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THE SOUTH AUSTRALIAN

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CONTENTS

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STATE GOVERNMENT INSTRUMENTS

RETURN TO WORK ACT 2014

Notice of Day Surgery Facilities

Preamble

The Scales of Charges for medical practitioners, medical and other charges, published by the Treasurer in the *Government Gazette* on 2 June 2021 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 20 November 2020, I, Michael Francis, Chief Executive Officer, declare that each of the following facilities is a day surgery facility for the purposes of the Scales of Charges for medical practitioners, medical and other charges, published by the Treasurer in the *Government Gazette* on 2 June 2021. This list will have effect from 1 July 2021.

Provider ID	Name and Address
0067240H	Adelaide Ambulatory Day Surgery, 10A and 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
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
0067290X	Cosmos Cosmetic Day Surgery Adelaide, 163 Archer Street, North Adelaide SA 5006
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, 24 Gordon Street, Glenelg SA 5045
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, Kurralta Park SA 5037
0067250F	Icon Cancer Centre Windsor Gardens, Level 1, 480 North East Road, Windsor Gardens SA 5087
0067300K	Lakeside Dental Care Yorketown, 38 Warooka Road, Yorketown SA 5576
0067230J	Lift Cancer Care Services 7/506-520 South Road, Kurralta Park SA 5037
0873741Y	North Adelaide Day Surgery Centre, 174 Ward Street, North Adelaide SA 5006
0067020X	North Adelaide Gastroenterology Centre, 254 Melbourne Street, North Adelaide SA 5006
0834441A	Northern Endoscopy Centre, 127 Frost Road, Salisbury South SA 5106
0067280Y	Norwood Day Surgery, 42 Nelson Street, Stepney SA 5069
0067140K	Oromax Day Surgery Pty Ltd, Level 3, Hutt Street, Adelaide, SA 5000
0067000A	Parkview Day Surgery, 215 Greenhill Road, Eastwood SA 5063
0067040T	Payneham Dialysis Clinic, 2 Portrush Road, Payneham SA 5070
0067080H	Repromed Day Surgery, 180 Fullarton Road, Dulwich SA 5065
0067260B	Seaford Day Surgery, 4 Vista Parade, Seaford Heights SA 5169
0067200T	Southern Endoscopy Centre, 271 Brighton Road, Somerton Park SA 5144
0067130L	The Tennyson Centre Day Hospital, Tenancy 18, Level 1, 520 South Road, Kurralta Park SA 5037
0067160H	Vista Day Surgery, 57 Greenhill Road, Wayville SA 5034
0882301T	Waverley House Plastic Surgery Centre, 360 South Terrace, Adelaide SA 5000
0067270A	Windsor Gardens Day Surgery, Suite 1, Level 1, 480 North East Road, Windsor Gardens SA 5087

Dated: 17 May 2021

MICHAEL FRANCIS
Chief Executive Officer

RETURN TO WORK ACT 2014

Scales of Charges for Medical Practitioners, Medical and Other Charges

Preamble

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

NOTICE

Pursuant to subsection 33(12)(a) of the Act, I publish the following scales of charges to have effect on and from 1 July 2021:

1. scales of charges set out in Schedules 1A and 1B for the provision of medical and related or supplementary services by registered medical practitioners;
2. scales of charges set out in Schedule 2 for the provision of services by chiropractors;
3. scales of charges set out in Schedule 3 for the provision of services by an exercise physiologists (being a class of services which have been authorised by the Corporation under subsection 33(2)(i) of the Act);
4. scales of charges set out in Schedule 4 for the provision of services by occupational therapists;
5. scales of charges set out in Schedule 5 for the provision of services by osteopaths;
6. scales of charges set out in Schedule 6 for the provision of services by physiotherapists;
7. scales of charges set out in Schedule 7 for the provision of services by psychologists;
8. scales of charges set out in Schedule 8 for the provision of services by speech pathologists;
9. scales of charges set out in Schedule 9 for the provision of services by audiologists or audiometrists;
10. scales of charges set out in Schedule 10 for 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*;

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

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

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

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

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

GST means the tax payable under the GST law;

GST law means—

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

(b) the related legislation of the Commonwealth dealing with the imposition of a tax on the supply of 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) a charge is payable for services provided for less than or more than an hour; and
    (b) the amount payable in such circumstances is to be determined by dividing the number of minutes taken to provide the service (rounded to the nearest 6 minutes) by 60, then multiplying by the hourly rate.
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: 8 May 2021

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 (other than a service to which another item applies) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management-each attendance	$41.50
00004	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies) that requires a short patient history and, if necessary, limited examination and management-an attendance on one or more patients at one place on one occasion-each patient.	$106.00
	Level B	
00023	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance	$84.00
00024	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one place on one occasion-each patient	$144.00
	Level C	
00036	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance	$154.00
00037	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one place on one occasion-each patient	$215.00
	Level D	
00044	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance	$235.00

Item no.	Description	Max fee (excl. GST)
00047	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one place on one occasion-each patient	$300.00
GROUP A3—SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES		
00099	Professional attendance on a patient by a specialist practising in the specialist's specialty if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 104 lasting more than 10 minutes; or (ii) provided with item 105; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies. Fee: 50% of the fee for item 104 or 105.	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	$171.90
00105	Professional attendance by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist-an attendance after the first in a single course of treatment, if that attendance is at consulting rooms or hospital, other than a service to which item 16404 applies	$91.30
00106	Professional attendance by a specialist in the practice of the specialist's specialty of ophthalmology and following referral of the patient to the specialist-an attendance (other than a second or subsequent attendance in a single course of treatment) at which the only service provided is refraction testing for the issue of a prescription for spectacles or contact lenses, if that attendance is at consulting rooms or hospital (other than a service to which any of items 104, 109 and 10801 to 10816 applies)	$161.70
00107	Professional attendance by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist-an attendance (other than a second or subsequent attendance in a single course of treatment), if that attendance is at a place other than consulting rooms or hospital	$216.60
00108	Professional attendance by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist-each attendance after the first in a single course of treatment, if that attendance is at a place other than consulting rooms or hospital	$141.80
00109	Professional attendance by a specialist in the practice of the specialist's specialty of ophthalmology following referral of the patient to the specialist-an attendance (other than a second or subsequent attendance in a single course of treatment) at which a comprehensive eye examination, including pupil dilation, is performed on: (a) a patient aged 9 years or younger; or (b) a patient aged 14 years or younger with developmental delay; (other than a service to which any of items 104, 106 and 10801 to 10816 applies)	$257.20
00111	Professional attendance at consulting rooms or in hospital by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist by a referring practitioner-an attendance after the first attendance in a single course of treatment, if: (a) during the attendance, the specialist determines the need to perform an operation on the patient that had not otherwise been scheduled; and (b) the specialist subsequently performs the operation on the patient, on the same day; and (c) the operation is a service to which an item in Group T8 applies; and (d) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $309.35 or more For any particular patient, once only on the same day	$82.90
00113	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist in the practice of the specialist's speciality if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment	$110.60
00115	Professional attendance at consulting rooms or in hospital on a day by a medical practitioner (the attending practitioner) who is a specialist or consultant physician in the practice of the attending practitioner s specialty after referral of the patient to the attending practitioner by a referring practitioner an attendance after the initial attendance in a single course of treatment, if: (a) the attending practitioner performs a scheduled operation on the patient on the same day; and (b) the operation is a service to which an item in Group T8 applies; and (c) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $309.35 or more; and (d) the attendance is unrelated to the scheduled operation; and (e) it is considered a clinical risk to defer the attendance to a later day For any particular patient, once only on the same day	$83.10

Item no.	Description	Max fee (excl. GST)
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, not being a service to which item 106 applies Specialist, referred consultation of MORE THAN 25 minutes—surgery or hospitalNote1: 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 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. Factors 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 reports—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 their rehabilitation provider.	$178.40
GROUP A4—CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES		
00110	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-initial attendance in a single course of treatment	$308.20
00112	Professional attendance on a patient by a consultant physician practising in the consultant physician's specialty if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 110 lasting more than 10 minutes; or (ii) provided with item 116, 119, 132 or 133; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies. 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 the consultant physician's specialty if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (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	$194.90
00116	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-each attendance (other than a service to which item 119 applies) after the first in a single course of treatment	$148.50
00117	Professional attendance at consulting rooms or in hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-an attendance after the first attendance in a single course of treatment, if: (a) the attendance is not a minor attendance; and (b) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (c) the consultant physician subsequently performs the operation on the patient, on the same day; and (d) the operation is a service to which an item in Group T8 applies; and (e) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $309.35 or more For any particular patient, once only on the same day	$139.40
00119	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-each minor attendance after the first in a single course of treatment	$115.40
00120	Professional attendance at consulting rooms or in hospital by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-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 $309.35 or more For any particular patient, once only on the same day	$113.90
00122	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-initial attendance in a single course of treatment	$356.30
00128	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-each attendance (other than a service to which item 131 applies) after the first in a single course of treatment	$170.90

Item no.	Description	Max fee (excl. GST)
00131	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner-each minor attendance after the first in a single course of treatment	$146.80
00132	Professional attendance of at least 45 minutes duration for an initial assessment of a patient with at least two morbidities where the patient is referred by a referring practitioner, and where a) assessment is undertaken that covers: - a comprehensive history, including psychosocial history and medication review; - comprehensive multi or detailed single organ system assessment; - the formulation of differential diagnoses; and b) a treatment and management plan is developed and provided to the referring practitioner that involves: - an opinion on diagnosis and risk assessment - treatment options and decisions including suggestions to facilitate a return to work - medication recommendations. Not being an attendance on a patient in respect of whom, an attendance under items 110, 116 and 119 has been received on the same day by the same consultant physician. Note1: Item 132 is only available once in the preceding 12 months. Note 2: A written copy of the treatment and management plan must be provided to the patient, the referring practitioner and relevant allied health provider involved in treatment.	$491.70
00133	Professional attendance of at least 20 minutes duration subsequent to the first attendance in a single course of treatment for a review of a patient with at least two morbidities where a) a review is undertaken that covers: - review of initial presenting problem/s and results of diagnostic investigations - review of responses to treatment and medication plans initiated at time of initial consultation comprehensive multi or detailed single organ system assessment, - review of original and differential diagnoses; and b) a modified treatment and management plan is provided to the referring practitioner (see Note 3) that involves, where appropriate: - a revised opinion on the diagnosis and risk assessment - treatment options and decisions including suggestions to facilitate a return to work - revised medication recommendations. Not being an attendance on a patient in respect of whom, an attendance under item 110, 116 and 119 has been received on the same day by the same consultant physician. Being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under item 132 by the same consultant physician, payable no more than twice in any 12 month period. The subsequent attendance under item 133 is to be provided by either the same consultant physician or a locum tenens. Note1: Item 133 is only available twice in the preceding 12 months. Note 2: Should further reviews of the treatment and management plan be required, the appropriate item for such service/s is 116. Note 3: A written copy of the treatment and management plan must be provided to the patient, referring practitioner and relevant allied health provider involved in treatment.	$249.00
GROUP A29—EARLY INTERVENTION SERVICES FOR CHILDREN WITH AUTISM PERVASIVE DEVELOPMENTAL DISORDER OR DISABILITY		
00135	Professional attendance of at least 45 minutes in duration at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty of paediatrics, following referral of the patient to the consultant by a referring practitioner, for assessment, diagnosis and preparation of a treatment and management plan for a patient aged under 13 years with autism or another pervasive developmental disorder, if the consultant paediatrician does all of the following: (a) undertakes a comprehensive assessment and makes a diagnosis (if appropriate, using information provided by an eligible allied health provider); (b) develops a treatment and management plan, which must include the following: (i) an assessment and diagnosis of the patient's condition; (ii) a risk assessment; (iii) treatment options and decisions; (iv) if necessary-medical recommendations; (c) provides a copy of the treatment and management plan to: (i) the referring practitioner; and (ii) one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 137, 139 or 289)	$378.40

Item no.	Description	Max fee (excl. GST)
00137	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.	$378.40
00139	Professional attendance of at least 45 minutes in duration at consulting rooms only, by a general practitioner (not including a specialist or consultant physician) for assessment, diagnosis and preparation of a treatment and management plan for a patient under 13 years with an eligible disability if the general practitioner does all of the following: (a) undertakes a comprehensive assessment and makes a diagnosis (if appropriate, using information provided by an eligible allied health provider); (b) develops a treatment and management plan, which must include the following: (i) an assessment and diagnosis of the patient's condition; (ii) a risk assessment; (iii) treatment options and decisions; (iv) if necessary-medication recommendations; (c) provides a copy of the treatment and management plan to one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 137 or 289)	$232.00
GROUP A28—CONSULTANT PHYSICIAN OR SPECIALIST IN GERIATRIC MEDICINE		
00141	Professional attendance of more than 60 minutes in duration at consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and (c) during the attendance: (i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail using appropriately validated assessment tools if indicated (the assessment); and (ii) the patient's various health problems and care needs are identified and prioritised (the formulation); and (iii) a detailed management plan is prepared (the management plan) setting out: (A) the prioritised list of health problems and care needs; and (B) short and longer term management goals; and (C) recommended actions or intervention strategies to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient and the patient's family and carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and (v) the management plan is communicated in writing to the referring practitioner; and (d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (e) an attendance to which this item or item 145 applies has not been provided to the patient by the same practitioner in the preceding 12 months	$595.40
00143	Professional attendance of more than 30 minutes in duration at consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under item 141 or 145, if: (a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and (b) during the attendance: (i) the patient's health status is reassessed; and (ii) a management plan prepared under item 141 or 145 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies was not provided to the patient on the same day by the same practitioner; and (d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and (e) an attendance to which this item or item 147 applies has not been provided to the patient in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review	$372.20

Item no.	Description	Max fee (excl. GST)
00145	Professional attendance of more than 60 minutes in duration at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and (c) during the attendance: (i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail utilising appropriately validated assessment tools if indicated (the assessment); and (ii) the patient's various health problems and care needs are identified and prioritised (the formulation); and (iii) a detailed management plan is prepared (the management plan) setting out: (A) the prioritised list of health problems and care needs; and (B) short and longer term management goals; and (C) recommended actions or intervention strategies, to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient, the patient's family and any carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and (v) the management plan is communicated in writing to the referring practitioner; and (d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (e) an attendance to which this item or item 141 applies has not been provided to the patient by the same practitioner in the preceding 12 months	$721.70
00147	Professional attendance of more than 30 minutes in duration at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under items 141 or 145, if: (a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and (b) during the attendance: (i) the patient's health status is reassessed; and (ii) a management plan that was prepared under item 141 or 145 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and (e) an attendance to which this item or 143 applies has not been provided by the same practitioner in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review	$451.10
00149	Professional attendance on a patient by a consultant physician or specialist practising in the consultant physician's or specialist's specialty of geriatric medicine if: (a) the attendance is by video conference; and (b) item 141 or 143 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the physician or specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (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 141 or 143.	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	$345.10
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	$557.70
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	$753.50
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	$937.50
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	$1109.40
GROUP A6—GROUP THERAPY		
00170	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of the consultant physician's specialty of psychiatry) involving members of a family and persons with close personal relationships with that family-each group of 2 patients	$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 the consultant physician's specialty of psychiatry) involving members of a family and persons with close personal relationships with that family-each group of 3 patients	$242.20

Item no.	Description	Max fee (excl. GST)
00172	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of the consultant physician's specialty of psychiatry) involving members of a family and persons with close personal relationships with that family-each group of 4 or more patients	$278.60
GROUP A7—ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS		
	Acupuncture	
00173	Professional attendance at which acupuncture is performed by a medical practitioner by application of stimuli on or through the surface of the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture was performed	$43.20
00193	Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	$70.20
00195	Professional attendance by a general practitioner who is a qualified medical acupuncturist, on one or more patients at a hospital, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	$115.90
00197	Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	$111.70
00199	Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	$186.90
	Non-Specialist Practitioner attendances to which no other item applies	
00179	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which any other item applies) each attendance, by a medical practitioner in an eligible area.	$21.60
00181	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies), not more than 5 minutes in duration an attendance on one or more patients at one place on one occasion each patient, by a medical practitioner in an eligible area	$52.70
00185	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes (other than a service to which any other item applies) each attendance, by a medical practitioner in an eligible area	$47.40
00187	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 5 minutes in duration but not more than 25 minutes an attendance on one or more patients at one place on one occasion each patient, by a medical practitioner in an eligible area	$78.00
00189	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes (other than a service to which any other item applies) each attendance, by a medical practitioner in an eligible area	$91.70
00191	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 25 minutes in duration but not more than 45 minutes an attendance on one or more patients at one place on one occasion each patient, by a medical practitioner in an eligible area	$121.60
00203	Professional attendance at consulting rooms of more than 45 minutes in duration (other than a service to which any other item applies) each attendance, by a medical practitioner in an eligible area	$134.90

