTIVE/SERIAL SPLINTING | | |
| PT300 | Fabrication/fitting/adjustment of a splint. | \$185.40 per hour |
| PT390 | Materials used to construct or modify a splint. | DF |
| 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. | \$65.00 flat fee |
| GROUP AQUATIC SESSION | | |
| PT420 | Group aquatic session. A session during which a maximum of eight participants are constantly and directly supervised and assessed by the physiotherapist. | \$27.20 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. | \$65.00 flat fee |
| GROUP EXERCISE | | |
| PT460 | Group exercise session. A session during which a maximum of eight participants are constantly and directly supervised and assessed by the physiotherapist. | \$19.20 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. | DF |
| PHYSIOTHERAPY MANAGEMENT PLAN | | |
| PTMP | A physiotherapy management plan completed and submitted by the treating physiotherapist. Physiotherapy management plan 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 case manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer. | \$46.50 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 case manager, self-insured employer, worker or worker's representative. Maximum 4 hours. | \$185.40 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 case manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the case manager or self-insured employer. Maximum 5 hours. | \$185.40 per hour Max 5 hours |

| Item no. | Description | Max fee (excl GST) |
|---|--|----------------------------------|
| ACTIVITIES OF DAILY LIVING RE-ASSESSMENT | | |
| PT762 | Activities of daily living re-assessment. 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 case manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the case manager or self-insured employer. Maximum 2 hours. | \$185.40 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 case 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. | \$25.70 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 case manager, self-insured employer, worker or worker's representative. | \$185.40 flat fee |
| CASE CONFERENCE | | |
| PT870 | Case conference. Attendance at a case conference as requested in writing by the case 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. | \$185.40 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. | \$157.40 per hour |
| TRAVEL EXPENSES | | |
| PT907 | Travel expenses. Travel expenses incurred for a medical service delivered at the request of the case 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. | DF |

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. | \$185.40 per hour Max 1 hour |
| 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. | \$185.40 per hour Max 1 hour |
| PSYCHOLOGICAL ASSESSMENT | | |
| PS230 | Psychological assessment. Clinical or psychometric assessment and interpretation of results. Maximum 2 hours. | \$185.40 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 case manager or self-insured employer. Maximum 12 hours. | \$185.40 per hour |
| CONSULTATION 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. | \$185.40 per hour Max 1 hour |
| 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. | \$36.70 per participant |
| 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: - 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 | \$46.50 flat fee |

| Item no. | Description | Max fee (excl GST) |
|---|--|----------------------------------|
| | additional treatment is required, or - at the request of the case manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer. | |
| 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 management. This service must be requested in writing by the case manager, self-insured employer, worker or worker's representative. | \$185.40 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 case 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. | \$185.40 per hour |
| 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 case manager, self-insured employer, worker or worker's representative. Maximum 4 hours. | \$185.40 per hour Max 4 hours |
| PS820 | Treating psychologist standard 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, requested in writing by the case manager, self-insured employer, worker or worker's representative. | \$185.40 flat fee |
| CASE CONFERENCE | | |
| PS870 | Case conference. Attendance at a case conference as requested in writing by the case 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. | \$185.40 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. | \$166.20 per hour |

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. | \$185.40 per hour |
| 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. | \$185.40 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 case manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer. | \$46.50 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 case 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. | \$25.70 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 case manager, self- | \$278.20 flat fee |

| Item no. | Description | Max fee (excl GST) |
|------------------------|---|--------------------|
| | insured employer, worker or worker's representative. | |
| CASE CONFERENCE | | |
| E0870 | Case conference. Attendance at a case conference as requested in writing by the case 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. | \$185.40 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 diagnostic testing, collaborative rehabilitative goal setting, reasonable cost effective recommendations, clinical justification and a brief written summary to the case manager inclusive of the above. The Audiologist/Audiometrist should refer the worker to another clinician if the patient presents with issues outside of their scope of practice. | Audiologist \$196.20 flat fee Audiometrist \$176.05 per hour |
| 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. | \$719.60 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. Binaural Hearing packages will only be provided for demonstrated compensable hearing loss in both ears. | \$1056.30 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. Provider specific wholesale price of hearing aid + 5% mark-up to maximum of \$2000 per aid | \$2000.00 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 case manager and each service to be rounded to the nearest 6 minutes. | Audiologist \$196.20 per hour Audiometrist \$176.05 per hour Max 6 hours |
| 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. | \$100.00 maximum |
| REPORT | | |
| AU105 | Standard report: A standard report can only be requested by the case 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 \$196.20 flat fee Audiometrist \$176.05 flat fee |

SCHEDULE 10—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—Interpretations

- (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:

$$\text{Maximum Charge} = \text{Rate per day} \times \text{LOS}$$

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:

$$\text{Maximum Charge} = \text{Schedule Charge} + (\text{rate per day} \times (\text{LOS} - \text{Upper trim point}))$$
 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 | \$821.90 |
| PR605 | Rehabilitation orthopaedic program: 17 or more days | \$889.20 |
| 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 | \$980.10 |
| PR615 | Rehabilitation trauma program: 21 or more days | \$884.90 |
| PSYCHIATRIC SERVICES | | |
| Inpatient services | | |
| PR800 | Psych inpatient: 1 or more days but not more than 14 days | \$788.60 |
| PR803 | Psych inpatient: 15 or more days | \$606.80 |
| PR822 | Psych inpatient: Electro-convulsive therapy (ECT) | \$337.60 |
| PR850 | Psych inpatient private room allocated on the basis of clinical need | \$19.70 |
| 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 | \$894.00 |

| Item no. | Description | Max fee (excl GST) |
|--|--|--------------------|
| PR991 | Drug & alcohol program - inpatient, 11 or more days | \$654.30 |
| 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 | \$107.60 |
| PRO82 | Psych same day ECT day program | \$560.50 |
| PRO83 | Psych same day half-day program | \$287.00 |
| PRO84 | Psych same day - day program | \$454.20 |
| PRO95 | Psych same day outreach | \$259.30 |
| OTHER SERVICES | | |
| Inpatient pain assessment/management | | |
| PR700 | Inpatient pain assess/mgmt: 1 or more days but not more than 7 days | \$721.30 |
| PR705 | Inpatient pain assess/mgmt: 8 or more days but not more than 14 days | \$677.70 |
| PR710 | Inpatient pain assess/mgmt: 15 or more days | \$440.50 |
| 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. | \$250.30 |

*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) | Upper trim point days | Lower trim point days | Max per day rate (ex GST) |
|----------|--|------------------|-----------------------|-----------------------|---------------------------|
| 801A | OR Procedures Unrelated to Principal Diagnosis W Catastrophic CC | \$19,378.90 | 35 | 7 | \$899.40 |
| 801B | OR Procedures Unrelated to Principal Diagnosis W Severe or Moderate CC | \$9,637.30 | 17 | 3 | \$1,043.10 |
| 801C | OR Procedures Unrelated to Principal Diagnosis W/O CC | \$3,655.70 | 4 | 0 | \$1,400.00 |
| 960Z | Ungroupable | \$526.70 | 6 | 0 | \$162.70 |
| 961Z | Unacceptable Principal Diagnosis | \$1,113.90 | 6 | 0 | \$411.10 |
| A06A | Tracheostomy W Ventilation >=96hrs W Catastrophic CC | \$120,847.20 | 35 | 16 | \$1,400.00 |
| A06B | Ventilation >=96hrs and OR Proc (W/O Tracheostomy or W/O Cat CC) | \$75,037.60 | 35 | 11 | \$1,400.00 |
| A06C | Tracheostomy W/O Ventilation >=96hrs, or Ventilation >=96hrs W/O OR Proc | \$44,875.10 | 35 | 6 | \$1,400.00 |
| A08A | Autologous Bone Marrow Transplant W Catastrophic CC | \$27,016.80 | 35 | 8 | \$1,080.40 |
| A08B | Autologous Bone Marrow Transplant W/O Catastrophic CC | \$5,409.00 | 6 | 0 | \$1,331.50 |
| A09B | Kidney Transplant, Age >=17 W/O Catastrophic CC | \$11,039.10 | 18 | 3 | \$1,245.90 |
| A11A | Insertion of Implantable Spinal Infusion Device W Catastrophic CC | \$9,374.50 | 35 | 6 | \$523.40 |
| A11B | Insertion of Implantable Spinal Infusion Device W/O Catastrophic CC | \$6,107.80 | 12 | 2 | \$965.10 |
| A12Z | Insertion of Neurostimulator Device | \$5,229.60 | 6 | 0 | \$1,400.00 |
| B01A | Ventricular Shunt Revision W Catastrophic or Severe CC | \$9,339.00 | 13 | 2 | \$1,325.70 |
| B01B | Ventricular Shunt Revision W/O Catastrophic or Severe CC | \$6,869.20 | 9 | 1 | \$1,400.00 |
| B02A | Cranial Procs W Cerebral Haemorrhage W Cat CC | \$44,280.60 | 35 | 8 | \$1,400.00 |
| B02B | Cranial Procs W/O Cerebral Haem W Cat CC or (W Cerebral Haem W Sev CC) | \$27,755.30 | 32 | 5 | \$1,400.00 |
| B02C | Cranial Procs W/O Cerebral Haem W Sev CC or W/O Cat/Sev CC | \$14,829.40 | 14 | 2 | \$1,400.00 |
| B03A | Spinal Procedures W Catastrophic or Severe CC | \$14,083.60 | 18 | 3 | \$1,385.50 |
| B03B | Spinal Procedures W/O Catastrophic or Severe CC | \$6,773.20 | 6 | 0 | \$1,400.00 |
| B04A | Extracranial Vascular Procedures W Catastrophic CC | \$15,106.80 | 19 | 3 | \$1,400.00 |

| Item no. | Description | Max fee (ex GST) | Upper trim point days | Lower trim point days | Max per day rate (ex GST) |
|----------|---|---------------------|--------------------------|--------------------------|------------------------------|
| B04B | Extracranial Vascular Procedures W/O Catastrophic CC | \$9,043.90 | 8 | 1 | \$1,400.00 |
| B05Z | Carpal Tunnel Release | \$1,377.80 | 4 | 0 | \$914.70 |
| B06A | Procs for Cerebral Palsy, Muscular Dystrophy, Neuropathy W Cat or Sev CC | \$13,433.80 | 24 | 4 | \$1,063.30 |
| B06B | Procs for Cerebral Palsy, Muscular Dystrophy, Neuropathy W/O Cat or Sev CC | \$3,398.10 | 4 | 0 | \$1,400.00 |
| B06C | Procs for Cerebral Palsy, Muscular Dystrophy, Neuropathy, Sameday | \$1,633.30 | 1 | 1 | N/A |
| B07A | Cranial or Peripheral Nerve and Other Nervous System Procedures W CC | \$12,263.60 | 26 | 4 | \$898.70 |
| B07B | Cranial or Peripheral Nerve and Other Nervous System Procedures W/O CC | \$2,754.60 | 4 | 0 | \$1,304.40 |
| B40Z | Plasmapheresis W Neurological Disease, Sameday | \$172.10 | 1 | 1 | N/A |
| B41Z | Telemetric EEG Monitoring | \$1,477.90 | 7 | 1 | \$430.90 |
| B42A | Nervous System Disorders W Ventilator Support W Catastrophic CC | \$10,951.50 | 25 | 4 | \$898.40 |
| B60A | Acute Paraplegia/Quadriplegia W or W/O OR Procs W Catastrophic CC | \$20,947.60 | 35 | 9 | \$794.70 |
| B60B | Acute Paraplegia/Quadriplegia W or W/O OR Procs W/O Catastrophic CC | \$3,789.20 | 12 | 2 | \$669.40 |
| B61A | Spinal Cord Conditions W or W/O OR Procedures W Catastrophic or Severe CC | \$15,585.50 | 33 | 5 | \$908.20 |
| B61B | Spinal Cord Conditions W or W/O OR Procedures W/O Catastrophic or Severe CC | \$4,111.50 | 7 | 1 | \$944.60 |
| B63Z | Dementia and Other Chronic Disturbances of Cerebral Function | \$6,050.40 | 18 | 3 | \$682.30 |
| B64A | Delirium W Catastrophic CC | \$11,511.60 | 32 | 5 | \$729.30 |
| B64B | Delirium W/O Catastrophic CC | \$5,083.60 | 14 | 2 | \$759.60 |
| B65A | Cerebral Palsy | \$2,306.10 | 9 | 1 | \$540.00 |
| B65B | Cerebral Palsy, Sameday | \$316.00 | 1 | 1 | N/A |
| B66A | Nervous System Neoplasms W Radiotherapy | \$11,435.50 | 35 | 6 | \$639.50 |
| B66B | Nervous System Neoplasms W/O Radiotherapy W Catastrophic or Severe CC | \$8,373.20 | 24 | 4 | \$720.90 |
| B66C | Nervous System Neoplasms W/O Radiotherapy W/O Catastrophic or Severe CC | \$2,967.30 | 9 | 1 | \$698.10 |
| B67A | Degenerative Nervous System Disorders W Catastrophic or Severe CC | \$12,838.30 | 33 | 6 | \$776.80 |
| B67B | Degenerative Nervous System Disorders W/O Catastrophic or Severe CC | \$6,447.80 | 17 | 3 | \$776.50 |
| B67C | Degenerative Nervous System Disorders, Sameday | \$323.30 | 1 | 1 | N/A |
| B68A | Multiple Sclerosis and Cerebellar Ataxia W CC | \$4,425.40 | 12 | 2 | \$738.30 |
| B68B | Multiple Sclerosis and Cerebellar Ataxia W/O CC | \$759.30 | 4 | 0 | \$548.90 |
| B69A | TIA and Precerebral Occlusion W Catastrophic or Severe CC | \$6,663.70 | 18 | 3 | \$766.50 |
| B69B | TIA and Precerebral Occlusion W/O Catastrophic or Severe CC | \$2,377.00 | 6 | 0 | \$798.30 |
| B70A | Stroke & Other Cerebrovascular Disorders W Catastrophic CC | \$14,869.00 | 35 | 6 | \$792.50 |
| B70B | Stroke & Other Cerebrovascular Disorders W Severe CC | \$4,320.10 | 12 | 2 | \$770.50 |
| B70C | Stroke & Other Cerebrovascular Disorders W/O Catastrophic or Severe CC | \$2,252.90 | 7 | 1 | \$723.50 |
| B70D | Stroke & Other Cerebrovascular Disorders, Died/Trans Acute Facility <5 Days | \$1,805.40 | 5 | 0 | \$837.70 |
| B71A | Cranial and Peripheral Nerve Disorders W CC | \$9,207.60 | 24 | 4 | \$772.50 |
| B71B | Cranial and Peripheral Nerve Disorders W/O CC | \$4,684.10 | 13 | 2 | \$743.20 |
| B71C | Cranial and Peripheral Nerve Disorders, Sameday | \$478.70 | 1 | 1 | N/A |
| B72A | Nervous System Infection Except Viral Meningitis W Cat or Sev CC | \$10,735.60 | 28 | 5 | \$778.20 |
| B72B | Nervous System Infection Except Viral Meningitis W/O Cat or Sev CC | \$2,831.70 | 8 | 1 | \$759.10 |
| B73Z | Viral Meningitis | \$3,024.70 | 8 | 1 | \$831.00 |
| B74A | Nontraumatic Stupor and Coma W Catastrophic or Severe CC | \$5,672.90 | 16 | 3 | \$714.50 |
| B74B | Nontraumatic Stupor and Coma W/O Catastrophic or Severe CC | \$1,414.30 | 4 | 0 | \$841.20 |

| Item no. | Description | Max fee (ex GST) | Upper trim point days | Lower trim point days | Max per day rate (ex GST) |
|----------|--|---------------------|--------------------------|--------------------------|------------------------------|
| B75Z | Febrile Convulsions | \$1,627.10 | 4 | 0 | \$1,291.30 |
| B76A | Seizures W Catastrophic or Severe CC | \$6,198.50 | 17 | 3 | \$749.50 |
| B76B | Seizures W/O Catastrophic or Severe CC | \$3,251.00 | 9 | 1 | \$804.70 |
| B76C | Seizures, Sameday | \$564.30 | 1 | 1 | N/A |
| B77Z | Headache | \$2,212.20 | 6 | 0 | \$737.30 |
| B78A | Intracranial Injuries W Catastrophic or Severe CC | \$13,466.20 | 30 | 5 | \$903.80 |
| B78B | Intracranial Injuries W/O Catastrophic or Severe CC | \$4,987.60 | 13 | 2 | \$808.40 |
| B78C | Intracranial Injuries, Died or Transferred to Acute Facility <5 Days | \$2,560.60 | 5 | 0 | \$1,237.20 |
| B79A | Skull Fractures W Catastrophic or Severe CC | \$8,113.50 | 19 | 3 | \$893.50 |
| B79B | Skull Fractures W/O Catastrophic or Severe CC | \$2,398.90 | 7 | 1 | \$699.40 |
| B80A | Other Head Injuries W Catastrophic or Severe CC | \$6,044.20 | 17 | 3 | \$738.00 |
| B80B | Other Head Injuries W/O Catastrophic or Severe CC | \$1,926.40 | 8 | 1 | \$542.50 |
| B81A | Other Disorders of the Nervous System W Catastrophic or Severe CC | \$6,945.30 | 20 | 3 | \$706.20 |
| B81B | Other Disorders of the Nervous System W/O Catastrophic or Severe CC | \$1,351.70 | 5 | 0 | \$590.70 |
| B82A | Chronic and Unspec Para/Quadriplegia W or W/O OR Proc W Skin Graft/Flap Repair | \$13,283.60 | 35 | 11 | \$369.30 |
| B82B | Chronic and Unspec Para/Quadriplegia W or W/O OR Proc W Cat CC | \$21,550.50 | 35 | 9 | \$798.70 |
| B82C | Chronic and Unspec Para/Quadriplegia W or W/O OR Proc W/O Cat CC | \$3,411.70 | 9 | 1 | \$740.40 |
| C01Z | Procedures for Penetrating Eye Injury | \$2,465.70 | 4 | 0 | \$931.80 |
| C02Z | Enucleations and Orbital Procedures | \$3,239.60 | 4 | 0 | \$1,400.00 |
| C03Z | Retinal Procedures | \$1,445.60 | 4 | 0 | \$908.90 |
| C04Z | Major Corneal, Scleral and Conjunctival Procedures | \$3,113.40 | 4 | 0 | \$1,400.00 |
| C05Z | Dacryocystorhinostomy | \$2,421.80 | 4 | 0 | \$1,369.80 |
| C10Z | Strabismus Procedures | \$1,780.40 | 4 | 0 | \$970.30 |
| C11Z | Eyelid Procedures | \$1,872.20 | 4 | 0 | \$983.50 |
| C12Z | Other Corneal, Scleral and Conjunctival Procedures | \$1,351.70 | 4 | 0 | \$824.50 |
| C13Z | Lacrimal Procedures | \$1,004.40 | 4 | 0 | \$599.00 |
| C14Z | Other Eye Procedures | \$1,226.60 | 4 | 0 | \$641.70 |
| C15Z | Glaucoma and Complex Cataract Procedures | \$1,923.30 | 4 | 0 | \$1,237.50 |
| C16Z | Lens Procedures | \$1,833.60 | 4 | 0 | \$1,325.00 |
| C60A | Acute and Major Eye Infections W CC | \$6,622.00 | 18 | 3 | \$748.20 |
| C60B | Acute and Major Eye Infections W/O CC | \$4,121.90 | 10 | 2 | \$851.70 |
| C61A | Neurological and Vascular Disorders of the Eye W CC | \$1,660.50 | 6 | 0 | \$626.40 |
| C61B | Neurological and Vascular Disorders of the Eye W/O CC | \$2,075.60 | 6 | 0 | \$786.40 |
| C62A | Hyphaema and Medically Managed Trauma to the Eye, W CC | \$3,658.80 | 11 | 2 | \$721.70 |
| C62B | Hyphaema and Medically Managed Trauma to the Eye W/O CC | \$2,011.90 | 5 | 0 | \$830.50 |
| C63A | Other Disorders of the Eye W CC | \$2,768.10 | 8 | 1 | \$696.90 |
| C63B | Other Disorders of the Eye W/O CC | \$915.80 | 4 | 0 | \$510.90 |
| D01Z | Cochlear Implant | \$5,459.10 | 4 | 0 | \$1,400.00 |
| D02A | Head and Neck Procedures W Microvascular Tissue Transfer or W Cat/Sev CC | \$14,070.10 | 14 | 2 | \$1,400.00 |
| D02B | Head and Neck Procedures W Malignancy or W Mod CC | \$6,167.30 | 6 | 0 | \$1,400.00 |
| D02C | Head and Neck Procedures W/O Malignancy W/O CC | \$3,340.70 | 4 | 0 | \$1,400.00 |
| D03Z | Surgical Repair for Cleft Lip and Palate Disorders | \$3,592.10 | 4 | 0 | \$1,400.00 |
| D04Z | Maxillo Surgery | \$3,392.90 | 4 | 0 | \$1,400.00 |
| D05Z | Parotid Gland Procedures | \$5,065.90 | 4 | 0 | \$1,400.00 |
| D06Z | Sinus and Complex Middle Ear Procedures | \$2,919.40 | 4 | 0 | \$1,400.00 |
| D10Z | Nasal Procedures | \$2,477.10 | 4 | 0 | \$1,400.00 |
| D11Z | Tonsillectomy and/or Adenoidectomy | \$1,756.40 | 4 | 0 | \$1,333.30 |

| Item no. | Description | Max fee (ex GST) | Upper trim point days | Lower trim point days | Max per day rate (ex GST) |
|----------|---|---------------------|--------------------------|--------------------------|------------------------------|
| D12A | Other Ear, Nose, Mouth and Throat Procedures W CC | \$3,376.20 | 5 | 0 | \$1,118.60 |
| D12B | Other Ear, Nose, Mouth and Throat Procedures W/O CC | \$2,033.90 | 4 | 0 | \$1,197.20 |
| D13Z | Myringotomy W Tube Insertion | \$1,136.90 | 4 | 0 | \$793.10 |
| D14A | Mouth and Salivary Gland Procedures W CC | \$2,399.90 | 4 | 0 | \$1,113.10 |
| D14B | Mouth and Salivary Gland Procedures W/O CC | \$1,518.60 | 4 | 0 | \$1,019.20 |
| D15Z | Mastoid Procedures | \$3,899.80 | 4 | 0 | \$1,400.00 |
| D40Z | Dental Extractions and Restorations | \$1,050.30 | 4 | 0 | \$911.00 |
| D60A | Ear, Nose, Mouth and Throat Malignancy W Catastrophic or Severe CC | \$11,185.10 | 30 | 5 | \$769.30 |
| D60B | Ear, Nose, Mouth and Throat Malignancy W/O Catastrophic or Severe CC | \$3,774.60 | 10 | 2 | \$697.60 |
| D60C | Ear, Nose, Mouth and Throat Malignancy, Sameday | \$1,106.60 | 1 | 1 | N/A |
| D61A | Dysequilibrium W CC | \$4,881.20 | 14 | 2 | \$696.50 |
| D61B | Dysequilibrium W/O CC | \$2,921.40 | 8 | 1 | \$816.30 |
| D61C | Dysequilibrium, Sameday | \$528.80 | 1 | 1 | N/A |
| D62A | Epistaxis | \$2,535.50 | 7 | 1 | \$729.50 |
| D62B | Epistaxis, Sameday | \$978.30 | 1 | 1 | N/A |
| D63A | Otitis Media and Upper Respiratory Infections W CC | \$5,249.40 | 14 | 2 | \$771.30 |
| D63B | Otitis Media and Upper Respiratory Infections W/O CC | \$2,533.40 | 7 | 1 | \$792.40 |
| D63C | Otitis Media and Upper Respiratory Infections, Sameday | \$748.90 | 1 | 1 | N/A |
| D64Z | Laryngotracheitis and Epiglottitis | \$1,528.00 | 4 | 0 | \$920.90 |
| D65Z | Nasal Trauma and Deformity | \$1,650.00 | 4 | 0 | \$654.60 |
| D66A | Other Ear, Nose, Mouth and Throat Disorders W CC | \$3,458.60 | 10 | 2 | \$722.50 |
| D66B | Other Ear, Nose, Mouth and Throat Disorders W/O CC | \$914.70 | 4 | 0 | \$707.30 |
| D66C | Other Ear, Nose, Mouth and Throat Disorders, Sameday | \$822.90 | 1 | 1 | N/A |
| D67A | Oral and Dental Disorders | \$3,436.70 | 10 | 2 | \$741.10 |
| D67B | Oral and Dental Disorders, Sameday | \$839.60 | 1 | 1 | N/A |
| E01A | Major Chest Procedures W Catastrophic CC | \$19,861.80 | 27 | 4 | \$1,400.00 |
| E01B | Major Chest Procedures W/O Catastrophic CC | \$11,381.20 | 14 | 2 | \$1,400.00 |
| E02A | Other Respiratory System OR Procedures W Catastrophic CC | \$15,191.30 | 26 | 4 | \$1,123.40 |
| E02B | Other Respiratory System OR Procedures W Severe or Moderate CC | \$5,740.70 | 8 | 1 | \$1,400.00 |
| E02C | Other Respiratory System OR Procedures W/O CC | \$2,388.50 | 4 | 0 | \$1,400.00 |
| E40A | Respiratory System Disorders W Ventilator Support | \$22,705.10 | 28 | 5 | \$1,400.00 |
| E40B | Respiratory System Disorders W Vent Supp, Died/Trans Acute Facility <5 Days | \$13,605.90 | 6 | 0 | \$1,400.00 |
| E41A | Respiratory System Disorders W Non-Invasive Ventilation W Catastrophic CC | \$18,121.10 | 30 | 5 | \$1,215.30 |
| E41B | Respiratory System Disorders W Non-Invasive Ventilation W/O Catastrophic CC | \$12,983.30 | 19 | 3 | \$1,381.20 |
| E42A | Bronchoscopy W Catastrophic CC | \$11,804.70 | 31 | 5 | \$745.00 |
| E42B | Bronchoscopy W/O Catastrophic CC | \$5,803.30 | 12 | 2 | \$931.90 |
| E42C | Bronchoscopy, Sameday | \$1,198.40 | 1 | 1 | N/A |
| E60B | Cystic Fibrosis W/O Catastrophic or Severe CC | \$1,022.10 | 14 | 2 | \$147.50 |
| E61A | Pulmonary Embolism W Catastrophic CC | \$9,124.20 | 26 | 4 | \$718.20 |
| E61B | Pulmonary Embolism W/O Catastrophic CC | \$4,365.00 | 10 | 2 | \$909.00 |
| E62A | Respiratory Infections/Inflammations W Catastrophic CC | \$9,364.10 | 24 | 4 | \$795.50 |
| E62B | Respiratory Infections/Inflammations W Severe or Moderate CC | \$5,697.90 | 14 | 2 | \$817.70 |
| E62C | Respiratory Infections/Inflammations W/O CC | \$3,651.50 | 9 | 2 | \$809.60 |
| E63Z | Sleep Apnoea | \$630.00 | 4 | 0 | \$613.70 |
| E64A | Pulmonary Oedema and Respiratory Failure | \$6,330.00 | 17 | 3 | \$777.20 |
| E64B | Pulmonary Oedema and Respiratory Failure, Died/Trans Acute Facility <5 Days | \$2,228.90 | 4 | 0 | \$1,137.20 |
| E65A | Chronic Obstructive Airways Disease W Catastrophic CC | \$9,130.40 | 25 | 4 | \$733.80 |