Item no.	Description	Max fee (excl. GST)
00206	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 45 minutes in duration an attendance on one or more patients at one place on one occasion each patient, by a medical practitioner in an eligible area	$164.10
	Non-Specialist Practitioner prolonged attendances to which no other item applies	
00214	Professional attendance by a medical practitioner for a period of not less than 1 hour but less than 2 hours (other than a service to which another item applies) on a patient in imminent danger of death	$278.80
00215	Professional attendance by a medical practitioner for a period of not less than 2 hours but less than 3 hours (other than a service to which another item applies) on a patient in imminent danger of death	$464.70
00218	Professional attendance by a medical practitioner for a period of not less than 3 hours but less than 4 hours (other than a service to which another item applies) on a patient in imminent danger of death	$650.40
00219	Professional attendance by a medical practitioner for a period of not less than 4 hours but less than 5 hours (other than a service to which another item applies) on a patient in imminent danger of death	$836.40
00220	Professional attendance by a medical practitioner for a period of 5 hours or more (other than a service to which another item applies) on a patient in imminent danger of death	$929.40
	Non-specialist Practitioner group therapy	
00221	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a medical practitioner involving members of a family and persons with close personal relationships with that family each Group of 2 patients	$148.00
00222	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a medical practitioner involving members of a family and persons with close personal relationships with that family each Group of 3 patients	$155.90
00223	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a medical practitioner involving members of a family and persons with close personal relationships with that family each Group of 4 or more patients	$189.70
	Non-Specialist Practitioner health assessments	
00177	Professional attendance for a heart health assessment by amedical practitioner (other than a specialist or consultant physician)at consulting rooms lasting at least 20 minutes and must include:(a) collection of relevant information, including taking a patient history that is aimed at identifying cardiovascular disease risk factors, including diabetes status, alcohol intake, smoking status and blood glucose;(b) a physical examination, which must include recording of blood pressure and cholesterol status;(c) initiating interventions and referrals to address the identified risk factors;(d) implementing a management plan for appropriate treatment of identified risk factors;(e) providing the patient with preventative health care advice and information, including modifiable lifestyle factors; with appropriate documentation. Claimable once only in a 12 month period.The heart health assessment item cannot be claimed if a patient has had a health assessment service(items 224, 225, 226, 227, 228) in the previous 12 months.	$105.50
00224	Professional attendance by a medical practitioner to perform a brief health assessment, lasting not more than 30 minutes and including: (a) collection of relevant information, including taking a patient history; and (b) a basic physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing the patient with preventive health care advice and information	$74.80
00225	Professional attendance by a medical practitioner to perform a standard health assessment, lasting more than 30 minutes but less than 45 minutes, including: (a) detailed information collection, including taking a patient history; and (b) an extensive physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing a preventive health care strategy for the patient	$173.60
00226	Professional attendance by a medical practitioner to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes, including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient s medical condition and physical function; and (c) initiating interventions and referrals as indicated; and (d) providing a basic preventive health care management plan for the patient	$239.50
00227	Professional attendance by a medical practitioner to perform a prolonged health assessment (lasting at least 60 minutes) including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient s medical condition, and physical, psychological and social function; and (c) initiating interventions or referrals as indicated; and (d) providing a comprehensive preventive health care management plan for the patient	$338.40
00228	Professional attendance by a medical practitioner at consulting rooms or in another place other than a hospital or residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent this item or items 715, 93470 or 93479 not more than once in a 9 month period.	$267.10
	Non-Specialist Practitioner management plans, team care arrangements and multidisciplinary care plans and case conferences	
00229	Attendance by a medical practitioner, for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items735 to 758 and items 235 to 240 apply)	$181.60

Item no.	Description	Max fee (excl. GST)
00230	Attendance by a medical practitioner, to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 735 to 758 and items 235 to 240 apply)	$143.90
00231	Contribution by a medical practitioner, to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758 and items 235 to 240 apply)	$88.60
00232	Contribution by a medical practitioner, to: (a) a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or (b) a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider (other than a service associated with a service to which items735 to 758 and items 235 to 240 apply)	$88.60
00233	Attendance by a medical practitioner to review or coordinate a review of: (a) a GP management plan prepared by a medical practitioner (or an associated medical practitioner) to which item721 or item 229 applies; or (b) team care arrangements which have been coordinated by the medical practitioner (or an associated medical practitioner) to which item723 or item 230 applies	$90.70
	Non-Specialist Practitioner domiciliary and residential medication management review	
00245	Participation by a medical practitioner in a Domiciliary Medication Management Review (DMMR) for a patient living in a community setting, in which the medical practitioner, with the patient s consent: (a) assesses the patient as: (i) having a chronic medical condition or a complex medication regimen; and (ii) not having their therapeutic goals met; and (b) following that assessment: (i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and (ii) provides relevant clinical information required for the DMMR; and (c) discusses with the reviewing pharmacist the results of the DMMR including suggested medication management strategies; and (d) develops a written medication management plan following discussion with the patient; and (e) provides the written medication management plan to a community pharmacy chosen by the patient For any particular patient this item or item 900 is applicable not more than once in each 12 month period, except if there has been a significant change in the patient s condition or medication regimen requiring a new DMMR	$194.90
00249	Participation by a medical practitioner in a residential medication management review (RMMR) for a patient who is a permanent resident of a residential aged care facility other than an RMMR for a resident in relation to whom, in the preceding 12 months, this item or item 903 has applied, unless there has been a significant change in the resident s medical condition or medication management plan requiring a new RMMR	$133.50
	Non-Specialist Practitioner attendances associated with Practice Incentive Program payments	
00251	Professional attendance at consulting rooms of less than 5 minutes in duration by a medical practitioner in an eligible area at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years	$21.30
00252	Professional attendance at consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner in an eligible area, at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years	$46.70
00253	Professional attendance at a place other than consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner in an eligible area, at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years	$77.30
00254	Professional attendance at consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner in an eligible area, at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years	$90.20
00255	Professional attendance at a place other than consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner in an eligible area, at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years	$120.10
00256	Professional attendance at consulting rooms of more than 45 minutes in duration by a medical practitioner in an eligible area, at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years	$132.90
00257	Professional attendance at a place other than consulting rooms of more than 45 minutes in duration by a medical practitioner in an eligible area, at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years	$162.10

Item no.	Description	Max fee (excl. GST)
00259	Professional attendance at consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus	$46.70
00260	Professional attendance at a place other than consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus	$77.30
00261	Professional attendance at consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the requirements for a cycle of care of a patient with established diabetes mellitus	$90.20
00262	Professional attendance at a place other than consulting rooms of more than 25 minutes but not more than 45 minutes, in duration by a medical practitioner in an eligible area, that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus	$120.10
00263	Professional attendance at consulting rooms of more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus	$132.90
00264	Professional attendance at a place other than consulting rooms of more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus	$162.10
00265	Professional attendance at consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements of the Asthma Cycle of Care	$46.70
00266	Professional attendance at a place other than consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements of the Asthma Cycle of Care	$77.30
00268	Professional attendance at consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements of the Asthma Cycle of Care	$90.20
00269	Professional attendance at a place other than consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements of the Asthma Cycle of Care	$120.10
00270	Professional attendance at consulting rooms of more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements of the Asthma Cycle of Care	$132.90
00271	Professional attendance at a place other than consulting rooms of more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements of the Asthma Cycle of Care	$162.10
	Non-Specialist Practitioner mental health care	
00272	Professional attendance by a medical practitioner (who has not undertaken mental health skills training) of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$90.20
00276	Professional attendance by a medical practitioner (who has not undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$132.90
00277	Professional attendance by a medical practitioner to review a GP mental health treatment plan which he or she, or an associated medical practitioner has prepared, or to review a Psychiatrist Assessment and Management Plan	$90.20
00279	Professional attendance by a medical practitioner in relation to a mental disorder and of at least 20 minutes in duration, involving taking relevant history and identifying the presenting problem (to the extent not previously recorded), providing treatment and advice and, if appropriate, referral for other services or treatments, and documenting the outcomes of the consultation	$90.20
00281	Professional attendance by a medical practitioner (who has undertaken mental health skills training) of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$114.70
00282	Professional attendance by a medical practitioner (who has undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$168.80
00283	Professional attendance at consulting rooms by a medical practitioner, for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes	$116.70
00285	Professional attendance at a place other than consulting rooms by a medical practitioner, for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes	$146.20

Item no.	Description	Max fee (excl. GST)
00286	Professional attendance at consulting rooms by a medical practitioner, for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 40 minutes	$167.10
00287	Professional attendance at a place other than consulting rooms by a medical practitioner, for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 40 minutes	$195.70
00371	Professional attendance at consulting rooms by a medical practitioner, for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient is located within a telehealth area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the medical practitioner.	$114.20
00372	Professional attendance at consulting rooms by a medical practitioner, for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 40 minutes if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient is located within a telehealth area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the medical practitioner.	$163.40
00941	Professional attendance by a medical practitioner (not including a general practitioner, specialist or a consultant physician), for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the person is a care recipient in a residential aged care facility (but not as an admitted patient of a hospital); and (b)the service is clinically indicated under a GP mental health treatment plan or a psychiatrist assessment and management plan; and (c) the service lasts at least 30 minutes, but less than 40 minutes	$135.00
00942	Professional attendance by a medical practitioner (not including a general practitioner, specialist or a consultant physician), for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the person is a care recipient in a residential aged care facility (but not as an admitted patient of a hospital); and (b)the service is clinically indicated under a GP mental health treatment plan or a psychiatrist assessment and management plan; and (c) the service lasts at least 40 minutes	$193.20
	Non-Specialist Practitioner after-hours attendances to which no other item applies	
00733	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which another item applies) by a medical practitioner each attendance	$36.50
00737	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes in duration (other than a service to which another item applies) by a medical practitioner each attendance	$61.70
00741	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes in duration (other than a service to which another item applies) by a medical practitioner each attendance	$105.70
00745	Professional attendance at consulting rooms of more than 45 minutes in duration (other than a service to which another item applies) by a medical practitioner each attendance	$148.20
00761	Professional attendance by a medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting not more than 5 minutes an attendance on one or more patients on one occasion each patient	$67.30
00763	Professional attendance by a medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 5 minutes, but not more than 25 minutes an attendance on one or more patients on one occasion each patient	$92.00
00766	Professional attendance by a medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 25 minutes, but not more than 45 minutes an attendance on one or more patients on one occasion each patient	$135.30
00769	Professional attendance by a medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 45 minutes an attendance on one or more patients on one occasion each patient	$177.20
00772	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self contained unit) of not more than 5 minutes in duration by a medical practitioner an attendance on one or more patients at one residential aged care facility on one occasion each patient	$92.40

Item no.	Description	Max fee (excl. GST)
00776	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self contained unit) of more than 5 minutes in duration but not more than 25 minutes in duration by a medical practitioner an attendance on one or more patients at one residential aged care facility on one occasion each patient	$117.10
00788	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self contained unit) of more than 25 minutes in duration but not more than 45 minutes by a medical practitioner an attendance on one or more patients at one residential aged care facility on one occasion each patient	$160.40
00789	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self contained unit) of more than 45 minutes in duration by a medical practitioner an attendance on one or more patients at one residential aged care facility on one occasion each patient	$202.30
	Non-Specialist Practitioner pregnancy support counselling	
00792	Professional attendance of at least 20 minutes in duration at consulting rooms by a medical practitioner who is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service for the purpose of providing non directive pregnancy support counselling to a person who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item or items 4001, 81000, 81005 or 81010 applies in relation to that pregnancy	$96.50
	Non-Specialist Practitioner video conferencing consultation	
00812	Professional attendance at consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance at least 15 kms by road from the specialist or physician mentioned in paragraph(a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service: for which a direction made under subsection19(2) of the Act applies	$28.80
00827	Professional attendance not in consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance at least 15 kms by road from the specialist or physician mentioned in paragraph(a); for an attendance on one or more patients at one place on one occasion each patient	$59.70
00829	Professional attendance of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self contained unit; for an attendance on one or more patients at one place on one occasion each patient	$84.90
00867	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 subsection19(2) of the Act applies	$62.80
00868	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	$93.10
00869	Professional attendance of less than 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self contained unit; for an attendance on one or more patients at one place on one occasion each patient	$118.30

Item no.	Description	Max fee (excl. GST)
00873	Professional attendance at consulting rooms of at least 20 minutes in duration (whether or not continuous) by a medical practitioner who provides clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance at least 15 kms by road from the specialist or physician mentioned in paragraph(a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service: for which a direction made under subsection19(2) of the Act applies	$122.00
00876	Professional attendance not in consulting rooms of at least 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance at least 15 kms by road from the specialist or physician mentioned in paragraph(a); for an attendance on one or more patients at one place on one occasion each patient	$151.40
00881	Professional attendance of at least 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self contained unit; for an attendance on one or more patients at one place on one occasion each patient	$176.50
00885	Professional attendance at consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance at least 15 kms by road from the specialist or physician mentioned in paragraph(a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection19(2) of the Act applies	$179.30
00891	Professional attendance not in consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance at least 15 kms by road from the specialist or physician mentioned in paragraph(a); for an attendance on one or more patients at one place on one occasion each patient	$207.80
00892	Professional attendance of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self contained unit; for an attendance on one or more patients at one place on one occasion each patient	$232.90
00894	Professional attendance by video conference by a medical practitioner, lasting more than 5 minutes but not more than 25 minutes, for providing mental health services to a patient with mental health issues, if the patient is affected by bushfire.	$54.50
00896	Professional attendance by video conference by a medical practitioner, lasting more than 25 minutes but not more than 45 minutes, for providing mental health services to a patient with mental health issues, if the patient is affected by bushfire.	$105.50
00898	Professional attendance by video conference by a medical practitioner, lasting more than 45 minutes, for providing mental health services to a patient with mental health issues if the patient is affected by bushfire.	$155.10
GROUP A8—CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES		
00288	Professional attendance on a patient by a consultant physician practising inthe consultant physician's specialty of psychiatry if: (a) the attendance is by video conference; and (b) item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 348, 350 or 352 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies. 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	Professional attendance of at least 45 minutes in duration at consulting rooms or hospital, by a consultant physician in the practice ofthe consultant physician's specialty of psychiatry, following referral of the patient to the consultant by a referring practitioner, for assessment, diagnosis and preparation of a treatment and management plan for a patient under 13 years with autism or another pervasive developmental disorder, if the consultant psychiatrist does all of the following: (a) undertakes a comprehensive assessment and makes a diagnosis (if appropriate, using information provided by an eligible allied health provider); (b) develops a treatment and management plan which must include the following: (i) an assessment and diagnosis of the patient's condition; (ii) a risk assessment; (iii) treatment options and decisions; (iv) if necessary-medication recommendations; (c) provides a copy of the treatment and management plan to the referring practitioner; (d) provides a copy of the treatment and management plan to one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 137 or 139)	$538.20

Item no.	Description	Max fee (excl. GST)
00291	Professional attendance of more than 45 minutes in duration at consulting rooms by a consultant physician in the practice of the consultant physician's specialty of psychiatry, if: (a) the attendance follows referral of the patient to the consultant for an assessment or management by a medical practitioner in general practice (including a general practitioner, but not a specialist or consultant physician) or a participating nurse practitioner; and (b) during the attendance, the consultant: (i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (c) the consultant decides that it is clinically appropriate for the patient to be managed by the referring practitioner without ongoing treatment by the consultant; and (d) within 2 weeks after the attendance, the consultant: (i) prepares a written diagnosis of the patient; and (ii) prepares a written management plan for the patient that: (A) covers the next 12 months; and (B) is appropriate to the patient's diagnosis; and (C) comprehensively evaluates the patient's biological, psychological and social issues; and (D) addresses the patient's diagnostic psychiatric issues; and (E) makes management recommendations addressing the patient's biological, psychological and social issues; and (iii) gives the referring practitioner a copy of the diagnosis and the management plan; and (iv) if clinically appropriate, explains the diagnosis and management plan, and a gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees	$695.20
00293	Professional attendance of more than 30 minutes but not more than 45 minutes in duration at consulting rooms by a consultant physician in the practice of the consultant physician's specialty of psychiatry, if: (a) the patient is being managed by a medical practitioner or a participating nurse practitioner in accordance with a management plan prepared by the consultant in accordance with item 291; and (b) the attendance follows referral of the patient to the consultant for review of the management plan by the medical practitioner or a participating nurse practitioner managing the patient; and (c) during the attendance, the consultant: (i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (iv) reviews the management plan; and (d) within 2 weeks after the attendance, the consultant: (i) prepares a written diagnosis of the patient; and (ii) revises the management plan; and (iii) gives the referring practitioner a copy of the diagnosis and the revised management plan; and (iv) if clinically appropriate, explains the diagnosis and the revised management plan, and gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees; and (e) in the preceding 12 months, a service to which item 291 applies has been provided; and (f) in the preceding 12 months, a service to which this item or item359 applies has not been provided	$451.10
00296	Professional attendance of more than 45 minutes in duration by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance at consulting rooms if the patient: (a) is a new patient for this consultant psychiatrist; or (b) has not received a professional attendance from this consultant psychiatrist in the preceding 24 months; other than attendance on a patient in relation to whom this item, item 297 or 299, or any of items 300 to 346, 353 to 358 and 361 to 370, has applied in the preceding 24 months	$419.10
00297	Professional attendance of more than 45 minutes by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance at hospital if the patient: (a) is a new patient for this consultant psychiatrist; or (b) has not received a professional attendance from this consultant psychiatrist in the preceding 24 months; other than attendance on a patient in relation to whom this item, item 296 or 299, or any of items 300 to 346, 353 to 358 and 361 to 370, has applied in the preceding 24 months (H)	$419.10
00299	Professional attendance of more than 45 minutes by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance at a place other than consulting rooms or a hospital if the patient: (a) is a new patient for this consultant psychiatrist; or (b) has not received a professional attendance from this consultant psychiatrist in the preceding 24 months; other than attendance on a patient in relation to whom this item, item 296 or 297, or any of items 300 to 346, 353 to 358 and 361 to 370, has applied in the preceding 24 months	$497.10
00300	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of not more than 15 minutes in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$91.00
00302	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 15 minutes, but not more than 30 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$181.00
00304	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration at consulting rooms), if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$276.70
00306	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 45 minutes, but not more than 75 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$399.20