| Item no. | Description | Max fee (ex GST) | Upper trim point days | Lower trim point days | Max per day rate (ex GST) |
|----------|--|---------------------|--------------------------|--------------------------|------------------------------|
| E65B | Chronic Obstructive Airways Disease W/O Catastrophic CC | \$4,472.40 | 12 | 2 | \$770.40 |
| E66A | Major Chest Trauma W Catastrophic CC | \$12,557.70 | 33 | 5 | \$762.50 |
| E66B | Major Chest Trauma W Severe or Moderate CC | \$5,249.40 | 14 | 2 | \$758.50 |
| E66C | Major Chest Trauma W/O CC | \$2,842.20 | 9 | 1 | \$707.00 |
| E67A | Respiratory Signs and Symptoms | \$4,317.00 | 11 | 2 | \$766.10 |
| E67B | Respiratory Signs and Symptoms, <2 Days | \$1,727.20 | 4 | 0 | \$1,199.00 |
| E68A | Pneumothorax W Catastrophic or Severe CC | \$6,625.10 | 19 | 3 | \$718.50 |
| E68B | Pneumothorax W/O Catastrophic or Severe CC | \$2,945.40 | 8 | 1 | \$836.60 |
| E69A | Bronchitis and Asthma W CC | \$5,321.40 | 13 | 2 | \$843.10 |
| E69B | Bronchitis and Asthma W/O CC | \$2,301.90 | 6 | 0 | \$774.70 |
| E70A | Whooping Cough and Acute Bronchiolitis W CC | \$5,254.60 | 11 | 2 | \$1,024.40 |
| E70B | Whooping Cough and Acute Bronchiolitis W/O CC | \$2,950.60 | 5 | 0 | \$1,266.50 |
| E71A | Respiratory Neoplasms W Catastrophic CC | \$9,035.50 | 25 | 4 | \$743.20 |
| E71B | Respiratory Neoplasms W/O Catastrophic CC | \$4,978.20 | 14 | 2 | \$714.50 |
| E71C | Respiratory Neoplasms, Sameday | \$700.90 | 1 | 1 | N/A |
| E72Z | Respiratory Problems Arising from Neonatal Period | \$1,125.40 | 4 | 0 | \$642.90 |
| E73A | Pleural Effusion W Catastrophic CC | \$8,425.40 | 22 | 4 | \$758.80 |
| E73B | Pleural Effusion W Severe or Moderate CC | \$4,290.90 | 11 | 2 | \$790.00 |
| E73C | Pleural Effusion W/O CC | \$2,367.60 | 6 | 0 | \$829.60 |
| E74A | Interstitial Lung Disease W Catastrophic CC | \$9,804.20 | 26 | 4 | \$769.50 |
| E74B | Interstitial Lung Disease W Severe or Moderate CC | \$5,720.90 | 15 | 2 | \$760.40 |
| E74C | Interstitial Lung Disease W/O CC | \$2,461.50 | 8 | 1 | \$679.50 |
| E75A | Other Respiratory System Disorders W CC | \$6,368.60 | 17 | 3 | \$773.20 |
| E75B | Other Respiratory System Disorders W/O CC | \$2,856.80 | 8 | 1 | \$791.10 |
| F01A | Implantation or Replacement of AICD, Total System W Catastrophic CC | \$17,766.50 | 21 | 3 | \$1,400.00 |
| F01B | Implantation or Replacement of AICD, Total System W/O Catastrophic CC | \$8,793.50 | 5 | 0 | \$1,400.00 |
| F02Z | Other AICD Procedures | \$8,153.10 | 6 | 0 | \$1,400.00 |
| F03A | Cardiac Valve Procs W CPB Pump W Invasive Cardiac Inves W Cat CC | \$41,748.20 | 35 | 6 | \$1,400.00 |
| F03B | Cardiac Valve Procs W CPB Pump W Invasive Cardiac Inves W/O Cat CC | \$34,394.00 | 24 | 4 | \$1,400.00 |
| F04A | Cardiac Valve Procs W CPB Pump W/O Invasive Cardiac Inves W Cat CC | \$33,621.10 | 25 | 4 | \$1,400.00 |
| F04B | Cardiac Valve Procs W CPB Pump W/O Invasive Cardiac Inves W/O Cat CC | \$25,423.10 | 18 | 3 | \$1,400.00 |
| F05A | Coronary Bypass W Invasive Cardiac Investigation W Catastrophic CC | \$38,158.20 | 31 | 5 | \$1,400.00 |
| F05B | Coronary Bypass W Invasive Cardiac Investigation W/O Catastrophic CC | \$29,623.30 | 24 | 4 | \$1,400.00 |
| F06A | Coronary Bypass W/O Invasive Cardiac Investigation W Catastrophic CC | \$29,466.80 | 24 | 4 | \$1,400.00 |
| F06B | Coronary Bypass W/O Invasive Cardiac Investigation W/O Catastrophic CC | \$25,031.00 | 19 | 3 | \$1,400.00 |
| F07A | Other Cardiothoracic/Vascular Procedures W CPB Pump W Catastrophic CC | \$32,110.80 | 25 | 4 | \$1,400.00 |
| F07B | Other Cardiothoracic/Vascular Procedures W CPB Pump W/O Catastrophic CC | \$25,943.60 | 19 | 3 | \$1,400.00 |
| F08A | Major Reconstructive Vascular Procedures W/O CPB Pump W Cat CC | \$26,429.60 | 28 | 5 | \$1,400.00 |
| F08B | Major Reconstructive Vascular Procedures W/O CPB Pump W/O Cat CC | \$12,696.40 | 11 | 2 | \$1,400.00 |
| F09A | Other Cardiothoracic Procs W/O CPB Pump W Catastrophic CC | \$23,641.70 | 23 | 4 | \$1,400.00 |
| F09B | Other Cardiothoracic Procs W/O CPB Pump W/O Catastrophic CC | \$10,163.00 | 7 | 1 | \$1,400.00 |
| F09C | Other Cardiothoracic Procs W/O CPB Pump, Died/Trans Acute Facility <5 Days | \$5,085.70 | 4 | 0 | \$1,400.00 |

| Item no. | Description | Max fee (ex GST) | Upper trim point days | Lower trim point days | Max per day rate (ex GST) |
|----------|---|---------------------|--------------------------|--------------------------|------------------------------|
| F10A | Interventional Coronary Procedures Admitted for AMI W Catastrophic CC | \$16,397.00 | 19 | 3 | \$1,357.60 |
| F10B | Interventional Coronary Procedures Admitted for AMI W/O Catastrophic CC | \$11,147.60 | 7 | 1 | \$1,400.00 |
| F11A | Amputation, Except Upper Limb and Toe, for Circulatory Disorders W Cat CC | \$39,101.00 | 35 | 13 | \$923.50 |
| F11B | Amputation, Except Upper Limb and Toe, for Circulatory Disorders W/O Cat CC | \$17,189.70 | 32 | 5 | \$1,025.60 |
| F12A | Implantation or Replacement of Pacemaker, Total System W Catastrophic CC | \$13,894.80 | 23 | 4 | \$1,101.90 |
| F12B | Implantation or Replacement of Pacemaker, Total System W/O Catastrophic CC | \$6,901.50 | 6 | 0 | \$1,400.00 |
| F13A | Amputation, Upper Limb and Toe, for Circulatory Disorders W Cat or Sev CC | \$16,046.60 | 34 | 6 | \$865.20 |
| F13B | Amputation, Upper Limb and Toe, for Circulatory Disorders W/O Cat or Sev CC | \$9,660.30 | 16 | 3 | \$1,105.10 |
| F14A | Vascular Procs, Except Major Reconstruction, W/O CPB Pump W Cat CC | \$17,919.80 | 23 | 4 | \$1,400.00 |
| F14B | Vascular Procs, Except Major Reconstruction, W/O CPB Pump W Sev or Mod CC | \$8,128.10 | 6 | 0 | \$1,400.00 |
| F14C | Vascular Procs, Except Major Reconstruction, W/O CPB Pump W/O CC | \$6,004.60 | 4 | 0 | \$1,400.00 |
| F15A | Interventional Coronary Procs, Not Adm for AMI W Stent Implant W Cat/Sev CC | \$12,026.80 | 8 | 1 | \$1,400.00 |
| F15B | Interventional Coronary Procs, Not Adm for AMI W Stent Implant W/O Cat/Sev CC | \$10,294.40 | 4 | 0 | \$1,400.00 |
| F16A | Interventional Coronary Procs, Not Adm for AMI W/O Stent Implant W CC | \$10,114.00 | 7 | 1 | \$1,400.00 |
| F16B | Interventional Coronary Procs, Not Adm for AMI W/O Stent Implant W/O CC | \$7,727.60 | 4 | 0 | \$1,400.00 |
| F17Z | Insertion or Replacement of Pacemaker Generator | \$3,565.00 | 4 | 0 | \$1,400.00 |
| F18A | Other Pacemaker Procedures W CC | \$9,476.70 | 15 | 2 | \$1,109.00 |
| F18B | Other Pacemaker Procedures W/O CC | \$4,732.10 | 4 | 0 | \$1,400.00 |
| F19A | Trans-Vascular Percutaneous Cardiac Intervention, Age >=80 or W CC | \$11,868.30 | 13 | 2 | \$1,400.00 |
| F19B | Trans-Vascular Percutaneous Cardiac Intervention, Age <80 W/O CC | \$6,678.30 | 4 | 0 | \$1,400.00 |
| F20Z | Vein Ligation and Stripping | \$3,392.90 | 4 | 0 | \$1,400.00 |
| F21A | Other Circulatory System OR Procedures W Catastrophic CC | \$20,778.60 | 35 | 7 | \$904.30 |
| F21B | Other Circulatory System OR Procedures W/O Catastrophic CC | \$7,041.30 | 12 | 2 | \$1,046.60 |
| F40A | Circulatory Disorders W Ventilator Support | \$31,429.80 | 33 | 5 | \$1,400.00 |
| F40B | Circulatory Disorders W Ventilator Support, Died/Trans Acute Facility <5 Days | \$7,172.70 | 5 | 0 | \$1,400.00 |
| F41A | Circulatory Disorders, Adm for AMI W Invasive Cardiac Inves W Cat or Sev CC | \$9,665.50 | 15 | 2 | \$1,184.50 |
| F41B | Circulatory Disorders, Adm for AMI W Invasive Cardiac Inves W/O Cat or Sev CC | \$5,751.10 | 6 | 0 | \$1,400.00 |
| F42A | Circulatory Dsrds, Not Adm for AMI W Invasive Cardiac Inves W Cat/Sev CC | \$7,955.00 | 13 | 2 | \$1,061.90 |
| F42B | Circulatory Dsrds, Not Adm for AMI W Invasive Cardiac Inves W/O Cat/Sev CC | \$5,290.10 | 4 | 0 | \$1,400.00 |
| F42C | Circulatory Dsrds, Not Adm for AMI W Invasive Cardiac Inves, Sameday | \$3,365.80 | 1 | 1 | N/A |
| F43Z | Circulatory Disorders W Non-Invasive Ventilation | \$16,367.80 | 29 | 5 | \$1,153.50 |
| F60A | Circulatory Dsrds, Adm for AMI W/O Invasive Cardiac Inves | \$4,031.20 | 11 | 2 | \$769.20 |
| F60B | Circulatory Dsrds, Adm for AMI W/O Invas Card Inves, Died/Trans Ac Fac <5 Days | \$1,958.80 | 4 | 0 | \$1,306.00 |
| F61A | Infective Endocarditis W Catastrophic CC | \$14,199.40 | 35 | 7 | \$671.20 |
| F61B | Infective Endocarditis W/O Catastrophic CC | \$9,613.30 | 27 | 4 | \$725.40 |
| F62A | Heart Failure and Shock W Catastrophic CC | \$10,831.60 | 27 | 4 | \$805.10 |
| F62B | Heart Failure and Shock W/O Catastrophic CC | \$5,848.10 | 14 | 2 | \$867.90 |