Item no.	Description	Max fee (excl. GST)
00308	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 75 minutes in duration at consulting rooms), if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$451.20
00310	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of not more than 15 minutes in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient	$92.70
00312	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 15 minutes, but not more than 30 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient	$165.30
00314	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient	$239.40
00316	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 45 minutes, but not more than 75 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient	$338.40
00318	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 75 minutes in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient	$366.00
00319	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 45 minutes in duration at consulting rooms, if the patient has: (a) been diagnosed as suffering severe personality disorder, anorexia nervosa, bulimia nervosa, dysthymic disorder, substance-related disorder, somatoform disorder or a pervasive development disorder; and (b) for persons 18 years and over-been rated with a level of functional impairment within the range 1 to 50 according to the Global Assessment of Functioning Scale; if that attendance and another attendance to which any of items 296, 300 to 319, 353 to 358 and 361 to 370 applies have not exceeded 160 attendances in a calendar year for the patient	$353.30
00320	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of not more than 15 minutes in duration at hospital	$91.50
00322	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 15 minutes, but not more than 30 minutes, in duration at hospital	$181.00
00324	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration at hospital	$276.70
00326	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 45 minutes, but not more than 75 minutes, in duration at hospital	$399.20
00328	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 75 minutes in duration at hospital	$455.70
00330	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of not more than 15 minutes in duration if that attendance is at a place other than consulting rooms or hospital	$138.90
00332	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 15 minutes, but not more than 30 minutes, in duration if that attendance is at a place other than consulting rooms or hospital	$224.90
00334	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration if that attendance is at a place other than consulting rooms or hospital	$308.20

Item no.	Description	Max fee (excl. GST)
00336	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 45 minutes, but not more than 75 minutes, in duration if that attendance is at a place other than consulting rooms or hospital	$442.80
00338	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-an attendance of more than 75 minutes in duration if that attendance is at a place other than consulting rooms or hospital	$516.70
00342	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hour in duration given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry, involving a group of 2 to 9 unrelated patients or a family group of more than 3 patients, each of whom is referred to the consultant physician by a referring practitioner-each patient	$105.20
00344	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hour in duration given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry, involving a family group of 3 patients, each of whom is referred to the consultant physician by a referring practitioner-each patient	$140.20
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 hour in duration given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry, involving a family group of 2 patients, each of whom is referred to the consultant physician by a referring practitioner-each patient	$206.20
00348	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant physician by a referring practitioner, involving an interview of a person other than the patient of not less than 20 minutes, but less than 45 minutes, in duration, in the course of initial diagnostic evaluation of a patient	$264.20
00350	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant physician by a referring practitioner, involving an interview of a person other than the patient of not less than 45 minutes in duration, in the course of initial diagnostic evaluation of a patient	$365.40
00352	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant physician by a referring practitioner, involving an interview of a person other than the patient of not less than 20 minutes in duration, in the course of continuing management of a patient-if that attendance and another attendance to which this item applies have not exceeded 4 in a calendar year for the patient	$181.40
00353	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a telepsychiatry consultation of not more than 15 minutes in duration, if: (a) that attendance and another attendance to which any of items 353 to 358 and 361 applies have not exceeded 12 attendances in a calendar year for the patient; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$103.10
00355	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a telepsychiatry consultation of more than 15 minutes, but not more than 30 minutes, in duration, if: (a) that attendance and another attendance to which any of items 353 to 358 and 361 applies have not exceeded 12 attendances in a calendar year for the patient; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$204.50
00356	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a telepsychiatry consultation of more than 30 minutes, but not more than 45 minutes, in duration, if: (a) that attendance and another attendance to which any of items 353 to 358 and 361 applies have not exceeded 12 attendances in a calendar year for the patient; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$302.60
00357	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a telepsychiatry consultation of more than 45 minutes, but not more than 75 minutes, in duration, if: (a) that attendance and another attendance to which any of items 353 to 358 and 361 applies have not exceeded 12 attendances in a calendar year for the patient; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$416.40

Item no.	Description	Max fee (excl. GST)
00358	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a telepsychiatry consultation of more than 75 minutes in duration, if: (a) that attendance and another attendance to which any of items 353 to 358 and 361 applies have not exceeded 12 attendances in a calendar year for the patient; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$482.00
00359	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry-a telepsychiatry consultation of more than 30 minutes but not more than 45 minutes in duration, if: (a) the patient is being managed by a medical practitioner or a participating nurse practitioner in accordance with a management plan prepared by the consultant physician in accordance with item 291; and (b) the attendance follows referral of the patient to the consultant physician for review of the management plan by the referring practitioner managing the patient; and (c) during the attendance, the consultant physician: (i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (iv) reviews the management plan; and (d) within 2 weeks after the attendance, the consultant physician: (i) prepares a written diagnosis of the patient; and (ii) revises the management plan; and (iii) gives the referring practitioner a copy of the diagnosis and the revised management plan; and (iv) if clinically appropriate, explains the diagnosis and the revised management plan, and gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees; and (e) the patient is located in a regional, rural or remote area; and (f) in the preceding 12 months, a service to which item 291 applies has been performed; and (g) in the preceding 12 months, a service to which this item or item 293 applies has not been performed	$562.10
00361	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a telepsychiatry consultation of more than 45 minutes in duration, if the patient: (a) either: (i) is a new patient for this consultant physician; or (ii) has not received a professional attendance from this consultant physician in the preceding 24 months; and (b) is located in a regional, rural or remote area; other than attendance on a patient in relation to whom this item, item 296, 297 or 299, or any of items 300 to 346 and 353 to 370, has applied in the preceding 24 month period	$441.70
00364	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a face-to-face consultation of not more than 15 minutes in duration, if: (a) the patient has had a telepsychiatry consultation to which any of items 353 to 358 and 361 applies before that attendance; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$87.40
00366	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a face-to-face consultation of more than 15 minutes, but not more than 30 minutes, in duration, if: (a) the patient has had a telepsychiatry consultation to which any of items 353 to 358 and 361 applies before that attendance; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$176.00
00367	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a face-to-face consultation of more than 30 minutes, but not more than 45 minutes, in duration, if: (a) the patient has had a telepsychiatry consultation to which any of items 353 to 358 and 361 applies before that attendance; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$262.20
00369	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a face-to-face consultation of more than 45 minutes, but not more than 75 minutes, in duration, if: (a) the patient has had a telepsychiatry consultation to which any of items 353 to 358 and 361 applies before that attendance; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$370.50
00370	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner-a face-to-face consultation of more than 75 minutes in duration, if: (a) the patient has had a telepsychiatry consultation to which any of items 353 to 358 and 361 applies before that attendance; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$411.10
GROUP A13—PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES		
00410	LEVEL A Professional attendance at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.	$38.50

Item no.	Description	Max fee (excl. GST)
00411	LEVEL B Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.	$80.70
00412	LEVEL C Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.	$149.90
00413	LEVEL D Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.	$225.40
00414	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine other than at consulting rooms for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management	$81.70
00415	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine other than at consulting rooms, lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.	$123.00
00416	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine other than at consulting rooms lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation	$190.30
00417	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine other than at consulting rooms lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.	$259.10
GROUP A21—PROFESSIONAL ATTENDANCES AT RECOGNISED EMERGENCY DEPARTMENTS OF PRIVATE HOSPITALS		
	Consultations	
05001	Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist s specialty of emergency medicine involving medical decision making of ordinary complexity	$110.70
05011	Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist s specialty of emergency medicine involving medical decision-making of ordinary complexity	$187.60
05012	Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist s specialty of emergency medicine involving medical decision-making of complexity that is more than ordinary but is not high	$292.70
05014	Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist s specialty of emergency medicine involving medical decision-making of complexity that is more than ordinary but is not high	$368.10
05016	Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist s specialty of emergency medicine involving medical decision-making of high complexity	$493.70
05019	Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist s specialty of emergency medicine involving medical decision-making of high complexity	$569.10
05021	Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) involving medical decision-making of ordinary complexity	$99.60
05027	Professional attendance, on a patient aged 75 years or over,at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) involving medical decision-making of ordinary complexity	$168.80

Item no.	Description	Max fee (excl. GST)
05030	Professional attendance, on a patient aged 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) involving medical decision-making of complexity that is more than ordinary but is not high	$263.30
05032	Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) involving medical decision-making of complexity that is more than ordinary but is not high	$331.10
05033	Professional attendance, on a patient 4 years or over but under 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) involving medical decision-making of high complexity	$444.00
05036	Professional attendance, on a patient aged 75 years or over, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) involving medical decision-making of high complexity	$511.80
	Prolonged professional attendances	
05039	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist s specialty of emergency medicine for preparation of goals of care by the specialist for a gravely ill patient lacking current goals of care if: (a) the specialist takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the first attendance by the specialist for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is in conjunction with, or after, an attendance on the patient by the specialist that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019	$268.60
05041	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist s specialty of emergency medicine for preparation of goals of care by the specialist for a gravely ill patient lacking current goals of care if: (a) the specialist takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the first attendance by the specialist for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is not in conjunction with, or after, an attendance on the patient by the specialist that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019; and (d) the attendance is for at least 60 minutes	$506.60
05042	Professional attendance at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) for preparation of goals of care by the practitioner for a gravely ill patient lacking current goals of care if: (a) the practitioner takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the first attendance by the practitioner for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is in conjunction with, or after, an attendance on the patient by the practitioner that is described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036	$241.50
05044	Professional attendance at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) for preparation of goals of care by the practitioner for a gravely ill patient lacking current goals of care if: (a) the practitioner takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the first attendance by the practitioner for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is not in conjunction with, or after, an attendance on the patient by the practitioner that is described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (d) the attendance is for at least 60 minutes	$455.60
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	$204.20
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	$204.20
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	$157.40

Item no.	Description	Max fee (excl. GST)
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	$66.00
00599	Professional attendance by a general practitioner on not more than one patient on one occasion each attendance in unsociable hours if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient s medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	$500.00
00600	Professional attendance by a medical practitioner (other than a general practitioner) on not more than one patient on one occasion each attendance in unsociable hours if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient s medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	$233.80
GROUP A14—HEALTH ASSESSMENTS		
00699	Professional attendance for a heart health assessment by a general practitioner at consulting roomslasting at least 20 minutes and must include: (a) collection of relevant information, including taking a patient history that is aimed at identifying cardiovascular disease risk factors, including diabetes status, alcohol intake, smoking status and blood glucose;(b) a physical examination, which must include recording of blood pressure and cholesterol status;(c) initiating interventions and referrals to address the identified risk factors;(d) implementing a management plan for appropriate treatment of identified risk factors;(e) providing the patient with preventative health care advice and information, including modifiable lifestyle factors; with appropriate documentation. Claimable once only in a 12 month period.The heart health assessment item cannot be claimed if a patient has had a health assessment service(items 701, 703, 705, 707, 715) in the previous 12 months.	$131.70
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	$77.20
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	$177.90
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	$245.40
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	$346.60
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	$273.70
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. Arebate 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.	$186.40
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; orii. 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.	$147.30

Item no.	Description	Max fee (excl. GST)
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.	$93.20
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	$274.30
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	$187.70
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	Professional attendance at consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service: for which a direction made under subsection 19(2) of the Act applies	$37.20
02122	Professional attendance not in consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion-each patient	$78.40
02126	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	$81.10
02137	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	$121.60
02143	Professional attendance at consulting rooms of at least 20 minutes in duration (whether or not continuous) by a medical practitioner who provides clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service: for which a direction made under subsection 19(2) of the Act applies	$157.20

Item no.	Description	Max fee (excl. GST)
02147	Professional attendance not in consulting rooms of at least 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion-each patient	$196.40
02195	Professional attendance at consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies	$231.40
02199	Professional attendance not in consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion-each patient	$269.40
	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	$111.80
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	$155.00
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	$229.70
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	$302.80
	Mental Health and Well-being Video Conferencing Consultation	
02121	Professional attendance by video conference by a general practitioner, lasting less than 20 minutes, for providing mental health services to a patient with mental health issues, if the patient is affected by bushfire.	$68.00
02150	Professional attendance by video conference by a general practitioner, lasting at least 20 minutes, for providing mental health services to a patient with mental health issues, if the patient is affected by bushfire.	$131.70
02196	Professional attendance by video conference by a general practitioner, lasting at least 40 minutes, for providing mental health services to a patient with mental health issues, if the patient is affected by bushfire.	$194.00
GROUP A30—MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST, OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES		
	General Practitioner Video Conferencing Consultation Attendance for patients in rural and remote areas	
02461	Professional attendance by video conference by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management, only if: the patient is not an admitted patient; and the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and the patient has received 3 face-to-face professional attendances from that practitioner in the preceding 12 months.	$26.30

Item no.	Description	Max fee (excl. GST)
02463	Professional attendance by video conference by a general practitioner (other than a service to which another item applies), lasting less than 20 minutes and including any of the following that are clinically relevant: taking a patient history; performing a clinical examination; (arranging any necessary investigation; implementing a management plan; providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation only if:—the patient is not an admitted patient; and—the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and—at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and—the patient has received 3 face-to-face professional attendances from that practitioner in the preceding 12 months.	$57.30
02464	Professional attendance by video conference by a general practitioner (other than a service to which another item applies), lasting at least 20 minutes but less than 40 minutes and including any of the following that are clinically relevant: taking a patient history; performing a clinical examination; arranging any necessary investigation; implementing a management plan; providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation only if:—the patient is not an admitted patient; and—the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and—at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and—the patient has received 3 face-to-face professional attendances from that practitioner in the preceding 12 months.	$110.90
02465	Professional attendance by video conference by a general practitioner (other than a service to which another item applies), lasting at least 40 minutes and including any of the following that are clinically relevant: taking a patient history; performing a clinical examination; arranging any necessary investigation; implementing a management plan; providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation only if:—the patient is not an admitted patient; and—the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and—at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and—the patient has received 3 face-to-face professional attendances from that practitioner in the preceding 12 months.	$163.30
	Non Specialist Practitioner Video Conferencing Consultation for patients in rural and remote areas	
02480	Professional attendance by video conference of not more than 5 minutes in duration by a medical practitioner, only if: (a) the patient is not an admitted patient; and (b) the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and (c) at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and (d) the patient has received 3 face to face professional attendances from that practitioner in the preceding 12 months.	$21.00
02481	Professional attendance by video conference of more than 5 minutes in duration but not more than 25 minutes by a medical practitioner, only if: (a) the patient is not an admitted patient; and (b) the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and (c) at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and (d) the patient has received 3 face to face professional attendances from that practitioner in the preceding 12 months.	$45.80
02482	Professional attendance by video conference of more than 25 minutes in duration but not more than 45 minutes by a medical practitioner, only if: (a) the patient is not an admitted patient; and (b) the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and (c) at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and (d) the patient has received 3 face to face professional attendances from that practitioner in the preceding 12 months.	$88.70
02483	Professional attendance by video conference of more than 45 minutes in duration by a medical practitioner, only if:(a) the patient is not an admitted patient; and (b) the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and (c) at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and (d) the patient has received 3 face to face professional attendances from that practitioner in the preceding 12 months.	$130.70
GROUP A18—GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS		
	Taking of a cervical smear from an unscreened or significantly underscreened woman	
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.	$29.90
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, andat 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.	$66.40

Item no.	Description	Max fee (excl. GST)
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.	$112.20
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, andat 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	$124.70
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, andat 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	$169.60
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 issues, with appropriate documentation, andat 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	$183.50
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, andat 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	$227.40
	Completion of a cycle of care for patients with established diabetes mellitus	
02517	Professional attendance by a general practitioner at consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus	$65.80
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 one or more health-related issues, with appropriate documentation, and completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus	$111.60
02521	Professional attendance by a general practitioner at consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus	$124.70
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 one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus	$169.60
02525	Professional attendance by a general practitioner at consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus	$183.50

Item no.	Description	Max fee (excl. GST)
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 one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus	$227.40
	Completion of the asthma cycle of care	
02546	Professional attendance by a general practitioner at consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care	$65.80
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 one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care	$111.60
02552	Professional attendance by a general practitioner at consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care	$124.70
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 one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care	$169.60
02558	Professional attendance by a general practitioner at consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care	$183.50
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 one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care	$227.40
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	$128.00
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	$188.30
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	$162.60
02717	Professional attendance by a general practitioner (including a general practitioner who has undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$239.30

Item no.	Description	Max fee (excl. GST)
	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	$144.40
02723	Professional attendance at a place other than consulting rooms by a general practitioner, for providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes	$189.00
02725	Professional attendance at consulting rooms by a general practitioner, for providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes	$193.80
02727	Professional attendance at a place other than consulting rooms by a general practitioner, for providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes	$237.50
02729	Professional attendance at consulting rooms, by a general practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, to provide focussed psychological strategies for assessed mental disorders, if: (a) the attendance is by video conference and lasts at least 30 minutes but less than 40 minutes; and (b) the patient is not an admitted patient; and (c) the patient is located within a Modified Monash 4, 5, 6 or 7 area and, at the time of the attendance, is at least 15 kilometres by road from the general practitioner	$142.70
02731	Professional attendance at consulting rooms, by a general practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, to provide focussed psychological strategies for assessed mental disorders, if: (a) the attendance is by video conference and lasts at least 40 minutes; and (b) the patient is not an admitted patient; and (c) the patient is located within a Modified Monash 4, 5, 6 or 7 area and, at the time of the attendance, is at least 15 kilometres by road from the general practitioner	$204.20
02733	Professional attendance by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the person is a care recipient in a residential aged care facility (but not as an admitted patient of a hospital); and (b)the service is clinically indicated under a GP mental health treatment plan or a psychiatrist assessment and management plan; and (c)the service lasts at least 30 minutes, but less than 40 minutes	$168.80
02735	Professional attendance by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the person is a care recipient in a residential aged care facility (but not as an admitted patient of a hospital); and (b)the service is clinically indicated under a GP mental health treatment plan or a psychiatrist assessment and management plan; and (c) the service lasts at least 40 minutes	$241.50
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 the specialist's or consultant physician's specialty of pain medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment	$194.90
02801	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-initial attendance in a single course of treatment	$320.20
02806	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each attendance (other than a service to which item 2814 applies) after the first in a single course of treatment	$148.50
02814	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each minor attendance after the first attendance in a single course of treatment	$115.40

Item no.	Description	Max fee (excl. GST)
02820	Professional attendance on a patient by a specialist or consultant physician practising in the specialist's or consultant physician's specialty of pain medicine if: (a) the attendance is by video conference; and (b) the 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 item 2801, 2806 or 2814.	DF
02824	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-initial attendance in a single course of treatment	$356.30
02832	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each attendance (other than a service to which item 2840 applies) after the first in a single course of treatment	$195.50
02840	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each minor attendance after the first attendance in a single course of treatment	$174.50
	Pain medicine case conferences	
02946	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes	$273.80
02949	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes	$409.50
02954	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes	$545.00
02958	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes	$155.80
02972	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes	$282.70
02974	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes	$341.40
02978	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	$284.90
02984	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	$409.50
02988	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H)	$545.00
02992	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	$175.70
02996	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	$282.70
03000	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H)	$385.40

Item no.	Description	Max fee (excl. GST)
	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 the specialist's or consultant physician's specialty of palliative medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment	$194.90
03005	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-initial attendance in a single course of treatment	$308.20
03010	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each attendance (other than a service to which item 3014 applies) after the first in a single course of treatment	$148.50
03014	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each minor attendance after the first attendance in a single course of treatment	$145.40
03015	Professional attendance on a patient by a specialist or consultant physician practising in the specialist's or consultant physician's specialty of palliative medicine if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 3005 lasting more than 10 minutes; or (ii) provided with item 3010 or 3014; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies. 50% of the fee for item 3005, 3010 or 3014.	DF
03018	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-initial attendance in a single course of treatment	$356.30
03023	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each attendance (other than a service to which item 3028 applies) after the first in a single course of treatment	$195.50
03028	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner-each minor attendance after the first attendance in a single course of treatment	$174.50
	Palliative medicine case conferences	
03032	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes	$273.80
03040	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes	$409.50
03044	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes	$545.00
03051	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes	$155.80
03055	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	$264.10
03062	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes	$385.40

Item no.	Description	Max fee (excl. GST)
03069	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	$284.90
03074	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	$426.20
03078	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H)	$567.20
03083	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	$175.70
03088	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	$282.70
03093	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H)	$385.40
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.	$135.60
GROUP A22—GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES		
05000	Professional attendance at consulting rooms (other than a service to which another item applies) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management-each attendance	$63.00
05003	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies) that requires a short patient history and, if necessary, limited examination and management-an attendance on one or more patients on one occasion-each patient	$126.00
05010	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is accommodated in a residential aged care facility (other than accommodation in a self-contained unit) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management-an attendance on one or more patients at one residential aged care facility on one occasion-each patient	$126.00
05020	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance	$126.00
05023	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients on one occasion-each patient	$186.00
05028	Professional attendance by a general practitioner (other than a service to which another item in the table applies), at a residential aged care facility to residents of the facility, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one residential aged care facility on one occasion-each patient	$186.00

Item no.	Description	Max fee (excl. GST)
05040	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance	$230.00
05043	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients on one occasion-each patient	$285.00
05049	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one residential aged care facility on one occasion-each patient	$285.00
05060	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance	$355.00
05063	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients on one occasion-each patient	$420.00
05067	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one residential aged care facility on one occasion-each patient	$420.00
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	$167.30
06007	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-an attendance (other than a second or subsequent attendance in a single course of treatment) at consulting rooms or hospital	$267.30
06009	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-a minor attendance after the first in a single course of treatment at consulting rooms or hospital	$92.20
06011	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-an attendance after the first in a single course of treatment, involving an extensive and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 15 minutes in duration but not more than 30 minutes in duration at consulting rooms or hospital	$182.60
06013	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-an attendance after the first in a single course of treatment, involving a detailed and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 30 minutes in duration but not more than 45 minutes in duration at consulting rooms or hospital	$251.60
06015	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to the specialist-an attendance after the first in a single course of treatment, involving an exhaustive and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 45 minutes in duration at consulting rooms or hospital	$316.70

Item no.	Description	Max fee (excl. GST)
06016	Professional attendance on a patient by a specialist practising in the specialist's specialty of neurosurgery if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 6007 lasting more than 10 minutes; or (ii) provided with item 6009, 6011, 6013 or 6015; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies. 50% of the fee for item 6007, 6009, 6011, 6013 or 6015.	DF
GROUP A31—ADDICTION MEDICINE		
	Addiction Medicine Attendances	
06018	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty following referral of the patient to the addiction medicine specialist by a referring practitioner, if the attendance: (a) includes a comprehensive assessment; and (b) is the first or only time in a single course of treatment that a comprehensive assessment is provided	$326.30
06019	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty following referral of the patient to the addiction medicine specialist by a referring practitioner, if the attendance is a patient assessment: (a) before or after a comprehensive assessment under item 6018 in a single course of treatment; or (b) that follows an initial assessment under item 6023 in a single course of treatment; or (c) that follows a review under item 6024 in a single course of treatment	$170.40
06023	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to the addiction medicine specialist by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) an addiction medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions; (iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6018 or 6019 applies did not take place on the same day by the same addiction medicine specialist; and (d) neither this item nor item 132 has applied to an attendance on the patient in the preceding 12 months by the same addiction medicine specialist	$513.40
06024	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty of at least 20 minutes, after the first attendance in a single course of treatment for a review of a patient with at least 2 morbidities if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified addiction medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6018 or 6019 applies did not take place on the same day by the same addiction medicine specialist; and (d) item 6023 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same addiction medicine specialist who claimed item 6023 or by a locum tenens; and (f) this item has not applied more than twice in any 12 month period	$255.60
06025	Initial professional attendance of 10 minutes or less, on a patient by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 km by road from the addiction medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment	$181.00
06026	Professional attendance on a patient by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, if: (a) the attendance is by video conference; and (b) the attendance is for a service: (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	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 the addiction medicine specialist's specialty for a group of 2 to 9 unrelated patients, or a family group of more than 2 patients, each of whom is referred to the addiction medicine specialist by a referring practitioner-for each patient	$99.50

Item no.	Description	Max fee (excl. GST)
GROUP A32—SEXUAL HEALTH MEDICINE		
	Sexual Health Medicine Attendances	
06051	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner, if the attendance: (a) includes a comprehensive assessment; and (b) is the first or only time in a single course of treatment that a comprehensive assessment is provided	$241.30
06052	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner, if the attendance is a patient assessment: (a) before or after a comprehensive assessment under item 6051 in a single course of treatment; or (b) that follows an initial assessment under item 6057 in a single course of treatment; or (c) that follows a review under item 6058 in a single course of treatment	$120.70
06057	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to the sexual health medicine specialist by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) a sexual health medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions; (iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6051 or 6052 applies did not take place on the same day by the same sexual health medicine specialist; and (d) neither this item nor item 132 has applied to an attendance on the patient in the preceding 12 months by the same sexual health medicine specialist	$421.80
06058	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty of at least 20 minutes, after the first attendance in a single course of treatment for a review of a patient with at least 2 morbidities if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified sexual health medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient, being an attendance to which item 104, 105, 110, 116, 119, 132, 133, 6051 or 6052 applies did not take place on the same day by the same sexual health medicine specialist; and (d) item 6057 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same sexual health medicine specialist who claimed item 6057 or by a locum tenens; and (f) this item has not applied more than twice in any 12 month period	$211.20
06059	Initial professional attendance of 10 minutes or less, on a patient by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 km by road from the sexual health medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment	$181.00
06060	DERIVED FEE, Professional attendance on a patient by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty if: (a) the attendance is by video conference; and (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	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 the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner-initial attendance in a single course of treatment	$292.80
06063	Professional attendance at a place other than consulting rooms or a hospital by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner-each attendance after the attendance under item 6062 in a single course of treatment	$177.10

Item no.	Description	Max fee (excl. GST)
GROUP A41—COVID-19 ADDITIONAL FOCUSSED PSYCHOLOGICAL STRATEGIES		
	GP additional focussed psychological strategies	
93287	Professional attendance by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the person is a care recipient in a residential aged care facility (but not as an admitted patient of a hospital); and (b)the service is clinically indicated under a GP mental health treatment plan or a psychiatrist assessment and management plan; and (c)the service lasts at least 30 minutes, but less than 40 minutes	$168.80
93288	Professional attendance by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the person is a care recipient in a residential aged care facility (but not as an admitted patient of a hospital); and (b)the service is clinically indicated under a GP mental health treatment plan or a psychiatrist assessment and management plan; and (c) the service lasts at least 40 minutes	$241.50
	Non specialist practitioner additional focussed psychological stratgies	
93291	Professional attendance by a medical practitioner (not including a general practitioner, specialist or a consultant physician), for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the person is a care recipient in a residential aged care facility (but not as an admitted patient of a hospital); and (b)the service is clinically indicated under a GP mental health treatment plan or a psychiatrist assessment and management plan; and (c) the service lasts at least 30 minutes, but less than 40 minutes	$135.00
93292	Professional attendance by a medical practitioner (not including a general practitioner, specialist or a consultant physician), for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the person is a care recipient in a residential aged care facility (but not as an admitted patient of a hospital); and (b)the service is clinically indicated under a GP mental health treatment plan or a psychiatrist assessment and management plan; and (c) the service lasts at least 40 minutes	$193.20
GROUP A42—MENTAL HEALTH PLANNING FOR CARE RECIPIENTS OF AN RESIDENTIAL AGED CARE FACILITY		
	GP mental health treatment plans for care recipients of an residential aged care facility	
93400	Professional attendance by a general practitioner who has not undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 20 minutes, but less than 40 minutes	$130.50
93401	Professional attendance by a general practitioner who has not undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 40 minutes	$192.10
93402	Professional attendance, by a general practitioner who has undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 20 minutes, but less than 40 minutes	$165.70
93403	Professional attendance, by a general practitioner who has undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 40 minutes	$244.10
93404	Telehealth attendance by a general practitioner who has not undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 20 minutes but less than 40 minutes	$130.50
93405	Telehealth attendance by a general practitioner who has not undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 40 minutes	$192.10
93406	Telehealth attendance by a general practitioner who has undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 20 minutes but less than 40 minutes	$165.70
93407	Telehealth attendance by a general practitioner who has undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 40 minutes	$244.10
93408	Phone attendance by a general practitioner who has not undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 20 minutes but less than 40 minutes	$130.50

Item no.	Description	Max fee (excl. GST)
93409	Phone attendance by a general practitioner who has not undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 40 minutes	$192.10
93410	Phone attendance by a general practitioner who has undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 20 minutes but less than 40 minutes	$165.70
93411	Phone attendance by a general practitioner who has undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 40 minutes	$244.10
	GP mental health treatment plan review for care recipients of an residential aged care facility	
93421	Professional attendance by a general practitioner to review a GP mental health treatment plan which the general practitioner, or an associated medical practitioner has prepared, or to review a psychiatrist assessment and management plan (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) one of the following services has been provided to the patient: (i) a mental health treatment plan under items 93400 to 93411 or 93431 to 93442; or (ii) a psychiatrist assessment and management plan; and (c) the reviewing practitioner modifies the person s GP mental health treatment plan or psychiatrist assessment and management plan to record that they recommend the person have an additional number of better access treatment services	$130.50
93422	Telehealth attendance by a general practitioner to review a GP mental health treatment plan which the general practitioner, or an associated medical practitioner has prepared, or to review a psychiatrist assessment and management plan (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) one of the following services has been provided to the patient: (i) a mental health treatment plan under items 93400 to 93411 or 93431 to 93442; or (ii) a psychiatrist assessment and management plan; and (c) the reviewing practitioner modifies the person s GP mental health treatment plan or psychiatrist assessment and management plan to record that they recommend the person have an additional number of better access treatment services	$130.50
93423	Phone attendance by a general practitioner to review a GP mental health treatment plan which the general practitioner, or an associated medical practitioner has prepared, or to review a psychiatrist assessment and management plan (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) one of the following services has been provided to the patient: (i) a mental health treatment plan under items 93400 to 93411 or 93431 to 93442; or (ii) a psychiatrist assessment and management plan; and (c) the reviewing practitioner modifies the person s GP mental health treatment plan or psychiatrist assessment and management plan to record that they recommend the person have an additional number of better access treatment services	$130.50
	Non specialist practitioner mental health treatment plans for car recipients of an residential aged care facility	
93431	Professional attendance by a medical practitioner who has not undertaken mental health skills training (not including a general practitioner, specialist or a consultant physician), for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 20 minutes, but less than 40 minutes	$104.30
93432	Professional attendance by a medical practitioner who has not undertaken mental health skills training (not including a general practitioner, specialist or a consultant physician), for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 40 minutes	$153.70
93433	Professional attendance, by a medical practitioner who has undertaken mental health skills training (but not including a general practitioner, specialist or consultant physician), for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 20 minutes, but less than 40 minutes	$132.50
93434	Professional attendance, by a medical practitioner who has undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 40 minutes	$195.20
93435	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), who has not undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 20 minutes but less than 40 minutes	$104.30
93436	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), who has not undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 40 minutes	$153.70

Item no.	Description	Max fee (excl. GST)
93437	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), who has undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 20 minutes but less than 40 minutes	$132.50
93438	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), who has undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 40 minutes	$195.20
93439	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), who has not undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 20 minutes but less than 40 minutes	$104.30
93440	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), who has not undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 40 minutes	$153.70
93441	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), who has undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) of at least 20 minutes but less than 40 minutes	$132.50
93442	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), who has undertaken mental health skills training, for the preparation of a GP mental health treatment plan for a patient (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) the service lasts at least 40 minutes	$195.20
	Non specialist practitioner mental health treatment plan review for car recipients of an residential aged care facility	
93451	Professional attendance by a medical practitioner to review a GP mental health treatment plan which the medical practitioner, or an associated medical practitioner has prepared, or to review a Psychiatrist Assessment and Management Plan (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) one of the following services has been provided to the patient: (i) a mental health treatment plan under items 93400 to 93411 or 93431 to 93442; or (ii) a psychiatrist assessment and management plan; and (c) the reviewing practitioner modifies the person s GP mental health treatment plan or psychiatrist assessment and management plan to record that they recommend the person have an additional number of better access treatment services	$104.30
93452	Telehealth attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician) to review a GP mental health treatment plan which the medical practitioner, or an associated medical practitioner has prepared, or to review a psychiatrist assessment and management plan (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) one of the following services has been provided to the patient: (i) a mental health treatment plan under items 93400 to 93411 or 93431 to 93442; or (ii) a psychiatrist assessment and management plan; and (c) the reviewing practitioner modifies the person s GP mental health treatment plan or psychiatrist assessment and management plan to record that they recommend the person have an additional number of better access treatment services	$104.30
93453	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician) to review a GP mental health treatment plan which the medical practitioner, or an associated medical practitioner has prepared, or to review a psychiatrist assessment and management plan (but not as an admitted patient of a hospital) if: (a) the person is a care recipient in a residential aged care facility; and (b) one of the following services has been provided to the patient: (i) a mental health treatment plan under items 93400 to 93411 or 93431 to 93442; or (ii) a psychiatrist assessment and management plan; and (c) the reviewing practitioner modifies the person s GP mental health treatment plan or psychiatrist assessment and management plan to record that they recommend the person have an additional number of better access treatment services	$104.30
	GROUP A43—PROFESSIONAL ATTENDANCE BY A MEDICAL PRACTITIONER (OTHER THAN A GENERAL PRACTITIONER, AND SPECIALIST) AT A RESIDENTIAL AGED CARE FACILITY TO RESIDENTS OF THE FACILITY (OTHER THAN A SERVICE TO WHICH ANOTHER ITEM IN THE TABLE APPLIES) CONTRIBUTION TO:	
	RACF	
93469	Professional attendance by a general practitioner at a residential aged care facility to contribute to a multidisciplinary care plan, prepared by that facility, or to a review of such a plan prepared by such a facility, if the practitioner performs any of the following as a face-to-face service: (a) prepares part of a multidisciplinary care plan and adding a copy of that part of the plan to the person s medical records; or (b) preparing amendments to part of a multidisciplinary care plan and adding a copy of the amendments to the person s medical records; (c) giving advice to a practitioner who prepares part of a multidisciplinary care plan and recording in writing, on the person s medical records, any advice provided to the practitioner; or (d) giving advice to a practitioner who reviews part of a multidisciplinary care plan and recording in writing, on the person s medical records, any advice provided to the practitioner not more than once in a 3 month period	$128.10