| Item no. | Description | Max fee (ex GST) | Upper trim point days | Lower trim point days | Max per day rate (ex GST) |
|----------|---|---------------------|--------------------------|--------------------------|------------------------------|
| F62C | Heart Failure and Shock, Died or Transferred to Acute Facility <5 Days | \$3,605.70 | 5 | 0 | \$1,400.00 |
| F63A | Venous Thrombosis W Catastrophic or Severe CC | \$6,252.80 | 17 | 3 | \$734.90 |
| F63B | Venous Thrombosis W/O Catastrophic or Severe CC | \$2,737.90 | 7 | 1 | \$804.80 |
| F64A | Skin Ulcers in Circulatory Disorders W Catastrophic or Severe CC | \$11,742.10 | 35 | 6 | \$678.70 |
| F64B | Skin Ulcers in Circulatory Disorders W/O Catastrophic or Severe CC | \$5,114.90 | 14 | 2 | \$737.40 |
| F65A | Peripheral Vascular Disorders W Catastrophic or Severe CC | \$7,839.20 | 21 | 3 | \$771.50 |
| F65B | Peripheral Vascular Disorders W/O Catastrophic or Severe CC | \$1,956.70 | 5 | 0 | \$756.70 |
| F66A | Coronary Atherosclerosis W Catastrophic or Severe CC | \$4,501.60 | 13 | 2 | \$706.80 |
| F66B | Coronary Atherosclerosis W/O Catastrophic or Severe CC | \$927.20 | 4 | 0 | \$547.60 |
| F67A | Hypertension W Catastrophic or Severe CC | \$6,008.70 | 16 | 3 | \$778.60 |
| F67B | Hypertension W/O Catastrophic or Severe CC | \$2,895.40 | 8 | 1 | \$791.00 |
| F68Z | Congenital Heart Disease | \$932.40 | 4 | 0 | \$683.90 |
| F69A | Valvular Disorders W Catastrophic or Severe CC | \$5,854.40 | 16 | 3 | \$769.00 |
| F69B | Valvular Disorders W/O Catastrophic or Severe CC | \$1,549.90 | 5 | 0 | \$662.20 |
| F72A | Unstable Angina W Catastrophic or Severe CC | \$6,024.40 | 15 | 2 | \$809.70 |
| F72B | Unstable Angina W/O Catastrophic or Severe CC | \$1,884.70 | 5 | 0 | \$861.00 |
| F73A | Syncope and Collapse W Catastrophic or Severe CC | \$6,963.10 | 18 | 3 | \$778.40 |
| F73B | Syncope and Collapse W/O Catastrophic or Severe CC | \$3,235.40 | 8 | 1 | \$805.50 |
| F73C | Syncope and Collapse, Sameday | \$1,319.40 | 1 | 1 | N/A |
| F74A | Chest Pain | \$2,998.60 | 8 | 1 | \$780.20 |
| F74B | Chest Pain, <2 Days | \$1,088.90 | 4 | 0 | \$1,072.00 |
| F75A | Other Circulatory Disorders W Catastrophic CC | \$9,954.40 | 23 | 4 | \$890.60 |
| F75B | Other Circulatory Disorders W Severe or Moderate CC | \$4,467.20 | 10 | 2 | \$945.20 |
| F75C | Other Circulatory Disorders W/O CC | \$1,935.80 | 5 | 0 | \$854.30 |
| F76A | Arrhythmia, Cardiac Arrest and Conduction Disorders W Cat or Sev CC | \$6,927.60 | 17 | 3 | \$849.40 |
| F76B | Arrhythmia, Cardiac Arrest and Conduction Disorders W/O Cat or Sev CC | \$2,952.70 | 6 | 0 | \$1,030.30 |
| F76C | Arrhythmia, Cardiac Arrest and Conduction Disorders, Sameday | \$712.40 | 1 | 1 | N/A |
| G01A | Rectal Resection W Catastrophic CC | \$22,027.10 | 32 | 5 | \$1,320.30 |
| G01B | Rectal Resection W/O Catastrophic CC | \$12,395.00 | 15 | 2 | \$1,400.00 |
| G02A | Major Small and Large Bowel Procedures W Catastrophic CC | \$21,136.40 | 30 | 5 | \$1,356.20 |
| G02B | Major Small and Large Bowel Procedures W/O Catastrophic CC | \$8,728.90 | 11 | 2 | \$1,400.00 |
| G03A | Stomach, Oesophageal and Duodenal Procedures W Malignancy or W Cat CC | \$21,299.10 | 26 | 4 | \$1,400.00 |
| G03B | Stomach, Oesophageal and Duodenal Procedures W/O Malignancy W Sev or Mod CC | \$9,584.10 | 8 | 1 | \$1,400.00 |
| G03C | Stomach, Oesophageal and Duodenal Procedures W/O Malignancy W/O CC | \$5,696.90 | 5 | 0 | \$1,400.00 |
| G04A | Peritoneal Adhesiolysis W Catastrophic CC | \$17,490.10 | 27 | 4 | \$1,237.80 |
| G04B | Peritoneal Adhesiolysis W Severe or Moderate CC | \$9,623.80 | 11 | 2 | \$1,400.00 |
| G04C | Peritoneal Adhesiolysis W/O CC | \$5,259.80 | 6 | 0 | \$1,400.00 |
| G05A | Minor Small and Large Bowel Procedures W Catastrophic CC | \$12,395.00 | 22 | 4 | \$1,080.60 |
| G05B | Minor Small and Large Bowel Procedures W Severe or Moderate CC | \$8,178.20 | 14 | 2 | \$1,099.90 |
| G05C | Minor Small and Large Bowel Procedures W/O CC | \$5,174.30 | 9 | 1 | \$1,121.80 |
| G07A | Appendicectomy W Malignancy or Peritonitis or W Catastrophic or Severe CC | \$5,147.20 | 7 | 1 | \$1,400.00 |
| G07B | Appendicectomy W/O Malignancy or Peritonitis W/O Cat or Sev CC | \$3,733.90 | 4 | 0 | \$1,400.00 |
| G10A | Hernia Procedures W CC | \$4,719.60 | 7 | 1 | \$1,308.00 |
| G10B | Hernia Procedures W/O CC | \$2,802.50 | 4 | 0 | \$1,400.00 |
| G11Z | Anal and Stomal Procedures | \$1,944.20 | 4 | 0 | \$1,018.30 |

| Item no. | Description | Max fee (ex GST) | Upper trim point days | Lower trim point days | Max per day rate (ex GST) |
|----------|--|---------------------|--------------------------|--------------------------|------------------------------|
| G12A | Other Digestive System OR Procedures W Catastrophic CC | \$13,871.90 | 29 | 5 | \$931.80 |
| G12B | Other Digestive System OR Procedures W Severe or Moderate CC | \$5,852.30 | 8 | 1 | \$1,365.20 |
| G12C | Other Digestive System OR Procedures W/O CC | \$3,237.50 | 5 | 0 | \$1,276.30 |
| G46A | Complex Endoscopy W Catastrophic CC | \$11,250.80 | 29 | 5 | \$783.50 |
| G46B | Complex Endoscopy W/O Catastrophic CC | \$3,494.10 | 6 | 0 | \$1,146.20 |
| G46C | Complex Endoscopy, Sameday | \$936.60 | 1 | 1 | N/A |
| G47A | Gastroscopy W Catastrophic CC | \$9,123.10 | 26 | 4 | \$698.00 |
| G47B | Gastroscopy W/O Catastrophic CC | \$3,591.00 | 7 | 1 | \$992.30 |
| G47C | Gastroscopy, Sameday | \$646.70 | 1 | 1 | N/A |
| G48A | Colonoscopy W Catastrophic or Severe CC | \$6,955.80 | 16 | 3 | \$892.10 |
| G48B | Colonoscopy W/O Catastrophic or Severe CC | \$2,339.40 | 5 | 0 | \$1,072.10 |
| G48C | Colonoscopy, Sameday | \$858.40 | 1 | 1 | N/A |
| G60A | Digestive Malignancy W Catastrophic CC | \$8,524.40 | 25 | 4 | \$678.30 |
| G60B | Digestive Malignancy W/O Catastrophic CC | \$3,272.90 | 9 | 2 | \$714.90 |
| G61A | Gastrointestinal Haemorrhage W Catastrophic or Severe CC | \$6,179.80 | 17 | 3 | \$731.10 |
| G61B | Gastrointestinal Haemorrhage W/O Catastrophic or Severe CC | \$2,383.30 | 6 | 0 | \$812.10 |
| G64A | Inflammatory Bowel Disease W CC | \$3,065.40 | 9 | 1 | \$745.70 |
| G64B | Inflammatory Bowel Disease W/O CC | \$514.20 | 4 | 0 | \$461.80 |
| G65A | Gastrointestinal Obstruction W Catastrophic or Severe CC | \$7,052.80 | 19 | 3 | \$755.00 |
| G65B | Gastrointestinal Obstruction W/O Catastrophic or Severe CC | \$2,928.70 | 8 | 1 | \$798.40 |
| G66A | Abdominal Pain and Mesenteric Adenitis | \$2,203.90 | 6 | 0 | \$740.80 |
| G66B | Abdominal Pain and Mesenteric Adenitis, Sameday | \$528.80 | 1 | 1 | N/A |
| G67A | Oesophagitis and Gastroenteritis W Catastrophic or Severe CC | \$5,787.60 | 15 | 2 | \$809.60 |
| G67B | Oesophagitis and Gastroenteritis W/O Catastrophic or Severe CC | \$2,203.90 | 6 | 0 | \$789.50 |
| G70A | Other Digestive System Disorders W Catastrophic or Severe CC | \$6,433.20 | 18 | 3 | \$736.50 |
| G70B | Other Digestive System Disorders W/O Catastrophic or Severe CC | \$2,767.10 | 8 | 1 | \$770.20 |
| G70C | Other Digestive System Disorders, Sameday | \$690.50 | 1 | 1 | N/A |
| H01A | Pancreas, Liver and Shunt Procedures W Catastrophic CC | \$27,060.60 | 31 | 5 | \$1,400.00 |
| H01B | Pancreas, Liver and Shunt Procedures W/O Catastrophic CC | \$13,409.90 | 13 | 2 | \$1,400.00 |
| H02A | Major Biliary Tract Procedures W Catastrophic CC | \$19,624.00 | 33 | 5 | \$1,143.20 |
| H02B | Major Biliary Tract Procedures W/O Catastrophic CC | \$8,476.50 | 11 | 2 | \$1,400.00 |
| H05A | Hepatobiliary Diagnostic Procedures W Catastrophic CC | \$11,652.40 | 19 | 3 | \$1,150.90 |
| H05B | Hepatobiliary Diagnostic Procedures W/O Catastrophic CC | \$3,536.80 | 4 | 0 | \$1,400.00 |
| H06A | Other Hepatobiliary and Pancreas OR Procedures W Catastrophic CC | \$12,448.20 | 22 | 4 | \$1,067.50 |
| H06B | Other Hepatobiliary and Pancreas OR Procedures W/O Catastrophic CC | \$5,768.80 | 4 | 0 | \$1,400.00 |
| H07A | Open Cholecystectomy W Closed CDE or W Catastrophic CC | \$15,000.40 | 26 | 4 | \$1,117.00 |
| H07B | Open Cholecystectomy W/O Closed CDE W/O Catastrophic CC | \$7,718.20 | 10 | 2 | \$1,388.90 |
| H08A | Laparoscopic Cholecystectomy W Closed CDE or W Cat or Sev CC | \$7,454.30 | 9 | 1 | \$1,400.00 |
| H08B | Laparoscopic Cholecystectomy W/O Closed CDE W/O Cat or Sev CC | \$4,125.10 | 4 | 0 | \$1,400.00 |
| H40B | Endoscopic Procedures for Bleeding Oesophageal Varices W/O Cat CC | \$3,568.10 | 6 | 0 | \$1,181.70 |
| H43A | ERCP Procedures W Catastrophic or Severe CC | \$9,017.80 | 18 | 3 | \$930.60 |
| H43B | ERCP Procedures W/O Catastrophic or Severe CC | \$3,871.60 | 6 | 0 | \$1,152.60 |
| H43C | ERCP Procedures, Sameday | \$2,217.40 | 1 | 1 | N/A |
| H60A | Cirrhosis and Alcoholic Hepatitis W Catastrophic CC | \$9,792.70 | 27 | 4 | \$737.50 |
| H60B | Cirrhosis and Alcoholic Hepatitis W/O Catastrophic CC | \$5,034.60 | 13 | 2 | \$802.80 |
| H60C | Cirrhosis and Alcoholic Hepatitis, Sameday | \$666.50 | 1 | 1 | N/A |
| H61A | Malignancy of Hepatobiliary System and Pancreas W Catastrophic CC | \$9,699.90 | 27 | 4 | \$717.30 |