Item no.	Description	Max fee (excl. GST)
93470	Professional face-to-face attendance by a general practitioner at a residential aged care facility to perform a health assessment of a person who is: (a) of Aboriginal or Torres Strait Islander descent; and (b) a care recipient in a residential aged care facility not more than once in a 9 month period	$386.30
	RACF	
93475	Professional attendance by a medical practitioner (not including a general practitioner, specialist or a consultant physician) at a residential aged care facility to contribute to a multidisciplinary care plan, prepared by that facility, or to a review of such a plan prepared by such a facility, if the practitioner performs any of the following as a face-to-face service: (a) prepares part of a multidisciplinary care plan and adding a copy of that part of the plan to the person s medical records; or (b) preparing amendments to part of a multidisciplinary care plan and adding a copy of the amendments to the person s medical records; (c) giving advice to a practitioner who prepares part of a multidisciplinary care plan and recording in writing, on the person s medical records, any advice provided to the practitioner; or (d) giving advice to a practitioner who reviews part of a multidisciplinary care plan and recording in writing, on the person s medical records, any advice provided to the practitioner not more than once in a 3 month period	$102.50
93479	Professional face-to-face attendance by a medical practitioner (not including a general practitioner, specialist or a consultant physician) at a residential aged care facility to perform a health assessment of a person who is: (a) of Aboriginal or Torres Strait Islander descent; and (b) a care recipient in a residential aged care facility not more than once in a 9 month period	$309.00
GROUP A9—CONTACT LENSES—ATTENDANCES		
10801	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with myopia of 5.0 dioptres or greater (spherical equivalent) in one eye	$219.60
10802	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in one eye	$219.60
10803	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with astigmatism of 3.0 dioptres or greater in one eye	$219.60
10804	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens	$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-one service in any period of 36 months-patient with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents)	$219.60
10806	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with corrected visual acuity of 0.7 logMAR (6/30) or worse in both eyes and for whom a contact lens is prescribed as part of a telescopic system	$219.60
10807	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by pathological mydriasis, aniridia, coloboma of the iris, pupillary malformation or distortion, significant ocular deformity or corneal opacity-whether congenital, traumatic or surgical in origin	$219.60
10808	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient who, because of physical deformity, are unable to wear spectacles	$219.60
10809	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with a medical or optical condition (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10806, 10807 or 10808 applies) requiring the use of a contact lens for correction, if the condition is specified on the patient’s account	$219.60
10816	Attendance for the refitting of contact lenses with keratometry and testing with trial lenses and the issue of a prescription, if the patient requires a change in contact lens material or basic lens parameters, other than simple power change, because of a structural or functional change in the eye or an allergic response within 36 months after the fitting of a contact lens to which items 10801 to 10809 apply	$219.60
GROUP D1—MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS		
	Neurology	
11000	ELECTROENCEPHALOGRAPHY, not being a service: (a)associated with a service to which item 11003 or 11009 applies; or (b)involving quantitative topographic mapping using neurometrics or similar devices (Anaes.)	$236.10

Item no.	Description	Max fee (excl. GST)
11003	Electroencephalography, prolonged recording lasting at least 3 hours, that requires multi channel recording using: (a) for a service not associated with a service to which an item in Group T8 applies standard 10 20 electrode placement; or (b) for a service associated with a service to which an item in Group T8 applies either standard 10 20 electrode placement or a different electrode placement and number of recorded channels; other than a service: (c) associated with a service to which item11000, 11004 or 11005 applies; or (d) involving quantitative topographic mapping using neurometrics or similar devices.	$554.00
11004	Electroencephalography, ambulatory or video, prolonged recording lasting at least 3 hours and up to 24 hours, that requires multi channel recording using standard 10-20 electrode placement, first day, other than a service:(a) associated with a service to which item 11000, 11003 or 11005 applies; or(b) involving quantitative topographic mapping using neurometrics or similar devices.	$618.00
11005	Electroencephalography, ambulatory or video, prolonged recording lasting at least 3 hours and up to 24 hours, that requires multi channel recording using standard 10-20 electrode placement, each day after the first day, other than a service:(a) associated with a service to which item 11000, 11003 or 11004 applies; or(b) involving quantitative topographic mapping using neurometrics or similar devices.	$591.60
11009	Electrocorticography	$383.20
11012	NEUROMUSCULAR ELECTRODIAGNOSISconduction 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)	$203.50
11015	NEUROMUSCULAR ELECTRODIAGNOSISconduction 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)	$290.00
11018	NEUROMUSCULAR ELECTRODIAGNOSISconduction 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)	$424.10
11021	NEUROMUSCULAR ELECTRODIAGNOSISrepetitive stimulation for study of neuromuscular conduction OR electromyography with quantitative computerised analysis OR both of these examinations	$286.90
11024	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials or multifocal multichannel objective perimetry—1 or 2 studies	$192.20
11027	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials or multifocal multichannel objective perimetry—3 or more studies	$283.90
	Opthalmology	
11200	Provocative test or tests for open angle glaucoma, including water drinking	$68.10
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.	$195.40
11205	ELECTROOCULOGRAPHY of one or both eyes performed according to current professional guidelines or standards, performed by or on behalf of a specialist or consultant physician in the practice of his or her speciality.	$195.40
11210	PATTERN ELECTRORETINOGRAPHY of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards	$195.40
11211	DARK ADAPTOMETRY of one or both eyes with a quantitative (log cd/m2) estimation of threshold in log lumens at 45 minutes of dark adaptations	$195.40
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 an ocular condition for the treatment of which there is a medication that is: (a) listed on the pharmaceutical benefits scheme; and (b) indicated for intraocular administration Applicable only once in any 12 month period	$64.00
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.	$64.00
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

Item no.	Description	Max fee (excl. GST)
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, one eye, not being a service associated with a service to which items in Group I1 of Category 5 apply	$156.90
11240	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of one eye prior to lens surgery on that eye, not being a service associated with a service to which items in Group I1 of Category 5 apply.	$156.90
11241	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for bilateral eye measurement prior to lens surgery on both eyes, not being a service associated with a service to which items in Group I1 apply	$198.40
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 items in Group I1 apply	$154.30
11243	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of a second eye where surgery for the first eye has resulted in more than 1 dioptre of error or where more than 3 years have elapsed since the surgery for the first eye, not being a service associated with a service to which items in Group I1 apply	$144.70
11244	Orbital contents, diagnostic B-scan of, by a specialist practising in his or her speciality of ophthalmology, not being a service associated with a service to which an item in Group I1 of the diagnostic imaging services table applies.	$135.60
	Otolaryngology	
11300	Brain stem evoked response audiometry (Anaes.)	$333.80
11303	Electrocochleography, extratympanic method, 1 or both ears	$333.80
11304	ELECTROCOCHLEOGRAPHY, transtympanic membrane insertion technique, 1 or both ears	$544.00
11306	Nondeterminate AUDIOMETRY	$37.50
11309	Audiogram, air conduction	$43.90
11312	Audiogram, air and bone conduction or air conduction and speech discrimination	$63.50
11315	Audiogram, air and bone conduction and speech	$83.00
11318	Audiogram, air and bone conduction and speech, with other cochlear tests	$116.00
11324	IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, where the patient is referred by a medical practitioner—not being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies	$63.50
11327	IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, where the patient is referred by a medical practitioner—being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies	$38.10
11330	IMPEDANCE AUDIOGRAM where the patient is not referred by a medical practitioner—1 examination in any 4 week period	$15.20
11332	OTO-ACOUSTIC EMISSION AUDIOMETRY for the detection of permanent congenital hearing impairment, performed by or on behalf of a specialist or consultant physician, on an infant or child who is at risk due to one or more of the following factors:- (i)admission to a neonatal intensive care unit; or (ii)family history of hearing impairment; or (iii)intra-uterine or perinatal infection (either suspected or confirmed); or (iv)birthweight less than 1.5kg; or (v)craniofacial deformity: or (vi)birth asphyxia; or (vii)chromosomal abnormality, including Down's Syndrome; or (viii)exchange transfusion; and where:- -the patient is referred by another medical practitioner; and -middle ear pathology has been excluded by specialist opinion	$105.90
11333	Caloric test of labyrinth or labyrinths	$82.60
11336	Simultaneous bithermal caloric test of labyrinths	$86.40
11339	Electronystagmography	$83.00

Item no.	Description	Max fee (excl. GST)
	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 item11505, 11506, 11507, 11508, 11512, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Not applicable to a service to which item11507 applies	$252.80
11505	Measurement of spirometry, that: (a) involves a permanently recorded tracing, performed before and after inhalation of a bronchodilator; and (b) is performed to confirm diagnosis of: (i) asthma; or (ii) chronic obstructive pulmonary disease (COPD); or (iii) another cause of airflow limitation; each occasion at which 3 or more recordings are made Applicable only once in any 12 month period	$63.30
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	$35.40
11507	Measurement of spirometry: (a) that includes continuous measurement of the relationship between flow and volume during expiration or during expiration and inspiration, performed before and after inhalation of a bronchodilator; and (b) fractional exhaled nitric oxide (FeNO) concentration in exhaled breath; if: (c) the measurement is performed: (i) under the supervision of a specialist or consultant physician; and (ii) with continuous attendance by a respiratory scientist; and (iii) in a respiratory laboratory equipped to perform complex lung function tests; and (d) a permanently recorded tracing and written report is provided; and (e) 3 or more spirometry recordings are performed unless difficult to achieve for clinical reasons; each occasion at which one or more such tests are performed Not applicable to a service associated with a service to which item11503 or 11512 applies	$154.20
11508	Maximal symptom limited incremental exercise test using a calibrated cycle ergometer or treadmill, if: (a) the test is performed for the evaluation of: (i) breathlessness of uncertain cause from tests performed at rest; or (ii) breathlessness out of proportion with impairment due to known conditions; or (iii) functional status and prognosis in a patient with significant cardiac or pulmonary disease for whom complex procedures such as organ transplantation are considered; or (iv) anaesthetic and perioperative risks in a patient undergoing major surgery who is assessed as substantially above average risk after standard evaluation; and (b) the test has been requested by a specialist or consultant physician following professional attendance on the patient by the specialist or consultant physician; and (c) a respiratory scientist and a medical practitioner are in constant attendance during the test; and (d) the test is performed in a respiratory laboratory equipped with airway management and defibrillator equipment; and (e) there is continuous measurement of at least the following: (i) work rate; (ii) pulse oximetry; (iii) respired oxygen and carbon dioxide partial pressures and respired volumes; (iv) ECG; (v) heart rate and blood pressure; and (f) interpretation and preparation of a permanent report is provided by a consultant respiratory physician who is also responsible for the supervision of technical staff and quality assurance	$447.50
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 item11503 or 11507 applies	$103.90

Item no.	Description	Max fee (excl. GST)
	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)	$110.80
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	$97.90
11604	Investigation of chronic venous disease in the upper and lower extremities, one or more limbs, by plethysmography (excluding photoplethysmography) examination, hard copy trace and written report, not being a service associated with a service to which item 32500 applies	$102.20
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	$99.40
11610	MEASUREMENT OF ANKLE: BRACHIAL INDICES AND ARTERIAL WAVEFORM ANALYSIS, measurement of posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of ankle (or toe) brachial systolic pressure indices and assessment of arterial waveforms for the evaluation of lower extremity arterial disease, examination, hard copy trace and report.	$97.90
11611	MEASUREMENT OF WRIST: BRACHIAL INDICES AND ARTERIAL WAVEFORM ANALYSIS, measurement of radial and ulnar (or finger) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of the wrist (or finger) brachial systolic pressure indices and assessment of arterial waveforms for the evaluation of upper extremity arterial disease, examination, hard copy trace and report.	$97.90
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.	$153.60
11614	TRANSCRANIAL DOPPLER, examination of the intracranial arterial circulation using CW Doppler or pulsed Doppler with hard copy recording of waveforms, examination and report, not associated with a service to which items 55229 or 55280 in Group I1 of Category 5 apply.	$102.20
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.	$143.80
11627	PULMONARY ARTERY pressure monitoring during open heart surgery, in a person under 12 years of age	$413.30
	Cardiovascular	
11704	Twelve lead electrocardiography, trace and formal report, by a specialist or a consultant physician, if the service: (a) is requested by a requesting practitioner; and (b) is not associated with a service to which item12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies. Note: the following are also requirements of the service: a formal report is completed; and a copy of the formal report is provided to the requesting practitioner; and the service is not provided to the patient as part of an episode of hospital treatment or hospital-substitute treatment; and is not provided in association with an attendance item (Part 2 of the schedule); and the specialist or consultant physician who renders the service does not have a financial relationship with the requesting practitioner.	$48.40
11705	Twelve lead electrocardiography, formal report only, by a specialist or a consultant physician, if the service: (a) is requested by a requesting practitioner; and (b) is not associated with a service to which item12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than twice on the same day Note: the following are also requirements of the service: a formal report is completed; and a copy of the formal report is provided to the requesting practitioner; and the specialist or consultant physician who renders the service does not have a financial relationship with the requesting practitioner.	$28.50
11707	Twelve lead electrocardiography, trace only, by a medical practitioner, if: (a) the trace: (i) is required to inform clinical decision making; and (ii) is reviewed in a clinically appropriate timeframe to identify potentially serious or life threatening abnormalities; and (iii) does not need to be fully interpreted or reported on; and (b) the service is not associated with a service to which item12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than twice on the same day Note: the service is not provided to the patient as part of an episode of: hospital treatment; or hospital-substitute treatment.	$28.50

Item no.	Description	Max fee (excl. GST)
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
11714	Twelve lead electrocardiography, trace and clinical note, by a specialist or consultant physician, if the service is not associated with a service to which item12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than twice on the same day Note: the service is not provided to the patient as part of an episode of: hospital treatment; or hospital-substitute treatment.	$37.50
11715	BLOOD DYEDILUTION INDICATOR TEST	$219.70
11716	Note:the service only applies if the patient meets one or more of the following and the requirements in Note: DR.1.1 Continuous ambulatory electrocardiogram recording for 12 or more hours, by a specialist or consultant physician, if the service: (a) is indicated for the evaluation of any of the following: (i) syncope; (ii) pre syncopal episodes; (iii) palpitations where episodes are occurring more than once a week; (iv) another asymptomatic arrhythmia is suspected with an expected frequency of greater than once a week; (v) surveillance following cardiac surgical procedures that have an established risk of causing dysrhythmia; and (b) utilises a system capable of superimposition and full disclosure printout of at least 12 hours of recorded electrocardiogram data (including resting electrocardiogram and the recording of parameters) and microprocessor based scanning analysis; and (c) includes interpretation and report; and (d) is not provided in association with ambulatory blood pressure monitoring; and (e) is not associated with a service to which item11704, 11705, 11707, 11714, 11717, 11723, 11735, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable only once in any 4 week period Note: this services does not apply if the patient is being provided with the service as part of an episode of: hospital treatment; or hospital substitute treatment.	$259.10
11717	Note: the service only applies if the patient meets one or more of the following and the requirements in Note: DR.1.1 Ambulatory electrocardiogram monitoring, by a specialist or consultant physician, if the service: (a) utilises a patient activated, single or multiple event memory recording device that: (i) is connected continuously to the patient for between 7 and 30 days; and (ii) is capable of recording for at least 20 seconds prior to each activation and for 15 seconds after each activation; and (b) includes transmission, analysis, interpretation and reporting (including the indication for the investigation); and (c) is for the investigation of recurrent episodes of: unexplained syncope; or palpitation; or other symptoms where a cardiac rhythm disturbance is suspected and where infrequent episodes have occurred; and (d) is not associated with a service to which item11716, 11723, 11735, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable only once in any 3 month period Note: the service does not apply if the patient is being provided with the service as part of an episode of: hospital treatment; or hospital substitute treatment.	$152.30
11718	IMPLANTED PACEMAKER TESTING involving electrocardiography, measurement of rate, width and amplitude of stimulus, including reprogramming when required, not being a service associated with a service to which item 11719, 11720, 11721, 11725 or 11726 applies	$66.20
11719	IMPLANTED PACEMAKER (including cardiac resynchronisation pacemaker) REMOTE MONITORING involving reviews (without patient attendance) of arrhythmias, lead and device parameters, if at least one remote review is provided in a 12 month period. Payable only once in any 12 month period	$109.00
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.	$109.00
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 11718, 11719, 11720, 11725 or 11726 applies	$130.80
11723	Note:the service only applies if the patient meets one or more of the following and the requirements in Note: DR.1.1 Ambulatory electrocardiogram monitoring, by a specialist or consultant physician, if the service: (a) utilises a patient activated, single or multiple event recording, on a memory recording device that: (i) is connected continuously to the patient for up to 7 days; and (ii) is capable of recording for at least 20 seconds prior to each activation and for 15 seconds after each activation; and (b) includes transmission, analysis, interpretation and formal report (including the indication for the investigation); and (c) is for the investigation of recurrent episodes of: (i) unexplained syncope; or (ii) palpitation; or (iii) other symptoms where a cardiac rhythm disturbance is suspected and where infrequent episodes have occurred; and (d) is not associated with a service to which item11716, 11717, 11735, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable only once in any 3 month period Note: The service does not apply if the patient is an admitted patient.	$80.30
11724	UP-RIGHT TILT TABLE TESTING for the investigation of syncope of suspected cardiothoracic origin, including blood pressure monitoring, continuous ECG monitoring and the recording of the parameters, and involving an established intravenous line and the continuous attendance of a specialist or consultant physician—on premises equipped with a mechanical respirator and defibrillator	$327.90
11725	IMPLANTED DEFIBRILLATOR (including cardiac resynchronisation defibrillator) REMOTE MONITORING involving reviews (without patient attendance) of arrhythmias, lead and device parameters, if at least 2 remote reviews are provided in a 12 month period. Payable only once in any 12 month period	$309.30