| Item no. | Description | Max fee (ex GST) | Upper trim point days | Lower trim point days | Max per day rate (ex GST) |
|----------|---|---------------------|--------------------------|--------------------------|------------------------------|
| H61B | Malignancy of Hepatobiliary System and Pancreas W/O Catastrophic CC | \$5,113.80 | 14 | 2 | \$741.30 |
| H61C | Malignancy of Hepatobiliary System and Pancreas, Sameday | \$766.60 | 1 | 1 | N/A |
| H62A | Disorders of Pancreas, Except Malignancy W Catastrophic or Severe CC | \$7,752.60 | 17 | 3 | \$928.20 |
| H62B | Disorders of Pancreas, Except Malignancy W/O Catastrophic or Severe CC | \$2,306.10 | 6 | 0 | \$806.50 |
| H63A | Other Disorders of Liver W Catastrophic CC | \$9,475.70 | 26 | 4 | \$725.60 |
| H63B | Other Disorders of Liver W/O Catastrophic CC | \$3,991.60 | 10 | 2 | \$799.80 |
| H63C | Other Disorders of Liver, Sameday | \$764.50 | 1 | 1 | N/A |
| H64A | Disorders of the Biliary Tract W CC | \$6,777.40 | 18 | 3 | \$779.90 |
| H64B | Disorders of the Biliary Tract W/O CC | \$2,579.30 | 7 | 1 | \$749.40 |
| H64C | Disorders of the Biliary Tract, Sameday | \$696.70 | 1 | 1 | N/A |
| I01A | Bilateral and Multiple Major Joint Proc of Lower Limb W Revision or W Cat CC | \$21,490.00 | 34 | 6 | \$1,145.20 |
| I01B | Bilateral and Multiple Major Joint Proc of Lower Limb W/O Revision W/O Cat CC | \$13,851.00 | 13 | 2 | \$1,400.00 |
| I02A | Microvascular Tissue Transfers or (Skin Grafts W Cat or Sev CC), Excl Hand | \$24,676.30 | 35 | 7 | \$1,120.10 |
| I02B | Skin Grafts W/O Cat or Sev CC, Excluding Hand | \$5,215.00 | 7 | 1 | \$1,275.50 |
| I03A | Hip Replacement W Catastrophic CC | \$16,471.10 | 25 | 4 | \$1,274.60 |
| I03B | Hip Replacement W/O Catastrophic CC | \$10,930.60 | 11 | 2 | \$1,400.00 |
| I04A | Knee Replacement W Catastrophic or Severe CC | \$12,130.10 | 15 | 3 | \$1,400.00 |
| I04B | Knee Replacement W/O Catastrophic or Severe CC | \$10,034.70 | 10 | 2 | \$1,400.00 |
| I05A | Other Joint Replacement W Catastrophic or Severe CC | \$11,890.20 | 17 | 3 | \$1,270.90 |
| I05B | Other Joint Replacement W/O Catastrophic or Severe CC | \$7,618.10 | 8 | 1 | \$1,400.00 |
| I06Z | Spinal Fusion for Deformity | \$21,671.50 | 20 | 3 | \$1,400.00 |
| I07Z | Amputation | \$19,464.50 | 35 | 7 | \$919.10 |
| I08A | Other Hip and Femur Procedures W Catastrophic CC | \$18,216.00 | 35 | 6 | \$997.40 |
| I08B | Other Hip and Femur Procedures W/O Catastrophic CC | \$6,841.00 | 8 | 1 | \$1,400.00 |
| I09A | Spinal Fusion W Catastrophic CC | \$22,762.40 | 28 | 5 | \$1,400.00 |
| I09B | Spinal Fusion W/O Catastrophic CC | \$12,870.60 | 13 | 2 | \$1,400.00 |
| I10A | Other Back and Neck Procedures W Catastrophic or Severe CC | \$11,746.30 | 15 | 2 | \$1,371.10 |
| I10B | Other Back and Neck Procedures W/O Catastrophic or Severe CC | \$7,035.00 | 7 | 1 | \$1,400.00 |
| I11Z | Limb Lengthening Procedures | \$7,897.60 | 11 | 2 | \$1,265.20 |
| I12A | Misc Musculoskeletal Procs for Infect/Inflam of Bone/Joint W Cat CC | \$19,925.50 | 35 | 7 | \$858.70 |
| I12B | Misc Musculoskeletal Procs for Infect/Inflam of Bone/Joint W Sev or Mod CC | \$9,978.40 | 21 | 3 | \$911.00 |
| I12C | Misc Musculoskeletal Procs for Infect/Inflam of Bone/Joint W/O CC | \$4,380.60 | 7 | 1 | \$1,155.90 |
| I13A | Humerus, Tibia, Fibula and Ankle Procedures W CC | \$9,418.30 | 16 | 3 | \$1,128.50 |
| I13B | Humerus, Tibia, Fibula and Ankle Procedures W/O CC, Age >=17 | \$4,002.00 | 5 | 0 | \$1,400.00 |
| I13C | Humerus, Tibia, Fibula and Ankle Procedures W/O CC, Age <17 | \$3,368.90 | 4 | 0 | \$1,400.00 |
| I15Z | Cranio-Facial Surgery | \$9,527.80 | 11 | 2 | \$1,400.00 |
| I16Z | Other Shoulder Procedures | \$3,636.40 | 4 | 0 | \$1,400.00 |
| I17A | Maxillo-Facial Surgery W CC | \$6,302.80 | 7 | 1 | \$1,400.00 |
| I17B | Maxillo-Facial Surgery W/O CC | \$3,957.10 | 4 | 0 | \$1,400.00 |
| I18Z | Other Knee Procedures | \$2,032.80 | 4 | 0 | \$1,305.50 |
| I19A | Other Elbow and Forearm Procedures W CC | \$5,845.00 | 12 | 2 | \$928.30 |
| I19B | Other Elbow and Forearm Procedures W/O CC | \$3,080.00 | 4 | 0 | \$1,400.00 |
| I20Z | Other Foot Procedures | \$3,012.20 | 4 | 0 | \$1,400.00 |
| I21Z | Local Excision and Removal of Internal Fixation Devices of Hip and Femur | \$2,302.90 | 4 | 0 | \$1,230.70 |

| Item no. | Description | Max fee (ex GST) | Upper trim point days | Lower trim point days | Max per day rate (ex GST) |
|----------|---|------------------|-----------------------|-----------------------|---------------------------|
| I23Z | Local Excision and Removal of Internal Fixation Devices, Except Hip and Femur | \$1,715.70 | 4 | 0 | \$1,006.10 |
| I24Z | Arthroscopy | \$2,098.50 | 4 | 0 | \$1,193.80 |
| I25A | Bone and Joint Diagnostic Procedures Including Biopsy W CC | \$6,366.50 | 18 | 3 | \$693.80 |
| I25B | Bone and Joint Diagnostic Procedures Including Biopsy W/O CC | \$3,060.20 | 5 | 0 | \$1,013.20 |
| I27A | Soft Tissue Procedures W Catastrophic or Severe CC | \$10,358.00 | 21 | 3 | \$933.80 |
| I27B | Soft Tissue Procedures W/O Catastrophic or Severe CC | \$3,254.20 | 4 | 0 | \$1,379.70 |
| I27C | Soft Tissue Procedures, Sameday | \$1,656.30 | 1 | 1 | N/A |
| I28A | Other Musculoskeletal Procedures W CC | \$9,446.50 | 18 | 3 | \$1,033.30 |
| I28B | Other Musculoskeletal Procedures W/O CC | \$2,771.30 | 4 | 0 | \$1,400.00 |
| I29Z | Knee Reconstructions, and Revisions of Reconstructions | \$3,290.70 | 4 | 0 | \$1,400.00 |
| I30Z | Hand Procedures | \$1,952.50 | 4 | 0 | \$1,098.20 |
| I31A | Revision of Hip Replacement for Infect/Inflam of Joint Prosth or W Cat CC | \$23,118.10 | 35 | 6 | \$1,184.20 |
| I31B | Revision of Hip Replacement not for Infect/Inflam of Joint Prosth W/O Cat CC | \$14,337.10 | 14 | 2 | \$1,400.00 |
| I32A | Revision of Knee Replacement for Infect/Inflam of Joint Prosth or W Cat CC | \$16,637.90 | 31 | 5 | \$963.10 |
| I32B | Revision of Knee Replacement not for Infect/Inflam of Joint Prosth W/O Cat CC | \$10,779.40 | 12 | 2 | \$1,400.00 |
| I40Z | Infusions for Musculoskeletal Disorders, Sameday | \$825.00 | 1 | 1 | N/A |
| I60Z | Femoral Shaft Fractures | \$16,608.70 | 35 | 7 | \$748.80 |
| I61A | Distal Femoral Fractures W CC | \$16,506.50 | 35 | 8 | \$687.80 |
| I61B | Distal Femoral Fractures W/O CC | \$11,612.80 | 32 | 5 | \$742.00 |
| I63A | Sprains, Strains and Dislocations of Hip, Pelvis and Thigh W CC | \$8,671.50 | 25 | 4 | \$699.70 |
| I63B | Sprains, Strains and Dislocations of Hip, Pelvis and Thigh W/O CC | \$4,872.90 | 13 | 2 | \$772.20 |
| I64A | Osteomyelitis W Catastrophic or Severe CC | \$12,002.80 | 34 | 6 | \$702.10 |
| I64B | Osteomyelitis W/O Catastrophic or Severe CC | \$8,331.50 | 25 | 4 | \$680.40 |
| I65A | Musculoskeletal Malignant Neoplasms W Radiotherapy or W Cat CC | \$10,806.50 | 31 | 5 | \$694.50 |
| I65B | Musculoskeletal Malignant Neoplasms W/O Radiotherapy W/O Cat CC | \$6,802.40 | 17 | 3 | \$812.60 |
| I66A | Inflammatory Musculoskeletal Disorders W Catastrophic or Severe CC | \$9,947.10 | 25 | 4 | \$810.20 |
| I66B | Inflammatory Musculoskeletal Disorders W/O Catastrophic or Severe CC | \$4,952.20 | 13 | 2 | \$751.60 |
| I67A | Septic Arthritis W Catastrophic or Severe CC | \$12,446.10 | 35 | 6 | \$687.40 |
| I67B | Septic Arthritis W/O Catastrophic or Severe CC | \$6,768.00 | 20 | 3 | \$681.60 |
| I68A | Non-surgical Spinal Disorders W CC | \$9,837.60 | 27 | 4 | \$741.10 |
| I68B | Non-surgical Spinal Disorders W/O CC | \$5,413.20 | 14 | 2 | \$784.70 |
| I69A | Bone Diseases and Arthropathies W Catastrophic or Severe CC | \$9,420.40 | 27 | 4 | \$713.70 |
| I69B | Bone Diseases and Arthropathies W/O Catastrophic or Severe CC | \$7,103.90 | 20 | 3 | \$739.20 |
| I71A | Other Musculotendinous Disorders W Catastrophic or Severe CC | \$8,249.10 | 25 | 4 | \$674.20 |
| I71B | Other Musculotendinous Disorders W/O Catastrophic or Severe CC | \$4,158.40 | 12 | 2 | \$702.40 |
| I72A | Specific Musculotendinous Disorders W Catastrophic or Severe CC | \$9,918.90 | 28 | 5 | \$713.20 |
| I72B | Specific Musculotendinous Disorders W/O Catastrophic or Severe CC | \$5,303.70 | 14 | 2 | \$756.10 |
| I73A | Aftercare of Musculoskeletal Implants or Prostheses W Cat or Sev CC | \$13,682.10 | 35 | 7 | \$661.50 |
| I73B | Aftercare of Musculoskeletal Implants or Prostheses W/O Cat or Sev CC | \$6,957.90 | 20 | 3 | \$692.70 |
| I74A | Injuries to Forearm, Wrist, Hand and Foot W CC | \$11,024.50 | 31 | 5 | \$713.00 |
| I74B | Injuries to Forearm, Wrist, Hand and Foot W/O CC | \$4,908.40 | 13 | 2 | \$750.90 |
| I75A | Injuries to Shoulder, Arm, Elbow, Knee, Leg and Ankle W CC | \$13,043.80 | 35 | 6 | \$705.10 |
| I75B | Injuries to Shoulder, Arm, Elbow, Knee, Leg and Ankle W/O CC | \$7,254.10 | 20 | 3 | \$736.70 |

| Item no. | Description | Max fee (ex GST) | Upper trim point days | Lower trim point days | Max per day rate (ex GST) |
|----------|---|---------------------|--------------------------|--------------------------|------------------------------|
| I76A | Other Musculoskeletal Disorders W Catastrophic or Severe CC | \$11,082.90 | 32 | 5 | \$695.30 |
| I76B | Other Musculoskeletal Disorders W/O Catastrophic or Severe CC | \$6,761.80 | 18 | 3 | \$751.70 |
| I77A | Fractures of Pelvis W Catastrophic or Severe CC | \$13,874.00 | 35 | 6 | \$717.70 |
| I77B | Fractures of Pelvis W/O Catastrophic or Severe CC | \$9,640.40 | 26 | 4 | \$748.40 |
| I78A | Fractures of Neck of Femur W Catastrophic or Severe CC | \$15,475.00 | 35 | 7 | \$705.70 |
| I78B | Fractures of Neck of Femur W/O Catastrophic or Severe CC | \$11,407.30 | 32 | 5 | \$714.30 |
| I79A | Pathological Fractures W Catastrophic CC | \$11,995.50 | 35 | 6 | \$691.20 |
| I79B | Pathological Fractures W/O Catastrophic CC | \$8,644.40 | 24 | 4 | \$726.40 |
| I80Z | Femoral Fractures, Transferred to Acute Facility <2 Days | \$1,167.10 | 4 | 0 | \$1,167.00 |
| I81Z | Musculoskeletal Injuries, Sameday | \$279.50 | 1 | 1 | N/A |
| I82Z | Other Sameday Treatment for Musculoskeletal Disorders | \$345.20 | 1 | 1 | N/A |
| J01A | Microvas Tiss Transf for Skin, Subcut Tiss & Breast Dsrds W Cat or Sev CC | \$19,941.10 | 23 | 4 | \$1,400.00 |
| J01B | Microvas Tiss Transf for Skin, Subcut Tiss & Breast Dsrds W/O Cat or Sev CC | \$14,801.20 | 14 | 2 | \$1,400.00 |
| J06A | Major Procedures for Malignant Breast Disorders | \$5,005.40 | 6 | 0 | \$1,400.00 |
| J06B | Major Procedures for Non-Malignant Breast Disorders | \$3,670.30 | 4 | 0 | \$1,400.00 |
| J07A | Minor Procedures for Malignant Breast Disorders | \$2,222.60 | 4 | 0 | \$1,089.30 |
| J07B | Minor Procedures for Non-Malignant Breast Disorders | \$1,705.30 | 4 | 0 | \$968.90 |
| J08A | Other Skin Grafts and Debridement Procedures W CC | \$9,083.50 | 16 | 3 | \$1,040.00 |
| J08B | Other Skin Grafts and Debridement Procedures W/O CC | \$3,411.70 | 5 | 0 | \$1,276.80 |
| J08C | Other Skin Grafts and Debridement Procedures, Sameday | \$1,843.00 | 1 | 1 | N/A |
| J09Z | Perianal and Pilonidal Procedures | \$1,994.20 | 4 | 0 | \$931.10 |
| J10Z | Plastic OR Procedures for Skin, Subcutaneous Tissue and Breast Disorders | \$2,287.30 | 4 | 0 | \$1,108.70 |
| J11Z | Other Skin, Subcutaneous Tissue and Breast Procedures | \$1,355.90 | 4 | 0 | \$740.40 |
| J12A | Lower Limb Procs W Ulcer/Cellulitis W Cat CC | \$23,122.30 | 35 | 8 | \$880.10 |
| J12B | Lower Limb Procs W Ulcer/Cellulitis W/O Cat CC W Skin Graft/Flap Repair | \$11,336.40 | 22 | 4 | \$974.40 |
| J12C | Lower Limb Procs W Ulcer/Cellulitis W/O Cat CC W/O Skin Graft/Flap Repair | \$8,438.90 | 17 | 3 | \$937.70 |
| J13A | Lwr Limb Procs W/O Ulcer/Cellulitis W (Skin Grafts and Sev CC) or W Cat CC | \$9,089.70 | 19 | 3 | \$887.40 |
| J13B | Lwr Limb Procs W/O Ulcer/Cellulitis W/O (Skin Grafts and Sev CC) W/O Cat CC | \$3,616.10 | 6 | 0 | \$1,004.60 |
| J14Z | Major Breast Reconstructions | \$9,735.40 | 12 | 2 | \$1,400.00 |
| J60A | Skin Ulcers W Catastrophic CC | \$12,198.90 | 35 | 6 | \$659.60 |
| J60B | Skin Ulcers W/O Catastrophic CC | \$8,908.30 | 24 | 4 | \$746.40 |
| J60C | Skin Ulcers, Sameday | \$316.00 | 1 | 1 | N/A |
| J62A | Malignant Breast Disorders | \$4,543.30 | 14 | 2 | \$674.20 |
| J62B | Malignant Breast Disorders, Sameday | \$272.20 | 1 | 1 | N/A |
| J63A | Non-Malignant Breast Disorders | \$2,870.30 | 8 | 1 | \$679.70 |
| J63B | Non-Malignant Breast Disorders, Sameday | \$743.70 | 1 | 1 | N/A |
| J64A | Cellulitis W Catastrophic or Severe CC | \$8,284.50 | 22 | 4 | \$751.20 |
| J64B | Cellulitis W/O Catastrophic or Severe CC | \$3,686.00 | 10 | 2 | \$773.10 |
| J65A | Trauma to Skin, Subcutaneous Tissue and Breast W Cat or Sev CC | \$7,892.40 | 23 | 4 | \$695.40 |
| J65B | Trauma to Skin, Subcutaneous Tissue and Breast W/O Cat or Sev CC | \$4,249.20 | 11 | 2 | \$797.20 |
| J65C | Trauma to Skin, Subcutaneous Tissue and Breast, Sameday | \$630.00 | 1 | 1 | N/A |
| J67A | Minor Skin Disorders | \$4,698.70 | 12 | 2 | \$805.10 |
| J67B | Minor Skin Disorders, Sameday | \$715.50 | 1 | 1 | N/A |
| J68A | Major Skin Disorders W Catastrophic or Severe CC | \$7,713.00 | 24 | 4 | \$662.60 |
| J68B | Major Skin Disorders W/O Catastrophic or Severe CC | \$4,388.90 | 10 | 2 | \$874.70 |