Item no.	Description	Max fee (excl. GST)
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.	$154.60
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 11718,11719, 11720, 11721, 11725 or 11726 applies	$174.10
11728	Implanted loop recording for the investigation of atrial fibrillation if the patient to whom the service is provided has been diagnosed as having had an embolic stroke of undetermined source, including reprogramming when required, retrieval of stored data, analysis, interpretation and report, other than a service to which item38288 applies For any particular patient applicable not more than 4 times in any 12 months	$54.70
11729	Note:the service only applies if the patient meets the requirements of the descriptor and the requirements in note DR.1.2 Multi channel electrocardiogram monitoring and recording during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts) or pharmacological stress, if: (a) the patient is 17 years or more; and (b) the patient: (i) has symptoms consistent with cardiac ischemia; or (ii) has other cardiac disease which may be exacerbated by exercise; or (iii) has a first degree relative with suspected heritable arrhythmia; and (c) the monitoring and recording: (i) is not less than 20 minutes; and (ii) includes resting electrocardiogram; and (d) a written report is produced by a medical practitioner that includes interpretation of the monitoring and recording data, commenting on the significance of the data, and the relationship of the data to clinical decision making for the patient in the clinical context; and (e) the service is not a service: (i) provided on the same occasion as a service to which item11704, 11705, 11707 or 11714 applies; or (ii) performed within 24 months of a service to which item55141, 55143, 55145, 55146, 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 or 61414 applies Applicable only once in any 24 month period	$235.40
11730	Note:the service only applies if the patient meets the requirements of the descriptor and the requirements in note DR.1.3 Multi channel electrocardiogram monitoring and recording during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts), if: (a) the patient is less than 17 years; and (b) the patient: (i) has symptoms consistent with cardiac ischemia; or (ii) has other cardiac disease which may be exacerbated by exercise; or (iii) has a first degree relative with suspected heritable arrhythmia; and (c) the monitoring and recording: (i) is not less than 20 minutes in duration; and (ii) includes resting electrocardiogram; and (d) a written report is produced by a medical practitioner that includes interpretation of the monitoring and recording data, commenting on the significance of the data, and the relationship of the data to clinical decision making for the patient in the clinical context; and (e) the service is not a service: (i) provided on the same occasion as a service to which item11704, 11705, 11707 or 11714 applies; or (ii) performed within 24 months of a service to which item55141, 55143, 55145, 55146, 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 or 61414 applies Applicable only once in any 24 month period	$235.40
11731	Implanted electrocardiogram loop recording, by a medical practitioner, including reprogramming (if required), retrieval of stored data, analysis, interpretation and report, if the service is: (a) an investigation for a patient with: (i) cryptogenic stroke; or (ii) recurrent unexplained syncope; and (b) not a service to which item38285 applies Applicable only once in any 4 week period	$53.80
11735	Note: the service only applies if the patient meets one or more of the following and the requirements in Note: DR.1.1 Continuous ambulatory electrocardiogram recording for 7 days, by a specialist or consultant physician, if the service: (a) utilises intelligent microprocessor based monitoring, with patient triggered recording and symptom reporting capability, real time analysis of electrocardiograms and alerts and daily or live data uploads; and (b) is for the investigation of: (i) episodes of suspected intermittent cardiac arrhythmia or episodes of syncope; or (ii) suspected intermittent cardiac arrhythmia in a patient who has had a previous cerebrovascular accident, is at risk of cerebrovascular accident or has had one or more previous transient ischemic attacks; and (c) includes interpretation and report; and (d) is not a service: (i) provided in association with ambulatory blood pressure monitoring; or (ii) associated with a service to which item11716, 11717, 11723, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than 4 times in any 12 month period Note:The service does not apply if the patient is an admitted patient.	$197.90
	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 cathetter-based ambulatory oesophageal pH-mnitoring: (i)has been attempted on the patient but failed due to clinical complications, or (ii)is not clinically appropriate for the patient due to anatomical reasons (nasopharyngeal anatomy) preventing the use of catheter-based pH monitoring; and (b)the services is performed by a specialist or consultant physician with endoscopic training that is recognised by The Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy. Not in association with another item in Category 2, sub-group 7 (Anaes.)	$429.20
11810	CLINICAL ASSESSMENT of GASTRO-OESOPHAGEAL REFLUX DISEASE involving 24 hour pH monitoring, including analysis, interpretation and report and including any associated consultation	$312.60

Item no.	Description	Max fee (excl. GST)
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 thebleeding; 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 Recognitionof Training in Gastrointestinal Endoscopy; and (e)the service is not associated with a service to which item30680, 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	$257.70
11833	Diagnosis of abnormalities of the pelvic floor and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency	$440.30
	Gentio/urinary physiological investigations	
11900	URINE FLOW STUDY including peak urine flow measurement, not being a service associated with a service to which item 11919 applies	$52.10
11903	CYSTOMETROGRAPHY, not being a service associated with a service to which any of items 11012-11027, 11912, 11915, 11919, 11921 and 36800 or any item in Group I3 of Category 5 applies	$213.60
11906	URETHRAL PRESSURE PROFILOMETRY, not being a service associated with a service to which any of items 11012-11027, 11909, 11919, 11921 and 36800 or any item in Group I3 of Category 5 applies	$205.30
11909	URETHRAL PRESSURE PROFILOMETRY WITH simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which item 11906, 11915, 11919, 36800 or any item in Group I3 of Category 5 applies	$299.80
11912	CYSTOMETROGRAPHY with simultaneous measurement of rectal pressure, not being a service associated with a service to which any of items 11012-11027, 11903, 11915, 11919, 11921 and 36800 or any item in Group I3 of Category 5 applies (Anaes.)	$306.50
11915	CYSTOMETROGRAPHY with simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which any of items 11012-11027, 11903, 11909, 11912, 11919, 11921 and 36800 or any item in Group I3 of Category 5 applies (Anaes.)	$306.50
11917	CYSTOMETROGRAPHY IN CONJUNCTION WITH ULTRASOUND OF 1 OR MORE COMPONENTS OF THE URINARY TRACT, with measurement of any 1 or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography; including all imaging associated with cystometrography, not being a service associated with a service to which items 11012-11027, 11900-11915, 11919, 11921 and 36800 apply. (Anaes.)	$792.70
11919	CYSTOMETROGRAPHY IN CONJUNCTION WITH CONTRAST MICTURATING CYSTOURETHROGRAPHY, with measurement of any one or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography, being a service associated with a service to which items 60506 or 60509 applies;other than a service associated with a service to which items 11012-11027, 11900-11917, 11921 and 36800 apply (Anaes.)	$792.70
11921	BLADDER WASHOUT TEST for localisation of urinary infectionnot 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
12001	Skin prick testing for aeroallergens, including all allergens tested on the same day, not being a service associated with a service to which item12000, 12002, 12005, 12012, 12017, 12021, 12022 or 12024 applies. Applicable only once in any 12 month period	$59.90
12002	Repeat skin prick testing of a patient for aeroallergens, including all allergens tested on the same day, if: (a) further testing for aeroallergens is indicated in the same 12 month period to which item12001 applies to a service for the patient; and (b) the service is not associated with a service to which item12000, 12001, 12005, 12012, 12017, 12021, 12022 or 12024 applies Applicable only once in any 12 month period	$59.90

Item no.	Description	Max fee (excl. GST)
12003	Skin prick testing for food and latex allergens, including all allergens tested on the same day, not being a service associated with a service to which item 12012, 12017, 12021, 12022 or 12024 applies	$106.00
12004	Skin testing for medication allergens (antibiotics or non general anaesthetics agents) and venoms (including prick testing and intradermal testing with a number of dilutions), including all allergens tested on the same day, not being a service associated with a service to which item 12012, 12017, 12021, 12022 or 12024 applies	$90.60
12005	Skin testing: (a) performed by or on behalf of a specialist or consultant physician in the practice of the specialist or consultant physician s specialty; and (b) for agents used in the perioperative period (including prick testing and intradermal testing with a number of dilutions), to investigate anaphylaxis in a patient with a history of prior anaphylactic reaction or cardiovascular collapse associated with the administration of an anaesthetic; and (c) including all allergens tested on the same day; and (d) not being a service associated with a service to which item12000, 12001, 12002, 12003, 12012, 12017, 12021, 12022 or 12024 applies	$121.90
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	$112.40
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	$217.00
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	$247.00
	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 the specialist s or consultant physician s specialty, of thyrotropin alfa-rch (recombinant human thyroid-stimulating hormone), and arranging services to which both items 61426 and 66650 apply, for the detection of recurrent well-differentiated thyroid cancer in a patient if: (a) the patient has had a total thyroidectomy and 1 ablative dose of radioactive iodine; and (b) the patient is maintained on thyroid hormone therapy; and (c) the patient is at risk of recurrence; and (d) on at least 1 previous whole body scan or serum thyroglobulin test when withdrawn from thyroid hormone therapy, the patient did not have evidence of well-differentiated thyroid cancer; and (e) either: (i) withdrawal from thyroid hormone therapy resulted in severe psychiatric disturbances when hypothyroid; or (ii) withdrawal is medically contra-indicated because the patient has: (a) unstable coronary artery disease; or (b) hypopituitarism; or (c) a high risk of relapse or exacerbation of a previous severe psychiatric illness applicable once only in a 12 month period	$3146.70
12203	Overnight diagnostic assessment of sleep, for at least 8 hours, for a patient aged 18 years or more, to confirm diagnosis of a sleep disorder, if: (a) either: (i) the patient has been referred by a medical practitioner to a qualified adult sleep medicine practitioner or a consultant respiratory physician who has determined that the patient has a high probability for symptomatic, moderate to severe obstructive sleep apnoea based on a STOP Bang score of3 or more, an OSA50 score of 5 or more or a high risk score on the Berlin Questionnaire, and an Epworth Sleepiness Scale score of 8 or more; or (ii) following professional attendance on the patient (either face to face or by video conference) by a qualified adult sleep medicine practitioner or a consultant respiratory physician, the qualified adult sleep medicine practitioner or consultant respiratory physician determines that assessment is necessary to confirm the diagnosis of a sleep disorder; and (b) the overnight diagnostic assessment is performed to investigate: (i) suspected obstructive sleep apnoea syndrome where the patient is assessed as not suitable for an unattended sleep study; or (ii) suspected central sleep apnoea syndrome; or (iii) suspected sleep hypoventilation syndrome; or (iv) suspected sleep related breathing disorders in association with non respiratory co morbid conditions including heart failure, significant cardiac arrhythmias, neurological disease, acromegaly or hypothyroidism; or (v) unexplained hypersomnolence which is not attributed to inadequate sleep hygiene or environmental factors; or (vi) suspected parasomnia or seizure disorder where clinical diagnosis cannot be established on clinical features alone (including associated atypical features, vigilance behaviours or failure to respond to conventional therapy); or (vii) suspected sleep related movement disorder, where the diagnosis of restless legs syndrome is not evident on clinical assessment; and (c) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (d) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the overnight diagnostic assessment is not provided to the patient on the same occasion that a service described in any of items11000, 11003, 11004, 11005, 11503, 11704, 11705,11707, 11713, 11714, 11716, 11717, 11723, 11735or 12250 is provided to the patient Applicable only once in any 12 month period	$970.20

Item no.	Description	Max fee (excl. GST)
12204	Overnight assessment of positive airway pressure, for at least 8 hours, for a patient aged 18 years or more, if: (a) the necessity for an intervention sleep study is determined by a qualified adult sleep medicine practitioner or consultant respiratory physician where a diagnosis of a sleep related breathing disorder has been made; and (b) the patient has not undergone positive airway pressure therapy in the previous 6 months; and (c) following professional attendance on the patient by a qualified adult sleep medicine practitioner or a consultant respiratory physician (either face to face or by video conference), the qualified adult sleep medicine practitioner or consultant respiratory physician establishes that the sleep related breathing disorder is responsible for the patient s symptoms; and (d) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (e) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement; (ix) position; and (f) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (g) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (h) the overnight assessment is not provided to the patient on the same occasion that a service mentioned in any of items11000, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716,11717, 11723, 11735or 12250 is provided to the patient Applicable only once in any 12 month period	$904.80
12205	Follow up study for a patient aged 18 years or more with a sleep related breathing disorder, following professional attendance on the patient by a qualified adult sleep medicine practitioner or consultant respiratory physician (either face-to-face or by video conference), if: (a) any of the following subparagraphs applies: (i) there has been a recurrence of symptoms not explained by known or identifiable factors such as inadequate usage of treatment, sleep duration or significant recent illness; (ii) there has been a significant change in weight or changes in co morbid conditions that could affect sleep related breathing disorders, and other means of assessing treatment efficacy (including review of data stored by a therapy device used by the patient) are unavailable or have been equivocal; (iii) the patient has undergone a therapeutic intervention (including, but not limited to, positive airway pressure, upper airway surgery, positional therapy, appropriate oral appliance, weight loss of more than 10% in the previous 6 months or oxygen therapy), and there is either clinical evidence of sub optimal response or uncertainty about control of sleep disordered breathing; and (b) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (c) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (d) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (e) interpretation and preparation of a permanent report is provided by a qualifiedadult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (f) the follow up study is not provided to the patient on the same occasion that a service mentioned in any of items 11000, 11003, 11004,11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735or 12250 is provided to the patient Applicable only once in any 12 month period	$904.80
12207	Overnight investigation, for a patient aged 18 years or more, for a sleep related breathing disorder, following professional attendance by a qualified adult sleep medicine practitioner or a consultant respiratory physician (either face to face or by video conference), if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner before the investigation; and (c) there is continuous monitoring and recording, in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen) (ix) position; and (d) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the investigation is not provided to the patient on the same occasion that a service mentioned in any of items 11000, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient; and (h) previous studies have demonstrated failure of continuous positive airway pressure or oxygen; and (i) if the patient has severe respiratory failure a further investigation is indicated in the same 12 month period to which items12204 and 12205 apply to a service for the patient, for the adjustment or testing, or both, of the effectiveness of a positive pressure ventilatory support device (other than continuous positive airway pressure) in sleep Applicable only once in any 12 month period	$970.20

Item no.	Description	Max fee (excl. GST)
12208	Overnight investigation, for sleep apnoea for at least 8 hours, for a patient aged 18 years or more, if: (a) a qualified adult sleep medicine practitioner or consultant respiratory physician has determined that the investigation is necessary to confirm the diagnosis of a sleep disorder; and (b) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (c) there is continuous monitoring and recording, in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (d) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (e) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (f) a further investigation is indicated in the same 12 month period to which item12203 applies to a service for the patient because insufficient sleep was acquired, as evidenced by a sleep efficiency of 25% or less, during the previous investigation to which that item applied; and (g) the investigation is not provided to the patient on the same occasion that a service mentioned in any of items 11000, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient Applicable only once in any 12 month period	$904.80
12210	Overnight paediatric investigation, for at least 8 hours, for a patient less than 12 years of age, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end tidal or transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and report are provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and (g) the investigation is not provided to the patient on the same occasion that a service to which item11704, 11705, 11707, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient For each particular patient applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period	$1268.10
12213	Overnight paediatric investigation, for at least 8 hours, for a patient aged at least 12 years but less than 18 years, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end tidal or transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and (g) the investigation is not provided to the patient on the same occasion that a service to which item11704, 11705, 11707, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient For each particular patient applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period	$1142.50

Item no.	Description	Max fee (excl. GST)
12215	Overnight paediatric investigation, for at least 8 hours, for a patient less than 12 years of age, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end tidal or transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and report are provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and (g) a further investigation is indicated in the same 12 month period to which item12210 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 item12210 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 item12210 applied for the patient, and repeat study is therefore required to determine the need for or the adequacy of respiratory support; and (h) the investigation is not provided to the patient on the same occasion that a service to which item11704, 11705, 11707, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient Applicable only once in the same 12 month period to which item12210 applies	$1268.10
12217	Overnight paediatric investigation, for at least 8 hours, for a patient aged at least 12 years but less than 18 years, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end tidal or transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and (g) a further investigation is indicated in the same 12 month period to which item12213 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 item12213 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 item12213 applied for the patient, and repeat study is therefore required to determine the need for or the adequacy of respiratory support; and (h) the investigation is not provided to the patient on the same occasion that a service to which item11704, 11705, 11707, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient Applicable only once in the same 12 month period to which item12213 applies	$1142.50

Item no.	Description	Max fee (excl. GST)
12250	Overnight investigation of sleep for at least 8 hours of a patient aged 18 years or more to confirm diagnosis of obstructive sleep apnoea, if: (a) either: (i) the patient has been referred by a medical practitioner to a qualified adult sleep medicine practitioner or a consultant respiratory physician who has determined that the patient has a high probability for symptomatic, moderate to severe obstructive sleep apnoea based on a STOP Bang score of3 or more, an OSA50 score of 5 or more or a high risk score on the Berlin Questionnaire, and an Epworth Sleepiness Scale score of 8 or more; or (ii) following professional attendance on the patient (either face to face or by video conference) by a qualified adult sleep medicine practitioner or a consultant respiratory physician, the qualified adult sleep medicine practitioner or consultant respiratory physician determines that investigation is necessary to confirm the diagnosis of obstructive sleep apnoea; and (b) during a period of sleep, there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) continuous ECG; (iv) continuous EEG; (v) EOG; (vi) oxygen saturation; (vii) respiratory effort; and (c) the investigation is performed under the supervision of a qualified adult sleep medicine practitioner; and (d) either: (i) the equipment is applied to the patient by a sleep technician; or (ii) if this is not possible the reason it is not possible for the sleep technician to apply the equipment to the patient is documented and the patient is given instructions on how to apply the equipment by a sleep technician supported by written instructions; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events and cardiac abnormalities) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the investigation is not provided to the patient on the same occasion that a service mentioned in any of items11000, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11714, 11716, 11717, 11723, 11735 and 12203 is provided to the patient Applicable only once in any 12 month period	$608.90
12254	Multiple sleep latency test for the assessment of unexplained hypersomnolence in a patient aged 18 years or more, if: (a) a qualified adult sleep medicine practitioner or neurologist determines that testing is necessary to confirm the diagnosis of a central disorder of hypersomnolence or to determine whether the eligibility criteria under the pharmaceutical benefits scheme for drugs relevant to treat that condition are met; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring and recording, in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (c) immediately following the overnight investigation a daytime investigation is performed where at least 4 nap periods are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12203, 12204, 12205, 12208, 12250 or 12258 is provided to the patient Applicable only once in a 12 month period	$1406.00
12258	Maintenance of wakefulness test for the assessment of the ability to maintain wakefulness in a patient aged 18 years or more, if: (a) a qualified adult sleep medicine practitioner or neurologist determines that testing is necessary to objectively confirm the ability to maintain wakefulness; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring and recording, in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (c) immediately following the overnight investigation, a daytime investigation is performed where at least 4 wakefulness trials are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f)interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12203, 12204, 12205, 12208, 12250 or 12254 is provided to the patient Applicable only once in a 12 month period	$1406.00