| Item no. | Description | Max fee (ex GST) | Upper trim point days | Lower trim point days | Max per day rate (ex GST) |
|----------|---|---------------------|--------------------------|--------------------------|------------------------------|
| J68C | Major Skin Disorders, Sameday | \$319.20 | 1 | 1 | N/A |
| J69A | Skin Malignancy W Catastrophic CC | \$11,748.40 | 33 | 5 | \$718.10 |
| J69B | Skin Malignancy W/O Catastrophic CC | \$7,767.20 | 22 | 4 | \$718.40 |
| J69C | Skin Malignancy, Sameday | \$445.40 | 1 | 1 | N/A |
| K01A | OR Procedures for Diabetic Complications W Catastrophic CC | \$23,083.70 | 35 | 9 | \$788.40 |
| K01B | OR Procedures for Diabetic Complications W/O Catastrophic CC | \$14,178.50 | 23 | 4 | \$1,177.60 |
| K02A | Pituitary Procedures W CC | \$17,007.20 | 19 | 3 | \$1,400.00 |
| K02B | Pituitary Procedures W/O CC | \$12,776.80 | 12 | 2 | \$1,400.00 |
| K03Z | Adrenal Procedures | \$9,692.60 | 9 | 1 | \$1,400.00 |
| K05A | Parathyroid Procedures W Catastrophic or Severe CC | \$7,067.40 | 9 | 1 | \$1,400.00 |
| K05B | Parathyroid Procedures W/O Catastrophic or Severe CC | \$3,759.00 | 4 | 0 | \$1,400.00 |
| K06A | Thyroid Procedures W Catastrophic or Severe CC | \$5,839.80 | 6 | 0 | \$1,400.00 |
| K06B | Thyroid Procedures W/O Catastrophic or Severe CC | \$4,345.10 | 4 | 0 | \$1,400.00 |
| K08Z | Thyroglossal Procedures | \$2,960.00 | 4 | 0 | \$1,400.00 |
| K09A | Other Endocrine, Nutritional and Metabolic OR Procs W Catastrophic CC | \$18,101.30 | 33 | 5 | \$1,047.10 |
| K09B | Other Endocrine, Nutritional and Metabolic OR Procs W Severe or Moderate CC | \$11,318.60 | 16 | 3 | \$1,262.70 |
| K09C | Other Endocrine, Nutritional and Metabolic OR Procs W/O CC | \$7,688.00 | 7 | 1 | \$1,400.00 |
| K10A | Revisional and Open Bariatric Procedures W CC | \$8,508.80 | 11 | 2 | \$1,379.20 |
| K10B | Revisional and Open Bariatric Procedures W/O CC | \$5,997.30 | 6 | 0 | \$1,400.00 |
| K11A | Major Laparoscopic Bariatric Procedures W CC | \$6,805.60 | 6 | 0 | \$1,400.00 |
| K11B | Major Laparoscopic Bariatric Procedures W/O CC | \$6,018.10 | 5 | 0 | \$1,400.00 |
| K12Z | Other Bariatric Procedures | \$4,590.20 | 4 | 0 | \$1,400.00 |
| K13Z | Plastic OR Procedures for Endocrine, Nutritional and Metabolic Disorders | \$6,530.20 | 8 | 1 | \$1,388.90 |
| K40A | Endoscopic and Investigative Procs for Metabolic Disorders W Cat CC | \$13,099.00 | 35 | 6 | \$750.20 |
| K40B | Endoscopic and Investigative Procs for Metabolic Disorders W/O Cat CC | \$3,633.80 | 8 | 1 | \$913.70 |
| K40C | Endoscopic and Investigative Procs for Metabolic Disorders, Sameday | \$897.00 | 1 | 1 | N/A |
| K60A | Diabetes W Catastrophic or Severe CC | \$9,217.00 | 23 | 4 | \$809.00 |
| K60B | Diabetes W/O Catastrophic or Severe CC | \$4,107.30 | 11 | 2 | \$771.30 |
| K60C | Diabetes, Sameday | \$549.70 | 1 | 1 | N/A |
| K61Z | Severe Nutritional Disturbance | \$9,125.20 | 24 | 4 | \$774.90 |
| K62A | Miscellaneous Metabolic Disorders W Catastrophic or Severe CC | \$7,010.00 | 18 | 3 | \$788.50 |
| K62B | Miscellaneous Metabolic Disorders W/O Catastrophic or Severe CC | \$3,413.70 | 9 | 1 | \$828.90 |
| K62C | Miscellaneous Metabolic Disorders, Sameday | \$480.80 | 1 | 1 | N/A |
| K63A | Inborn Errors of Metabolism W Catastrophic or Severe CC | \$3,871.60 | 15 | 2 | \$543.10 |
| K63B | Inborn Errors of Metabolism W/O Catastrophic or Severe CC | \$1,178.60 | 4 | 0 | \$689.20 |
| K64A | Endocrine Disorders W Catastrophic or Severe CC | \$8,187.60 | 20 | 3 | \$852.90 |
| K64B | Endocrine Disorders W/O Catastrophic or Severe CC | \$3,381.40 | 9 | 1 | \$793.70 |
| K64C | Endocrine Disorders, Sameday | \$325.40 | 1 | 1 | N/A |
| L02A | Operative Insertion of Peritoneal Catheter for Dialysis W Cat or Sev CC | \$9,408.90 | 19 | 3 | \$973.80 |
| L02B | Operative Insertion of Peritoneal Catheter for Dialysis W/O Cat or Sev CC | \$3,196.80 | 4 | 0 | \$1,400.00 |
| L03A | Kidney, Ureter and Major Bladder Procedures for Neoplasm W Cat CC | \$20,728.60 | 28 | 5 | \$1,400.00 |
| L03B | Kidney, Ureter and Major Bladder Procedures for Neoplasm W Sev CC | \$14,896.10 | 14 | 2 | \$1,400.00 |
| L03C | Kidney, Ureter and Major Bladder Procedures for Neoplasm W/O Cat or Sev CC | \$8,935.40 | 9 | 1 | \$1,400.00 |
| L04A | Kidney, Ureter and Major Bladder Procedures for Non-Neoplasm W | \$15,169.40 | 27 | 4 | \$1,080.40 |

| Item no. | Description | Max fee (ex GST) | Upper trim point days | Lower trim point days | Max per day rate (ex GST) |
|----------|---|---------------------|--------------------------|--------------------------|------------------------------|
| | Cat CC | | | | |
| L04B | Kidney, Ureter and Major Bladder Procedures for Non-Neoplasm W/O Cat CC | \$4,611.10 | 4 | 0 | \$1,400.00 |
| L04C | Kidney, Ureter and Major Bladder Procedures for Non-Neoplasm, Sameday | \$1,811.70 | 1 | 1 | N/A |
| L05A | Transurethral Prostatectomy for Urinary Disorder W Cat or Sev CC | \$10,276.70 | 17 | 3 | \$1,141.00 |
| L05B | Transurethral Prostatectomy for Urinary Disorder W/O Cat or Sev CC | \$4,498.50 | 6 | 0 | \$1,400.00 |
| L06A | Minor Bladder Procedures W Catastrophic or Severe CC | \$8,506.70 | 15 | 2 | \$1,139.00 |
| L06B | Minor Bladder Procedures W/O Catastrophic or Severe CC | \$2,675.30 | 4 | 0 | \$1,225.80 |
| L07A | Other Transurethral Procedures W CC | \$3,135.30 | 6 | 0 | \$962.00 |
| L07B | Other Transurethral Procedures W/O CC | \$1,756.40 | 4 | 0 | \$1,113.00 |
| L08A | Urethral Procedures W CC | \$3,248.90 | 7 | 1 | \$948.20 |
| L08B | Urethral Procedures W/O CC | \$1,790.80 | 4 | 0 | \$1,102.30 |
| L09A | Other Procedures for Kidney and Urinary Tract Disorders W Cat CC | \$21,454.50 | 35 | 6 | \$1,087.50 |
| L09B | Other Procedures for Kidney and Urinary Tract Disorders W Sev CC | \$5,415.30 | 7 | 1 | \$1,288.50 |
| L09C | Other Procedures for Kidney and Urinary Tract Disorders W/O Cat or Sev CC | \$2,989.20 | 4 | 0 | \$1,400.00 |
| L40Z | Ureteroscopy | \$2,023.40 | 4 | 0 | \$1,118.10 |
| L41Z | Cystourethroscopy for Urinary Disorder, Sameday | \$876.10 | 1 | 1 | N/A |
| L42Z | ESW Lithotripsy | \$2,781.70 | 4 | 0 | \$1,400.00 |
| L60A | Kidney Failure W Catastrophic CC | \$12,114.40 | 27 | 4 | \$899.50 |
| L60B | Kidney Failure W Severe CC | \$6,064.00 | 15 | 2 | \$806.00 |
| L60C | Kidney Failure W/O Catastrophic or Severe CC | \$3,562.90 | 9 | 1 | \$806.60 |
| L61Z | Haemodialysis | \$388.00 | 4 | 0 | \$388.00 |
| L62A | Kidney and Urinary Tract Neoplasms W Catastrophic or Severe CC | \$7,310.40 | 21 | 3 | \$698.90 |
| L62B | Kidney and Urinary Tract Neoplasms W/O Catastrophic or Severe CC | \$1,996.30 | 6 | 0 | \$680.20 |
| L63A | Kidney and Urinary Tract Infections W Catastrophic or Severe CC | \$7,433.50 | 20 | 3 | \$755.20 |
| L63B | Kidney and Urinary Tract Infections W/O Catastrophic or Severe CC | \$3,336.60 | 9 | 1 | \$816.00 |
| L64A | Urinary Stones and Obstruction W Catastrophic or Severe CC | \$4,216.80 | 11 | 2 | \$716.10 |
| L64B | Urinary Stones and Obstruction W/O Catastrophic or Severe CC | \$1,914.90 | 4 | 0 | \$930.60 |
| L64C | Urinary Stones and Obstruction, Sameday | \$883.40 | 1 | 1 | N/A |
| L65A | Kidney and Urinary Tract Signs and Symptoms W Catastrophic or Severe CC | \$6,197.50 | 16 | 3 | \$764.70 |
| L65B | Kidney and Urinary Tract Signs and Symptoms W/O Catastrophic or Severe CC | \$1,774.10 | 5 | 0 | \$741.50 |
| L66Z | Urethral Stricture | \$1,596.80 | 4 | 0 | \$925.40 |
| L67A | Other Kidney and Urinary Tract Disorders W Catastrophic or Severe CC | \$6,132.80 | 16 | 3 | \$766.20 |
| L67B | Other Kidney and Urinary Tract Disorders W/O Catastrophic or Severe CC | \$1,972.30 | 5 | 0 | \$822.90 |
| L67C | Other Kidney and Urinary Tract Disorders, Sameday | \$486.00 | 1 | 1 | N/A |
| M01A | Major Male Pelvic Procedures W Catastrophic or Severe CC | \$10,821.10 | 10 | 2 | \$1,400.00 |
| M01B | Major Male Pelvic Procedures W/O Catastrophic or Severe CC | \$9,359.90 | 6 | 0 | \$1,400.00 |
| M02A | Transurethral Prostatectomy for Reproductive System Disorder W Cat/Sev CC | \$7,803.70 | 13 | 2 | \$1,160.50 |
| M02B | Transurethral Prostatectomy for Reproductive System Disorder W/O Cat/Sev CC | \$4,222.10 | 5 | 0 | \$1,400.00 |
| M03Z | Penis Procedures | \$2,544.90 | 4 | 0 | \$1,382.70 |
| M04Z | Testes Procedures | \$1,922.20 | 4 | 0 | \$1,096.40 |
| M05Z | Circumcision | \$1,259.90 | 4 | 0 | \$761.20 |
| M06A | Other Male Reproductive System OR Procedures W CC | \$3,309.40 | 6 | 0 | \$959.00 |
| M06B | Other Male Reproductive System OR Procedures W/O CC | \$2,313.40 | 4 | 0 | \$1,400.00 |
| M40Z | Cystourethroscopy for Male Reproductive System Disorder, Sameday | \$881.30 | 1 | 1 | N/A |