Item no.	Description	Max fee (excl. GST)
12261	Multiple sleep latency test for the assessment of unexplained hypersomnolence in a patient aged at least 12 years but less than 18 years, if: (a) a qualified sleep medicine practitioner determines that testing is necessary to confirm the diagnosis of a central disorder of hypersomnolence or to determine whether the eligibility criteria under the pharmaceutical benefits scheme for drugs relevant to treat that condition are met; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end tidal or transcutaneous); and (c) immediately following the overnight investigation, a daytime investigation is performed where at least 4 nap periods are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12213, 12217 or 12265 is provided to the patient Applicable only once in a 12 month period	$1474.10
12265	Maintenance of wakefulness test for the assessment of the ability to maintain wakefulness in a patient aged at least 12 years but less than 18 years, if: (a)a qualified sleep medicine practitioner determines that testing to objectively confirm the ability to maintain wakefulness is necessary; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end tidal or transcutaneous); and (c)immediately following the overnight investigation, a daytime investigation is performed where at least 4 wakefulness trials are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and (d)a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e)polygraphic records are: (i)analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f)interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12213, 12217 or 12261 is provided to the patient Applicable only once in a 12 month period	$1474.10
12268	Multiple sleep latency test for the assessment of unexplained hypersomnolence for a patient less than 12 years of age, if: (a) a qualified paediatric sleep medicine practitioner determines that testing is necessary to confirm the diagnosis of a central disorder of hypersomnolence or to determine whether the eligibility criteria under the pharmaceutical benefits scheme for drugs relevant to treat that condition are met; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end tidal or transcutaneous); and (c)immediately following the overnight investigation, a daytime investigation is performed where at least 4 nap periods are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and (e)polygraphic records are: (i)analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii)stored for interpretation and preparation of a report; and (f)interpretation and preparation of a permanent report is provided by a qualified paediatric sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12210, 12215 or 12272 is provided to the patient Applicable only once in a 12 month period	$1581.10

Item no.	Description	Max fee (excl. GST)
12272	Maintenance of wakefulness test for the assessment of the ability to maintain wakefulness for a patient less than 12 years of age, if: (a)a qualified paediatric sleep medicine practitioner determines that testing to objectively confirm the ability to maintain wakefulness is necessary; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi channel polygraph, and recordings of the following, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end tidal or transcutaneous); and (c)immediately following the overnight investigation, a daytime investigation is performed where at least 4 wakefulness trials are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and (d)a sleep technician is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and (e) polygraphic records are: (i)analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii)stored for interpretation and preparation of a report; and (f)interpretation and preparation of a permanent report is provided by a qualified paediatric sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12210, 12215 or 12268 is provided to the patient Applicable only once in a 12 month period	$1581.10
12306	Bone densitometry, using dual energy X ray absorptiometry, involving the measurement of 2 or more sites (including interpretation and reporting), for: (a) confirmation of a presumptive diagnosis of low bone mineral density made on the basis of one or more fractures occurring after minimal trauma; or (b) monitoring of low bone mineral density proven by bone densitometry at least 12 months previously; other than a service associated with a service to which item12312, 12315 or 12321 applies For any particular patient, once only in a 24 month period	$196.00
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 item12306, 12315 or 12321 applies For any particular patient, once only in a 12 month period	$196.00
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 item12306, 12312 or 12321 applies For any particular patient, once only in a 24 monthperiod	$196.00
12320	Bone densitometry, using dual energy X ray absorptiometry or quantitative computed tomography, involving the measurement of 2 or more sites (including interpretation and reporting) for measurement of bone mineral density, if:(a) the patient is 70 years of age or over, and (b) either: (i) the patient has not previously had bone densitometry; or (ii) the t-score for the patient's bone mineral density is -1.5 or more; other than a service associated with a service to which item 12306, 12312, 12315, 12321 or 12322 applies For any particular patient, once only in a 5 year period	$161.20
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 item12306, 12312 or 12315 applies For any particular patient, once only in a 12 monthperiod	$196.00
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	$161.20
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	$79.90

Item no.	Description	Max fee (excl. GST)
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	$79.90
GROUP D2—NUCLEAR MEDICINE (NON-IMAGING)		
12500	Blood volume estimation	$366.70
12524	Renal function test (without imaging procedure)	$287.40
12527	Renal function test (with imaging and at least 2 blood samples)	$154.20
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 13CO2 or 14CO2, for either:- (a)the confirmation of Helicobacter pylori colonisation, OR (b)the monitoring of the success of eradication of Helicobacter pylori in patients with peptic ulcer disease. not being a service to which 66900 applies	$153.60
GROUP T1—MISCELLANEOUS THERAPEUTIC PROCEDURES		
	Hyperbaric oxygen therapy	
13015	HYPERBARIC, OXYGEN THERAPY, for treatment of localised non-neurological soft tissue radiation injuries excluding radiation-induced soft tissue lymphoedema of the arm after treatment for breast cancer, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance.	$460.30
13020	HYPERBARIC OXYGEN THERAPY, for treatment of decompression illness, gas gangrene, air or gas embolism; diabetic wounds including diabetic gangrene and diabetic foot ulcers; necrotising soft tissue infections including necrotising fasciitis or Fournier's gangrene; or for the prevention and treatment of osteoradionecrosis, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance	$470.50
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)	$296.70
	Dialysis	
13100	SUPERVISION IN HOSPITAL by a medical specialist ofhaemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in 1 day	$263.50
13103	SUPERVISION IN HOSPITAL by a medical specialist ofhaemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist does not exceed 45 minutes in 1 day	$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	$268.90
13105	Haemodialysis for a patient with end stage renal disease if: (a) the service is provided by a registered nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner; and (b) the service is supervised by the medical practitioner (either in person or remotely); and (c) the patient s care is managed by a nephrologist; and (d) the patient is treated or reviewed by the nephrologist every 3 to 6 months (either in person or remotely); and (e) the patient is not an admitted patient of a hospital; and (f) the service is provided in a Modified Monash 7 area	$910.90
13106	Declotting of an arteriovenous shunt	$199.00
13109	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSISINSERTION AND FIXATION OF (Anaes.)	$436.40
13110	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS , removal of (including catheter cuffs) (Anaes.)	$412.90

Item no.	Description	Max fee (excl. GST)
	Assisted reproductive services	
13200	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE PROCEEDING TO OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item13201, 13202, 13203, 13206, 13218 applies—being services rendered during 1 treatment cycle—INITIAL cycle in a single calendar year	$5400.20
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 item13200, 13202, 13203, 13206, 13218 applies—being services rendered during 1 treatment cycle—each cycle SUBSEQUENT to the first in a single calendar year	$5048.10
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	$810.10
13203	OVULATION MONITORING SERVICES, for artificial insemination—including quantitative estimation of hormones and ultrasound examinations, being services rendered during 1 treatment cycle but excluding a service to which Item 13200, 13201, 13202, 13206, 13212, 13215, 13218, applies	$945.40
13206	ASSISTED REPRODUCTIVE TECHNOLOGIES TREATMENT CYCLE using either the natural cycle or oral medication only to induce oocyte growth and development, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, frozen embryo transfer or donated embryos or ova or treatment involving the use of injectable drugs to induce superovulation being services rendered during 1 treatment cycle but only if rendered in conjunction with a service to which item 13212 applies	$1251.10
13209	PLANNING and MANAGEMENT of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies or for artificial insemination payable once only during 1 treatment cycle	$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.)	$658.20
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 13203 or 13218 applies	$780.40
13260	Processing and cryopreservation of semen for fertility preservation treatment before or after completion of gonadotoxic treatment for malignant or non-malignant conditions, in a post-pubertal male in Tanner stages II-V, up to 60 years old, if the patient is referred by a specialist or consultant physician, initial cryopreservation of semen (not including storage)—one of a maximum of two semen collection cycles per patient in a lifetime.	$638.60
13290	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, bya medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required	$369.00
13292	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, bya medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required, under general anaesthetic, in a hospital (Anaes.)	$738.70

Item no.	Description	Max fee (excl. GST)
	Paediatric and neonatal	
13300	UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate	$102.90
13303	Umbilical artery catheterisation with or without infusion	$152.60
13306	BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor	$603.50
13309	BLOOD TRANSFUSION with venesection and complete replacement of blood, using blood already collected	$514.60
13312	BLOOD for pathology test, collection of, BY FEMORAL OR EXTERNAL JUGULAR VEIN PUNCTURE IN INFANTS	$51.40
13318	CENTRAL VEIN CATHETERISATION—by open exposure in a person under 12 years of age (Anaes.)	$410.90
13319	Central vein catheterisation in a neonate via peripheral vein (Anaes.)	$410.90
	Cardiovascular	
13400	Restoration of cardiac rhythm by electrical stimulation (cardioversion), other than in the course of cardiac surgery (Anaes.)	$172.50
	Gastroenterology	
13506	Gastro-oesophageal balloon intubation, for control of bleeding from gastric oesophageal varices	$333.80
	Haematology	
13700	HARVESTING OF HOMOLOGOUS (including allogeneic) or AUTOLOGOUS bone marrow for the purpose of transplantation (Anaes.)	$562.80
13703	Transfusion of blood, including collection from donor, when used for intra-operative normovolaemic haemodilution	$205.30
13706	Transfusion of blood or bone marrow already collected	$140.20
13750	THERAPEUTIC HAEMAPHERESIS for the removal of plasma or cellular (or both) elements of blood, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies, if performed; continuous monitoring of vital signs, fluid balance, blood volume and other parameters with continuous registered nurse attendance under the supervision of a consultant physician, not being a service associated with a service to which item 13755 applies - payable once per day	$229.50
13755	DONOR HAEMAPHERESIS for the collection of blood products for transfusion, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies; continuous monitoring of vital signs, fluid balance, blood volume and other parameters; with continuous registered nurse attendance under the supervision of a consultant physician; not being a service associated with a service to which item 13750 applies—payable once per day	$229.50
13757	THERAPEUTIC VENESECTION for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda	$111.00
13760	In vitro processing with cryopreservation of bone marrow or peripheral blood, for autologous stem cell transplantation for a patient receiving high dose chemotherapy for management of: (a) aggressive malignancy; or (b) malignancy that has proven refractory to prior treatment	$1292.90
	Procedures associated with intensive care and cardiopulmonary support	
13815	Central vein catheterisation, including under ultrasound guidance where clinically appropriate, by percutaneous or open exposure other than a service to which item 13318 applies (Anaes.) No separate ultrasound item is payable with this item. (Anaes.)	$146.60
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	$127.80
13832	Peripheral cannulation, including under ultrasound guidance where clinically appropriate, for veno-arterial cardiopulmonary extracorporeal life support No separate ultrasound item is payable with this item	$1343.80
13834	Veno arterial cardiopulmonary extracorporeal life support, management of the first day	$752.30
13835	Veno arterial cardiopulmonary extracorporeal life support, management of each day after the first	$175.10
13837	Veno-venous pulmonary extracorporeal life support, management of the first day	$752.30
13838	Veno-venous pulmonary extracorporeal life support, management of each day after the first	$175.10
13839	Arterial puncture and collection of blood for diagnostic purposes	$41.80
13840	Peripheral cannulation, including under ultrasound guidance where clinically appropriate, for veno-venous pulmonary extracorporeal life support No separate ultrasound item is payable with this item	$900.30

Item no.	Description	Max fee (excl. GST)
13842	Intra-arterial cannulation, including under ultrasound guidance where clinically appropriate, for the purpose of intra-arterial pressure monitoring or arterial blood sampling (or both) No separate ultrasound item is payable with this item	$115.90
13848	Counterpulsation by intra-aortic balloon-management including associated consultations and monitoring of parameters by means of full haemodynamic assessment and management on several occasions on a day each day	$235.10
13851	Ventricular assist device, management of,for a patient admitted to an intensive care unit for implantation of the device or for complications arising from implantation or management of the device—first day	$913.30
13854	Ventricular assist device, management of, for a patient admitted to an intensive care unit, including management ofcomplications arising from implantation or management of the device—each day after the first day	$211.60
13857	AIRWAY ACCESS, ESTABLISHMENT OF AND INITIATION OF MECHANICAL VENTILATION (other than in the context of an anaesthetic for surgery), outside an Intensive Care Unit, for the purpose of subsequent ventilatory support in an Intensive Care Unit	$261.70
	Management and procedures undertaken in an intensive care unit	
13870	(Note: See para T1.8 of Explanatory Notes to this Category for definition of an Intensive Care Unit) MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care—including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation—management on the first day (H)	$570.80
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)	$418.30
13876	Central venous pressure, pulmonary arterial pressure, systemic arterial pressure or cardiac intracavity pressure, continuous monitoring by indwelling catheter in an intensive care unit and managed by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care—once only for each type of pressure on any calendar day (up to a maximum of 4 pressures) (H)	$117.40
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
13899	Preparation of Goals of Care is provided outside of an intensive care unit. Refer to explanatory note TN.1.11 for further information aboutGoals of Care attendance Professional attendance, outside an intensive care unit, for at least 60 minutes spent in preparation of goals of care for a gravely ill patient lacking current goals of care, by aspecialist in the specialty of intensive care who takes overall responsibility for the preparation of the goals of care for the patient Item 13899 cannot be co-claimed with item 13870 or item 13873 on the same day	$408.20
	Chemotherapeutic procedures	
13950	Parenteral administration of one or more antineoplastic agents, including agents used in cytotoxic chemotherapy or monoclonal antibody therapy but not agents used in anti-resorptive bone therapy or hormonal therapy, by or on behalf of a specialist or consultant physician attendance for one or more episodes of administration Note: The fee for item 13950 contains a component which covers the accessing of a long-term drug delivery device. TN.1.27 refers	$167.10
	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	$95.90
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 items14106 to 14118 apply) in any 12 month period (Anaes.)	$405.40

Item no.	Description	Max fee (excl. GST)
14106	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, caf au lait macules and naevi of Ota, other than melanocytic naevi (common moles), if the abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12 month period area of treatment less than 150 cm2 (Anaes.)	$405.40
14115	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, caf au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12 month period area of treatment 150 cm2 to 300 cm2 (Anaes.)	$596.00
14118	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, caf au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14115 apply) in any 12 month period area of treatment more than 300 cm2 (Anaes.)	$835.20
14124	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, caf au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, if: (a) a seventh or subsequent session (including any sessions to which this item or any of items14100 to 14118 apply) is indicated in a 12 month period commencing on the day of the first session; and (b) photographic evidence demonstrating the need for this service is documented in the patient notes (Anaes.)	$322.00
	Other therapeutic procedures	
14201	Poly-l-lactic acid, one or more injections of, for the initial session only, for the treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the national health act 1953—once per patient	$423.10
14202	Poly-l-lactic acid, one or more injections of (subsequent sessions), for the continuation of treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the national health act 1953	$214.00
14203	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes.)	$89.20
14206	HORMONE OR LIVING TISSUE IMPLANTATIONby cannula	$57.20
14209	INTRAARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent	$156.70
14212	Intussusception, management of fluid or gas reduction for (Anaes.)	$336.70
14218	IMPLANTED INFUSION PUMP REFILLING OF reservoir, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of chronic intractable pain	$172.50
14221	LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessing of, not being a service associated with a service to which item 13950 applies	$97.20
14224	ELECTROCONVULSIVE THERAPY, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.)	$124.00
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	$177.00
14234	Infusion pump or components of an infusion pump, removal or replacement of, and connection to intrathecal or epidural catheter, and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.)	$559.80
14237	Infusion pump or components of an infusion pump, subcutaneous implantation of, and intrathecal or epidural spinal catheter insertion, and connection of pump to catheter, and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.)	$1020.80
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	$177.00
14247	Extracorporeal photopheresis for the treatment of erythrodermic stage III-IVa T4 M0 cutaneous T-cell lymphoma; if the service is provided in the initial six months of treatment; and the service is delivered using an integrated, closed extracorporeal photopheresis system; and the patient is 18 years old or over; and the patient has received prior systemic treatment for this condition and experienced either disease progression or unacceptable toxicity while on this treatment; and the service is provided in combination with the use of Pharmaceutical Benefits Scheme-subsidised methoxsalen; and the service is supervised by a specialist or consultant physician in the speciality of haematology. Applicable once per treatment cycle	$2862.50