| Item no. | Description | Max fee (ex GST) | Upper trim point days | Lower trim point days | Max per day rate (ex GST) |
|----------|---|------------------|-----------------------|-----------------------|---------------------------|
| M60A | Male Reproductive System Malignancy W Catastrophic or Severe CC | \$7,887.20 | 22 | 4 | \$738.70 |
| M60B | Male Reproductive System Malignancy W/O Catastrophic or Severe CC | \$1,007.50 | 4 | 0 | \$625.00 |
| M61A | Benign Prostatic Hypertrophy W CC | \$5,194.10 | 14 | 2 | \$723.40 |
| M61B | Benign Prostatic Hypertrophy W/O CC | \$1,142.10 | 4 | 0 | \$710.20 |
| M62A | Male Reproductive System Inflammation W CC | \$4,353.50 | 13 | 2 | \$694.20 |
| M62B | Male Reproductive System Inflammation W/O CC | \$1,929.60 | 5 | 0 | \$720.20 |
| M63Z | Male Sterilisation Procedures | \$994.00 | 4 | 0 | \$777.00 |
| M64Z | Other Male Reproductive System Disorders | \$1,152.50 | 4 | 0 | \$627.60 |
| N01A | Pelvic Evisceration and Radical Vulvectomy W Catastrophic or Severe CC | \$13,029.20 | 23 | 4 | \$1,079.40 |
| N01B | Pelvic Evisceration and Radical Vulvectomy W/O Catastrophic or Severe CC | \$8,816.50 | 9 | 1 | \$1,400.00 |
| N04A | Hysterectomy for Non-Malignancy W Catastrophic or Severe CC | \$6,873.40 | 9 | 1 | \$1,348.90 |
| N04B | Hysterectomy for Non-Malignancy W/O Catastrophic or Severe CC | \$5,709.40 | 6 | 0 | \$1,400.00 |
| N05A | Oophorectomy and Complex Fallopian Tube Procs for Non-Malig W Cat or Sev CC | \$7,048.60 | 8 | 1 | \$1,400.00 |
| N05B | Oophorectomy and Complex Fallopian Tube Procs for Non-Malig W/O Cat or Sev CC | \$3,665.10 | 4 | 0 | \$1,400.00 |
| N06Z | Female Reproductive System Reconstructive Procedures | \$4,204.30 | 5 | 0 | \$1,400.00 |
| N07A | Other Uterus and Adnexa Procedures for Non-Malignancy | \$3,202.00 | 4 | 0 | \$1,400.00 |
| N07B | Other Uterus and Adnexa Procedures for Non-Malignancy, Sameday | \$1,644.80 | 1 | 1 | N/A |
| N08Z | Endoscopic and Laparoscopic Procedures, Female Reproductive System | \$2,210.10 | 4 | 0 | \$1,324.60 |
| N09Z | Other Vagina, Cervix and Vulva Procedures | \$1,309.00 | 4 | 0 | \$798.10 |
| N10Z | Diagnostic Curettage and Diagnostic Hysteroscopy | \$1,118.10 | 4 | 0 | \$822.80 |
| N11Z | Other Female Reproductive System OR Procedures | \$578.90 | 4 | 0 | \$454.20 |
| N12A | Uterus and Adnexa Procedures for Malignancy W Catastrophic CC | \$12,579.60 | 17 | 3 | \$1,400.00 |
| N12B | Uterus and Adnexa Procedures for Malignancy W/O Catastrophic CC | \$6,501.00 | 7 | 1 | \$1,400.00 |
| N60A | Female Reproductive System Malignancy W Catastrophic CC | \$8,822.70 | 27 | 4 | \$664.40 |
| N60B | Female Reproductive System Malignancy W/O Catastrophic CC | \$2,806.70 | 9 | 1 | \$637.10 |
| N61Z | Female Reproductive System Infections | \$1,884.70 | 6 | 0 | \$679.20 |
| N62Z | Menstrual and Other Female Reproductive System Disorders | \$893.90 | 4 | 0 | \$568.70 |
| O01A | Caesarean Delivery W Catastrophic CC | \$8,763.30 | 16 | 3 | \$1,092.80 |
| O01B | Caesarean Delivery W Severe CC | \$7,369.80 | 12 | 2 | \$1,269.20 |
| O01C | Caesarean Delivery W/O Catastrophic or Severe CC | \$6,816.00 | 10 | 2 | \$1,400.00 |
| O02A | Vaginal Delivery W OR Procedures W Catastrophic or Severe CC | \$6,398.80 | 11 | 2 | \$1,231.50 |
| O02B | Vaginal Delivery W OR Procedures W/O Catastrophic or Severe CC | \$5,420.50 | 9 | 1 | \$1,278.50 |
| O03A | Ectopic Pregnancy W CC | \$2,571.00 | 4 | 0 | \$1,400.00 |
| O03B | Ectopic Pregnancy W/O CC | \$2,566.80 | 4 | 0 | \$1,400.00 |
| O04A | Postpartum and Post Abortion W OR Procedures W Catastrophic or Severe CC | \$2,967.30 | 11 | 2 | \$591.00 |
| O04B | Postpartum and Post Abortion W OR Procedures W/O Catastrophic or Severe CC | \$2,535.50 | 5 | 0 | \$1,104.80 |
| O04C | Postpartum and Post Abortion W OR Procedures, Sameday | \$1,274.50 | 1 | 1 | N/A |
| O05Z | Abortion W OR Procedures | \$979.40 | 4 | 0 | \$779.40 |
| O60A | Vaginal Delivery W Catastrophic or Severe CC | \$5,395.40 | 11 | 2 | \$1,073.10 |
| O60B | Vaginal Delivery W/O Catastrophic or Severe CC | \$5,032.50 | 9 | 1 | \$1,194.30 |
| O60C | Vaginal Delivery, Single Uncomplicated | \$4,561.00 | 8 | 1 | \$1,237.30 |
| O61Z | Postpartum and Post Abortion W/O OR Procedures | \$2,130.80 | 6 | 0 | \$721.40 |
| O63Z | Abortion W/O OR Procedures | \$502.70 | 4 | 0 | \$380.30 |
| O66A | Antenatal and Other Obstetric Admissions W Catastrophic or Severe CC | \$2,555.40 | 8 | 1 | \$631.30 |

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|----------|---|---------------------|--------------------------|--------------------------|------------------------------|
| O66B | Antenatal and Other Obstetric Admissions W/O Catastrophic or Severe CC | \$1,766.80 | 5 | 0 | \$846.20 |
| O66C | Antenatal and Other Obstetric Admissions, Sameday | \$266.00 | 1 | 1 | N/A |
| P06A | Neonate, AdmWt >=2500g W Significant OR Procedure W Multiple Major Problems | \$9,130.40 | 35 | 6 | \$468.70 |
| P06B | Neonate, AdmWt >=2500g W Significant OR Procedure W/O Multiple Major Problems | \$1,305.80 | 23 | 4 | \$118.20 |
| P60A | Neonate W/O Sig OR Proc, Died or Transferred to Acute Facility <5 Days | \$1,117.10 | 4 | 0 | \$638.30 |
| P60B | Neonate W/O Sig OR Proc, Died or Transferred to Acute Facility Sameday | \$182.50 | 1 | 1 | N/A |
| P62Z | Neonate, AdmWt 750-999g W/O Significant OR Procedure | \$4,723.70 | 35 | 17 | \$95.20 |
| P63B | Neonate, AdmWt 1000-1249g W/O Sig OR Proc >=32 Completed Wks Gestation | \$326.50 | 18 | 3 | \$36.70 |
| P64A | Neonate, AdmWt 1250-1499g W/O Sig OR Proc <32 Completed Wks Gestation | \$16,160.20 | 35 | 10 | \$523.30 |
| P64B | Neonate, AdmWt 1250-1499g W/O Sig OR Proc >=32 Completed Wks Gestation | \$16,084.10 | 35 | 10 | \$559.10 |
| P65A | Neonate, AdmWt 1500-1999g W/O Significant OR Proc W Multiple Major Problems | \$4,996.00 | 35 | 7 | \$230.30 |
| P65B | Neonate, AdmWt 1500-1999g W/O Significant OR Proc W Major Problem | \$16,500.30 | 35 | 8 | \$661.90 |
| P65C | Neonate, AdmWt 1500-1999g W/O Significant OR Proc W Other Problem | \$13,544.40 | 35 | 8 | \$591.20 |
| P65D | Neonate, AdmWt 1500-1999g W/O Significant OR Proc W/O Problem | \$12,162.40 | 35 | 6 | \$647.30 |
| P66A | Neonate, AdmWt 2000-2499g W/O Significant OR Proc W Multiple Major Problems | \$7,509.60 | 32 | 5 | \$478.00 |
| P66B | Neonate, AdmWt 2000-2499g W/O Significant OR Proc W Major Problem | \$9,362.00 | 31 | 5 | \$619.20 |
| P66C | Neonate, AdmWt 2000-2499g W/O Significant OR Proc W Other Problem | \$8,162.50 | 26 | 4 | \$645.30 |
| P66D | Neonate, AdmWt 2000-2499g W/O Significant OR Proc W/O Problem | \$2,312.30 | 10 | 2 | \$490.90 |
| P67A | Neonate, AdmWt >=2500g W/O Sig OR Proc <37 Comp Wks Gest W Mult Major Probs | \$4,108.40 | 26 | 4 | \$327.30 |
| P67B | Neonate, AdmWt >=2500g W/O Sig OR Proc <37 Comp Wks Gest W Major Problem | \$7,097.60 | 23 | 4 | \$640.00 |
| P67C | Neonate, AdmWt >=2500g W/O Sig OR Proc <37 Comp Wks Gest W Other Problem | \$5,108.60 | 18 | 3 | \$586.60 |
| P67D | Neonate, AdmWt >=2500g W/O Sig OR Proc <37 Comp Wks Gest W/O Problem | \$1,548.90 | 9 | 1 | \$375.10 |
| P68A | Neonate, AdmWt >=2500g W/O Sig OR Proc >=37 Comp Wks Gest W Mult Major Probs | \$3,772.50 | 14 | 2 | \$546.80 |
| P68B | Neonate, AdmWt >=2500g W/O Sig OR Proc >=37 Comp Wks Gest W Major Problem | \$2,738.90 | 8 | 1 | \$695.20 |
| P68C | Neonate, AdmWt >=2500g W/O Sig OR Proc >=37 Comp Wks Gest W Other Problem | \$1,693.80 | 7 | 1 | \$521.20 |
| P68D | Neonate, AdmWt >=2500g W/O Sig OR Proc >=37 Comp Wks Gest W/O Problem | \$116.80 | 8 | 1 | \$31.40 |
| Q01A | Splenectomy W Catastrophic or Severe CC | \$14,938.90 | 27 | 4 | \$1,124.10 |
| Q01B | Splenectomy W/O Catastrophic or Severe CC | \$8,770.60 | 10 | 2 | \$1,400.00 |
| Q02A | Blood and Immune System Disorders W Other OR Procedures W Cat or Sev CC | \$15,140.20 | 27 | 4 | \$1,078.40 |
| Q02B | Blood and Immune System Disorders W Other OR Procedures W/O Cat or Sev CC | \$2,614.80 | 4 | 0 | \$1,182.10 |
| Q60A | Reticuloendothelial and Immunity Disorders W Catastrophic or Severe CC | \$7,224.90 | 17 | 3 | \$860.40 |
| Q60B | Reticuloendothelial and Immunity Disorders W/O Catastrophic or Severe CC | \$2,582.50 | 7 | 1 | \$738.70 |
| Q60C | Reticuloendothelial and Immunity Disorders, Sameday | \$475.60 | 1 | 1 | N/A |
| Q61A | Red Blood Cell Disorders W Catastrophic or Severe CC | \$6,002.50 | 15 | 2 | \$795.90 |

| Item no. | Description | Max fee (ex GST) | Upper trim point days | Lower trim point days | Max per day rate (ex GST) |
|----------|--|---------------------|--------------------------|--------------------------|------------------------------|
| Q61B | Red Blood Cell Disorders W/O Catastrophic or Severe CC | \$2,222.60 | 6 | 0 | \$813.90 |
| Q61C | Red Blood Cell Disorders, Sameday | \$615.40 | 1 | 1 | N/A |
| Q62A | Coagulation Disorders | \$4,062.50 | 12 | 2 | \$710.10 |
| Q62B | Coagulation Disorders, Sameday | \$744.70 | 1 | 1 | N/A |
| R01A | Lymphoma and Leukaemia W Major OR Procedures W Catastrophic or Severe CC | \$21,847.70 | 33 | 5 | \$1,286.00 |
| R01B | Lymphoma and Leukaemia W Major OR Procedures W/O Catastrophic or Severe CC | \$6,084.90 | 7 | 1 | \$1,400.00 |
| R02A | Other Neoplastic Disorders W Major OR Procedures W Catastrophic CC | \$17,141.70 | 27 | 4 | \$1,241.70 |
| R02B | Other Neoplastic Disorders W Major OR Procedures W Severe or Moderate CC | \$10,944.20 | 14 | 2 | \$1,400.00 |
| R02C | Other Neoplastic Disorders W Major OR Procedures W/O CC | \$6,382.10 | 8 | 1 | \$1,400.00 |
| R03A | Lymphoma and Leukaemia W Other OR Procedures W Catastrophic or Severe CC | \$19,175.60 | 35 | 6 | \$1,019.60 |
| R03B | Lymphoma and Leukaemia W Other OR Procedures W/O Catastrophic or Severe CC | \$4,428.60 | 7 | 1 | \$1,201.50 |
| R03C | Lymphoma and Leukaemia W Other OR Procedures, Sameday | \$1,586.40 | 1 | 1 | N/A |
| R04A | Other Neoplastic Disorders W Other OR Procedures W CC | \$5,494.50 | 9 | 1 | \$1,067.70 |
| R04B | Other Neoplastic Disorders W Other OR Procedures W/O CC | \$2,689.90 | 4 | 0 | \$1,184.00 |
| R60A | Acute Leukaemia W Catastrophic CC | \$21,677.70 | 35 | 8 | \$939.70 |
| R60B | Acute Leukaemia W/O Catastrophic CC | \$6,240.30 | 16 | 3 | \$790.60 |
| R60C | Acute Leukaemia, Sameday | \$607.00 | 1 | 1 | N/A |
| R61A | Lymphoma and Non-Acute Leukaemia W Catastrophic CC | \$14,854.40 | 35 | 6 | \$815.40 |
| R61B | Lymphoma and Non-Acute Leukaemia W/O Catastrophic CC | \$4,054.10 | 10 | 2 | \$858.90 |
| R61C | Lymphoma and Non-Acute Leukaemia, Sameday | \$469.40 | 1 | 1 | N/A |
| R62A | Other Neoplastic Disorders W CC | \$6,155.80 | 17 | 3 | \$743.50 |
| R62B | Other Neoplastic Disorders W/O CC | \$1,893.00 | 6 | 0 | \$617.50 |
| R63Z | Chemotherapy | \$501.70 | 4 | 0 | \$490.00 |
| T01A | Infectious and Parasitic Diseases W OR Procedures W Catastrophic CC | \$25,786.10 | 35 | 7 | \$1,132.80 |
| T01B | Infectious and Parasitic Diseases W OR Procedures W Severe or Moderate CC | \$10,910.80 | 20 | 3 | \$1,031.00 |
| T01C | Infectious and Parasitic Diseases W OR Procedures W/O CC | \$5,857.50 | 10 | 2 | \$1,029.90 |
| T40Z | Infectious and Parasitic Diseases W Ventilator Support | \$19,874.40 | 26 | 4 | \$1,400.00 |
| T60A | Septicaemia W Catastrophic CC | \$11,570.00 | 26 | 4 | \$888.10 |
| T60B | Septicaemia W/O Catastrophic CC | \$6,017.10 | 14 | 2 | \$878.60 |
| T61A | Postoperative and Post-Traumatic Infections W Catastrophic or Severe CC | \$6,993.30 | 22 | 4 | \$652.20 |
| T61B | Postoperative and Post-Traumatic Infections W/O Catastrophic or Severe CC | \$3,837.20 | 10 | 2 | \$763.20 |
| T62A | Fever of Unknown Origin W CC | \$4,573.60 | 12 | 2 | \$790.60 |
| T62B | Fever of Unknown Origin W/O CC | \$2,313.40 | 6 | 0 | \$810.20 |
| T63A | Viral Illnesses W CC | \$3,914.40 | 11 | 2 | \$733.00 |
| T63B | Viral Illnesses W/O CC | \$2,245.60 | 5 | 0 | \$911.00 |
| T64A | Other Infectious and Parasitic Diseases W Catastrophic CC | \$10,363.20 | 29 | 5 | \$716.90 |
| T64B | Other Infectious and Parasitic Diseases W Severe or Moderate CC | \$5,132.60 | 13 | 2 | \$776.40 |
| T64C | Other Infectious and Parasitic Diseases W/O CC | \$2,158.00 | 6 | 0 | \$720.00 |
| U40Z | Mental Health Treatment W ECT, Sameday | \$377.60 | 1 | 1 | N/A |
| U60Z | Mental Health Treatment W/O ECT, Sameday | \$306.60 | 1 | 1 | N/A |
| U61A | Schizophrenia Disorders, Involuntary Admission | \$41,264.20 | 35 | 9 | \$1,400.00 |
| U61B | Schizophrenia Disorders | \$14,691.70 | 35 | 7 | \$712.40 |
| U62A | Paranoia & Acute Psyc Disorders, Involuntary Admission or W Cat or Sev CC | \$16,366.80 | 35 | 12 | \$451.00 |
| U62B | Paranoia & Acute Psyc Disorders W/O Cat or Sev CC | \$13,415.10 | 35 | 6 | \$743.60 |

| Item no. | Description | Max fee (ex GST) | Upper trim point days | Lower trim point days | Max per day rate (ex GST) |
|----------|---|---------------------|--------------------------|--------------------------|------------------------------|
| U63A | Major Affective Disorders Age >=70 or W Catastrophic or Severe CC | \$15,031.70 | 35 | 7 | \$668.90 |
| U63B | Major Affective Disorders Age <70 W/O Catastrophic or Severe CC | \$13,011.40 | 35 | 6 | \$687.30 |
| U64Z | Other Affective and Somatoform Disorders | \$11,883.90 | 33 | 5 | \$726.00 |
| U65Z | Anxiety Disorders | \$11,268.60 | 32 | 5 | \$718.70 |
| U66Z | Eating and Obsessive-Compulsive Disorders | \$18,102.30 | 35 | 8 | \$720.90 |
| U67Z | Personality Disorders and Acute Reactions | \$13,159.50 | 35 | 6 | \$725.50 |
| U68Z | Childhood Mental Disorders | \$13,432.80 | 35 | 6 | \$692.40 |
| V60A | Alcohol Intoxication and Withdrawal W CC | \$7,492.90 | 18 | 3 | \$833.50 |
| V60B | Alcohol Intoxication and Withdrawal W/O CC | \$5,203.50 | 14 | 2 | \$745.60 |
| V61Z | Drug Intoxication and Withdrawal | \$10,401.80 | 25 | 4 | \$865.40 |
| V62Z | Alcohol Use and Dependence | \$11,333.20 | 32 | 5 | \$712.20 |
| V63Z | Opioid Use and Dependence | \$11,145.50 | 32 | 5 | \$703.10 |
| V64Z | Other Drug Use and Dependence | \$11,364.50 | 34 | 6 | \$683.40 |
| V65Z | Treatment for Alcohol Disorders, Sameday | \$308.70 | 1 | 1 | N/A |
| V66Z | Treatment for Drug Disorders, Sameday | \$278.50 | 1 | 1 | N/A |
| W02A | Hip, Femur & Lower Limb Procs for Mult Significant Trauma W Cat or Sev CC | \$23,100.40 | 33 | 5 | \$1,374.70 |
| W02B | Hip, Femur & Lower Limb Procs for Mult Significant Trauma W/O Cat or Sev CC | \$14,716.70 | 25 | 4 | \$1,180.20 |
| W04A | Multiple Significant Trauma W Other OR Procs W Catastrophic or Severe CC | \$33,704.50 | 35 | 11 | \$1,053.30 |
| W60Z | Multiple Trauma, Died or Transferred to Acute Facility <5 Days | \$1,997.30 | 5 | 0 | \$907.70 |
| W61A | Multiple Trauma W/O OR Procedures W Catastrophic or Severe CC | \$28,897.40 | 35 | 10 | \$992.10 |
| W61B | Multiple Trauma W/O OR Procedures W/O Catastrophic or Severe CC | \$5,799.10 | 14 | 2 | \$873.30 |
| X02A | Microvascular Tiss Transfer or (Skin Graft W Cat/Sev CC) for Injuries to Hand | \$5,430.90 | 6 | 0 | \$1,118.30 |
| X02B | Skin Graft for Injuries to Hand W/O Catastrophic or Severe CC | \$2,881.80 | 4 | 0 | \$1,108.80 |
| X04A | Other Procedures for Injuries to Lower Limb W Catastrophic or Severe CC | \$9,088.70 | 19 | 3 | \$905.70 |
| X04B | Other Procedures for Injuries to Lower Limb W/O Catastrophic or Severe CC | \$3,352.20 | 5 | 0 | \$1,341.80 |
| X05A | Other Procedures for Injuries to Hand W CC | \$4,184.50 | 7 | 1 | \$1,063.80 |
| X05B | Other Procedures for Injuries to Hand W/O CC | \$2,306.10 | 4 | 0 | \$1,074.40 |
| X06A | Other Procedures for Other Injuries W Catastrophic or Severe CC | \$9,432.90 | 16 | 3 | \$1,124.20 |
| X06B | Other Procedures for Other Injuries W/O Catastrophic or Severe CC | \$3,380.40 | 4 | 0 | \$1,283.90 |
| X07A | Skin Graft for Injuries Excl Hand W Microvascular Tiss Trans or W Cat/Sev CC | \$13,584.00 | 30 | 5 | \$821.60 |
| X07B | Skin Graft for Injuries Excl Hand W/O Microvascular Tiss Trans W/O Cat/Sev CC | \$5,992.00 | 10 | 2 | \$1,063.10 |
| X40Z | Injuries, Poisoning and Toxic Effects of Drugs W Ventilator Support | \$10,693.90 | 11 | 2 | \$1,400.00 |
| X60A | Injuries W Catastrophic or Severe CC | \$7,563.80 | 21 | 3 | \$733.60 |
| X60B | Injuries W/O Catastrophic or Severe CC | \$2,680.50 | 8 | 1 | \$700.80 |
| X61Z | Allergic Reactions | \$1,568.70 | 4 | 0 | \$862.10 |
| X62A | Poisoning/Toxic Effects of Drugs and Other Substances W Cat or Sev CC | \$6,309.10 | 13 | 2 | \$975.10 |
| X62B | Poisoning/Toxic Effects of Drugs and Other Substances W/O Cat or Sev CC | \$2,423.90 | 5 | 0 | \$1,143.40 |
| X63A | Sequelae of Treatment W Catastrophic or Severe CC | \$5,486.20 | 14 | 2 | \$772.10 |
| X63B | Sequelae of Treatment W/O Catastrophic or Severe CC | \$2,077.70 | 6 | 0 | \$713.70 |
| X64A | Other Injuries, Poisonings and Toxic Effects W Catastrophic or Severe CC | \$6,893.20 | 19 | 3 | \$753.30 |
| X64B | Other Injuries, Poisonings and Toxic Effects W/O Catastrophic or Severe CC | \$1,540.50 | 5 | 0 | \$755.40 |
| Y02C | Skin Grafts for Other Burns W/O Catastrophic or Severe CC, Non Emergency | \$5,557.10 | 6 | 0 | \$1,400.00 |
| Y03Z | Other OR Procedures for Other Burns | \$3,991.60 | 6 | 0 | \$1,006.90 |

| Item no. | Description | Max fee (ex GST) | Upper trim point days | Lower trim point days | Max per day rate (ex GST) |
|----------|---|------------------|-----------------------|-----------------------|---------------------------|
| Y61Z | Severe Burns | \$1,327.70 | 8 | 1 | \$368.90 |
| Y62A | Other Burns W CC | \$6,971.40 | 17 | 3 | \$853.20 |
| Y62B | Other Burns W/O CC | \$2,929.80 | 7 | 1 | \$839.50 |
| Y62C | Other Burns, Sameday | \$278.50 | 1 | 1 | N/A |
| Z01A | Other Contacts W Health Services W OR Procedures | \$3,674.50 | 5 | 0 | \$1,400.00 |
| Z01B | Other Contacts W Health Services W OR Procedures, Sameday | \$1,361.10 | 1 | 1 | N/A |
| Z40Z | Other Contacts W Health Services W Endoscopy, Sameday | \$763.50 | 1 | 1 | N/A |
| Z60Z | Rehabilitation | \$557.00 | 4 | 0 | \$452.80 |
| Z61A | Signs and Symptoms | \$4,111.50 | 11 | 2 | \$766.70 |
| Z61B | Signs and Symptoms, Sameday | \$407.80 | 1 | 1 | N/A |
| Z63A | Other Follow Up After Surgery or Medical Care W Catastrophic CC | \$8,801.90 | 29 | 5 | \$626.90 |
| Z63B | Other Follow Up After Surgery or Medical Care W/O Catastrophic CC | \$3,433.60 | 10 | 2 | \$724.60 |
| Z64A | Other Factors Influencing Health Status | \$3,123.80 | 11 | 2 | \$543.30 |
| Z64B | Other Factors Influencing Health Status, Sameday | \$413.00 | 1 | 1 | N/A |
| Z65Z | Congenital Anomalies and Problems Arising from Neonatal Period | \$1,383.00 | 6 | 0 | \$480.20 |

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. | \$410.70 |
| PR420 | Band 2: including procedures other than Band 1 performed under local anaesthetic with no sedation. Theatre time less than 1 hour. | \$488.90 |
| 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. | \$571.10 |
| PR440 | Band 4: including procedures other than Band 1 performed under general or regional anaesthesia or intravenous sedation. Theatre time 1 hour or more. | \$605.40 |
| Theatre fee bands | | |
| The band into which services fall will be determined in accordance with the <i>Group Accommodation and Theatre Banding Schedule</i> 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 | \$471.80 |
| PRT02 | Theatre fee band: 2 | \$602.10 |
| PRT03 | Theatre fee band: 3 | \$837.10 |
| PRT04 | Theatre fee band: 4 | \$1210.80 |
| PRT05 | Theatre fee band: 5 | \$1553.90 |
| PRT06 | Theatre fee band: 6 | \$2046.10 |
| PRT07 | Theatre fee band: 7 | \$2799.10 |
| PRT08 | Theatre fee band: 8 | \$2987.60 |
| PRT09 | Theatre fee band: 9 | \$3985.50 |
| PRT10 | Theatre fee band: 10 | \$5217.30 |
| PRT11 | Theatre fee band: 11 | \$7403.70 |
| PRT12 | Theatre fee band: 12 | \$7949.40 |
| PRT13 | Theatre fee band: 13 | \$7517.00 |
| PRT1A | Theatre fee band: 1A | \$235.80 |
| PRT50 | Theatre fee band: Dental minor | \$445.90 |
| PRT55 | Theatre fee band: Dental major | \$804.30 |
| PRT9A | Theatre fee band: 9A | \$3474.70 |