Item no.	Description	Max fee (excl. GST)
14249	Extracorporeal photopheresis for the continuing treatment of erythrodermic stage III-IVa T4 M0 cutaneous T-cell lymphoma; if in the preceding 6 months:(i) a service to which item 14247 applies has been provided; and(ii) the patient has demonstrated a response to this service; and(iii)the patient requires further treatment; and the service is delivered using an integrated, closed extracorporeal photopheresis system; and the patient is 18 years old or over; and the service is provided in combination with the use of Pharmaceutical Benefits Scheme-subsidised methoxsalen; and the service is supervised by a specialist or consultant physician in the speciality of haematology. Applicable once per treatment cycle	$2862.50
	Management and procedures undertaken in an emergency department	
14255	Resuscitation of a patient provided for at least 30 minutes but less than 1 hour, by a specialist in the practice of the specialist s specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.)	$226.10
14256	Resuscitation of a patient provided for at least 1 hour but less than 2 hours, by a specialist in the practice of the specialist s specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.)	$434.90
14257	Resuscitation of a patient provided for at least 2 hours, by a specialist in the practice of the specialist s specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.)	$866.00
14258	Resuscitation of a patient provided for at least 30 minutes but less than 1 hour, by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)	$169.70
14259	Resuscitation of a patient provided for at least 1 hour but less than 2 hours, by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)	$326.20
14260	Resuscitation of a patient provided for at least 2 hours, by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)	$649.50
14263	Minor procedure on a patient by a specialist in the practice of the specialist s specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.)	$79.60
14264	Procedure (except a minor procedure) on a patient by a specialist in the practice of the specialist s specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.)	$179.20
14265	Minor procedure on a patient by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)	$59.70
14266	Procedure (except a minor procedure) on a patient by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)	$134.40
14270	Management, without aftercare, of all fractures and dislocations suffered by a patient that: (a) is provided by a specialist in the practice of the specialist's specialty of emergency medicine in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019; and (b) occurs at a recognised emergency department of a private hospital (Anaes.)	$200.90
14272	Management, without aftercare, of all fractures and dislocations suffered by a patient that: (a) is provided by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) in conjunction with an attendance on the patient by thepractitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (b) occurs at a recognised emergency department of a private hospital (Anaes.)	$150.80
14277	Application of chemical or physical restraint of a patient by a specialist in the practice of the specialist s specialty of emergency medicine at a recognised emergency department of a private hospital	$226.10
14278	Application of chemical or physical restraint of a patient by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) at a recognised emergency department of a private hospital	$169.70

Item no.	Description	Max fee (excl. GST)
14280	Anaesthesia (whether general anaesthesia or not) of a patient that: (a) is managed by a specialist in the practice of the specialist s specialty of emergency medicine at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies	$226.10
14283	Anaesthesia (whether general anaesthesia or not) of a patient that: (a) is managed by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies	$169.70
14285	Emergent intubation, airway management or both of a patient that: (a) is managed by a specialist in the practice of the specialist s specialty of emergency medicine at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies	$226.10
14288	Emergent intubation, airway management or both of a patient that: (a) is managed by a medical practitioner (except a specialist in the practice of the specialist s specialty of emergency medicine) at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies	$169.70
GROUP T2—RADIATION ONCOLOGY		
	Superficial	
15000	(Benefits for administration of general anaesthetic for radiotherapy are payable under Group T10) RADIOTHERAPY, SUPERFICIAL (including treatment with xrays, radium rays or other radioactive substances), not being a service to which another item in this Group applies each attendance at which fractionated treatment is given—1 field	$77.40
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	DF
15006	RADIOTHERAPY, SUPERFICIAL, attendance at which 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 to a maximum of 5 additional fields	DF
15012	RADIOTHERAPY, SUPERFICIALeach 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	$86.70
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)	DF
15106	RADIOTHERAPY, DEEP OR ORTHOVOLTAGEeach attendance at which fractionated treatment is given at 2 treatments per week or less frequently—1 field	$102.40
15109	Radiotherapy, deep or orthovoltage each attendance at which fractionated treatment is given at 2 treatments per week or less frequently—2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)	DF
15112	RADIOTHERAPY, DEEP OR ORTHOVOLTAGEattendance at which single dose technique is applied 1 field	$218.40
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)	DF
	Megavoltage	
15211	RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy uniteach attendance at which treatment is given—1 field	$96.40
15214	Radiation oncology treatment, using cobalt unit or caesium teletherapy unit—each attendance at which treatment is given 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields	DF
15215	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities—each attendance at which treatment is given—1 field—treatment delivered to primary site (lung)	$108.20
15218	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities—each attendance at which treatment is given—1 field—treatment delivered to primary site (prostate)	$108.20

Item no.	Description	Max fee (excl. GST)
15221	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities—each attendance at which treatment is given—1 field—treatment delivered to primary site (breast)	$108.20
15224	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities—each attendance at which treatment is given—1 field—treatment delivered to primary site for diseases and conditions not covered by items 15215, 15218 and 15221	$110.50
15227	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities—each attendance at which treatment is given—1 field—treatment delivered to secondary site	$110.50
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)	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	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)	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	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	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)	$110.50
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)	$108.20
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)	$110.50
15254	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—each attendance at which treatment is given—1 field—treatment delivered to primary site for diseases and conditions not covered by items 15245, 15248 or 15251	$110.50
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	$110.50
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)	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	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)	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	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	DF

Item no.	Description	Max fee (excl. GST)
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.	$298.60
	Brachytherapy	
15303	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)	$648.30
15304	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)	$648.30
15307	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.)	$1229.20
15308	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.)	$1229.20
15311	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)	$605.20
15312	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)	$600.70
15315	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.)	$1188.20
15316	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.)	$1200.00
15319	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)	$737.30
15320	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)	$737.30
15323	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.)	$1311.20
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 afterloading techniques (Anaes.)	$1336.90
15327	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using manual afterloading techniques (Anaes.)	$1426.50
15328	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using automatic afterloading techniques (Anaes.)	$1625.00
15331	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using manual afterloading techniques (Anaes.)	$1354.40
15332	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using automatic afterloading techniques (Anaes.)	$1459.60
15335	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using manual afterloading techniques (Anaes.)	$1229.20
15336	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using automatic afterloading techniques (Anaes.)	$1229.20

Item no.	Description	Max fee (excl. GST)
15338	Prostate, radioactive seed implantation of, radiation oncology component, using transrectal ultrasound guidance: (a) for a patient with: (i) localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate); and (ii) a Gleason score of less than or equal to 7 (Grade Group 1 to Grade Group 3); and (iii) a prostate specific antigen (PSA) of not more than 10ng/ml at the time of diagnosis; and (b) performed by an oncologist at an approved site in association with a urologist; and (c) being a service associated with: (i) services to which items 37220 and 55603 apply; and (ii) a service to which item 60506or 60509 applies	$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	$345.60
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	$937.40
15348	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15342 or 15345each attendance	$107.40
15351	CONSTRUCTION WITH OR WITHOUT INITIAL APPLICATION OF RADIOACTIVE MOULD not exceeding 5 cm. diameter to an external surface	$231.80
15354	CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD 5 cm. or more in diameter to an external surface	$256.90
15357	"SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD, attendance upon a patient to apply a radioactive mould constructed for application to an external surface of the patient other than an attendance which is the first attendance to apply the mould each attendance"	$79.50
	Computerised planning	
15500	RADIOTHERAPY PLANNINGRADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15509 applies)	$399.70
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)	$546.20
15506	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15515 applies)	$856.00
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)	$380.50
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)	$356.70
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
15515	RADIATION FIELD SETTING using a diagnostic xray unit of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15506 applies)	$657.50
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 offaxis 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	$143.70
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	$562.80

Item no.	Description	Max fee (excl. GST)
15533	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields, or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields	$1108.20
15536	Brachytherapy planning, computerised radiation dosimetry	$560.40
15539	BRACHYTHERAPY PLANNING, computerised radiation dosimetry for I125 seed implantation of localised prostate cancer, in association with item 15338	$1490.00
15550	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY without intravenous contrast medium, where: (a)treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and (b)patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and three dimensional conformal radiotherapy treatment; and (c)a high-quality CT-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and (d)the image set must be suitable for the generation of quality digitally reconstructed radiographic images	$913.70
15553	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY pre and post intravenous contrast medium, where: (a)treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and (b)patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and three dimensional conformal radiotherapy treatment; and (c)a high-quality CT-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and (d)the image set must be suitable for the generation of quality digitally reconstructed radiographic images	$934.30
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.	$1159.70
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	$898.10
15559	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 2 COMPLEXITY where: (a)dosimetry for a two phase three dimensional conformal treatment plan using CT image volume dataset(s) with at least one gross tumour volume, two planning target volumes and one organ at risk defined in the prescription; or (b)dosimetry for a one phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, one planning target volume and two organ at risk dose goals or constraints defined in the prescription; or (c)image fusion with a secondary image (CT, MRI or PET) volume dataset used to define target and organ at risk volumes in conjunction with and as specified in dosimetry for three dimensional conformal radiotherapy of level 1 complexity. All gross tumour targets, clinical targets, planning targets and organs at risk as defined in the prescription must be rendered as volumes. The organ at risk must be nominated as planning dose goals or constraints and the prescription must specify the organs at risk as dose goals or constraints. Dose volume histograms must be generated, approved and recorded with the plan. A CT image volume dataset must be used for the relevant region to be planned and treated. The CT images must be suitable for the generation of quality digitally reconstructed radiographic images	$1199.70
15562	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 3 COMPLEXITY—where: (a)dosimetry for a three or more phase three dimensional conformal treatment plan using CT image volume dataset(s) with at least one gross tumour volume, three planning target volumes and one organ at risk defined in the prescription; or (b)dosimetry for a two phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, and (i) two planning target volumes; or (ii) two organ at risk dose goals or constraints defined in the prescription. or (c)dosimetry for a one phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, one planning target volume and three organ at risk dose goals or constraints defined in the prescription; or (d)image fusion with a secondary image (CT, MRI or PET) volume dataset used to define target and organ at risk volumes in conjunction with and as specified in dosimetry for three dimensional conformal radiotherapy of level 2 complexity. All gross tumour targets, clinical targets, planning targets and organs at risk as defined in the prescription must be rendered as volumes. The organ at risk must be nominated as planning dose goals or constraints and the prescription must specify the organs at risk as dose goals or constraints. Dose volume histograms must be generated, approved and recorded with the plan. A CT image volume dataset must be used for the relevant region to be planned and treated. The CT images must be suitable for the generation of quality digitally reconstructed radiographic images	$1661.20

Item no.	Description	Max fee (excl. GST)
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 assessmentby a radiation oncologist; and (ii)all gross tumour targets, clinical targets, planning targets and organs at risk are rendered as volumes as defined in the prescription; and (iii)organs at risk are nominated as planning dose goals or constraints and the prescription specifies the organs at risk as dose goals or constraints; and (iv)dose calculations and dose volume histograms are generated in an inverse planned process, using a specialised calculation algorithm, with prescription and plan details approved and recorded in the plan; and (v)a CT image volume dataset is used for the relevant region to be planned and treated; and (vi)the CT images are suitable for the generation of quality digitally reconstructed radiographic images; and (b) the final IMRT dosimetry plan is validated by the radiation therapist and the medical physicist, using robust quality assurance processes that include: (i)determination of the accuracy of the dose fluence delivered by the multi-leaf collimator and gantryposition (static or dynamic); and (ii)ensuring that the plan is deliverable, data transfer is acceptable and validation checks are completed on a linear accelerator; and (iii)validating the accuracy of the derived IMRT dosimetry plan; and (c)the final IMRT dosimetry plan is approved by the radiation oncologist prior to delivery.	$5408.40
	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)—when prescribed and reviewed by a radiation oncologist and not associated with item 15705 or 15710—each attendance at which treatment is verified (ie maximum one per attendance).	$87.80
15705	RADIATION ONCOLOGY TREATMENT VERIFICATION—multiple projection acquisition when prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15710—each attendance at which treatment involving three or more fields is verified (ie maximum one per attendance).	$146.50
15710	RADIATION ONCOLOGY TREATMENT VERIFICATION—volumetric acquisition, when prescribed and reviewedby a radiation oncologist and not associated with item 15700 or 15705—each attendance at which treatment involving three fields or more is verified (ie maximum one per attendance). (see para T2.5 of explanatory notes to this Category)	$147.10
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.	$125.00
	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 brachytherapy 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.)	$1222.70
16006	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique	$937.40
16009	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique	$619.50
16012	Intravenous administration of a therapeutic dose of Phosphorous 32	$536.10
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	$6536.60

Item no.	Description	Max fee (excl. GST)
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.	$3484.30
GROUP T2—TARGETED INTRAOPERATIVE RADIOTHERAPY		
	Intraoperative radiotherapy	
15900	BREAST, MALIGNANT TUMOUR, targeted intraoperative radiation therapy, using an Intrabeam or Xoft Axxent device, delivered at the time of breast-conserving surgery (partial mastectomy or lumpectomy) for a patient who: a) is 45 years of age or more; and b) has a T1 or small T2 (less than or equal to 3cm in diameter) primary tumour; and c) has an histologic Grade 1 or 2 tumour; and d) has an oestrogen-receptor positive tumour; and e) has a node negative malignancy; and f) is suitable for wide local excision of a primary invasive ductal carcinoma that was diagnosed as unifocal on conventional examination and imaging; and g) has no contra-indications to breast irradiation Applicable only once per breast per lifetime (H)	$408.10
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 CARE Antenatal service provided by a midwife, nurse or an Aboriginal and Torres Strait Islander health practitionerif: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; (b) the service is provided at, or from, a practice location in a regional, rural or remote area; (c) the service is not performed in conjunction with another antenatal attendance item (same patient, same practitioner on the same day); (d) the service is not provided for an admitted patient of a hospital; and to a maximum of 10 service per pregnancy	$44.90
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	$239.10
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	$112.80
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	$84.00
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	$253.90
16502	POLYHYDRAMNIOS, UNSTABLE LIE, MULTIPLE PREGNANCY, PREGNANCY COMPLICATED BY DIABETES OR ANAEMIA, THREATENED PREMATURE LABOUR treated by bed rest only or oral medication, requiring admission to hospitaleach attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day	$84.10
16505	THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS GRAVIDARUM, requiring admission to hospital, treatment ofeach attendance that is not a routine antenatal attendance	$90.20
16508	Pregnancy complicatedby acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital—each professional attendance (other than a service to which item 16533 applies) that is not a routine antenatal attendance, to a maximum of one visit per day	$84.00

Item no.	Description	Max fee (excl. GST)
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)	$66.40
16515	Management of vaginal birth as an independent procedure, ifthe patient's care has been transferred by another medical practitioner for management of the birth and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the birth (Anaes.)	$1221.80
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 labourand birth by any means (including Caesarean section) including post-partum care for 5 days (Anaes.)	$1788.60
16520	Caesarean section and post operative care for 7 days, if the patient s care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (Anaes.)	$1933.50
16522	Management of labour and birth, or birth alone, (including caesarean section), on or after 23 weeks gestation, if in the course of antenatal supervision or intrapartum management one or more of the following conditions is present, including postnatal care for 7 days: (a) fetal loss; (b) multiple pregnancy; (c) antepartum haemorrhage that is: (i) of greater than 200 ml; or (ii) associated with disseminated intravascular coagulation; (d) placenta praevia on ultrasound in the third trimester with the placenta within 2 cm of the internal cervical os; (e) baby with a birth weight less than or equal to 2,500 g; (f) trial of vaginal birth in a patient with uterine scar where there has been a planned vaginal birth after caesarean section; (g) trial of vaginal breech birth where there has been a planned vaginal breech birth; (h) prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress as evidenced by cervical dilatation at less than 1 cm/hr in the active phase of labour (after 3 cm cervical dilatation and effacement until full dilatation of the cervix); (i) acute fetal compromise evidenced by: (i) scalp pH less than 7.15; or (ii) scalp lactate greater than 4.0; (j) acute fetal compromise evidenced by at least one of the following significant cardiotocograph abnormalities: (i) prolonged bradycardia (less than 100 bpm for more than 2 minutes); (ii) absent baseline variability (less than 3 bpm); (iii) sinusoidal pattern; (iv) complicated variable decelerations with reduced (3 to 5 bpm) or absent baseline variability; (v) late decelerations; (k) pregnancy induced hypertension of at least 140/90 mm Hg associated with: (i) at least 2+ proteinuria on urinalysis; or (ii) protein-creatinine ratio greater than 30 mg/mmol; or (iii) platelet count less than 150 x 109/L; or (iv) uric acid greater than 0.36 mmol/L; (l) gestational diabetes mellitus requiring at least daily blood glucose monitoring; (m) mental health disorder (whether arising prior to pregnancy, during pregnancy or postpartum) that is demonstrated by: (i) the patient requiring hospitalisation; or (ii) the patient receiving ongoing care by a psychologist or psychiatrist to treat the symptoms of a mental health disorder; or (iii) the patient having a GP mental health treatment plan; or (iv) the patient having a management plan prepared in accordance with item 291; (n) disclosure or evidence of domestic violence; (o) any of the following conditions either diagnosed pre-pregnancy or evident at the first antenatal visit before 20 weeks gestation: (i) pre-existing hypertension requiring antihypertensive medication prior to pregnancy; (ii) cardiac disease (co-managed with a specialist physician and with echocardiographic evidence of myocardial dysfunction); (iii) previous renal or liver transplant; (iv) renal dialysis; (v) chronic liver disease with documented oesophageal varices; (vi) renal insufficiency in early pregnancy (serum creatinine greater than 110 mmol/L); (vii) neurological disorder that confines the patient to a wheelchair throughout pregnancy; (viii) maternal height of less than 148 cm; (ix) a body mass index greater than or equal to 40; (x) pre-existing diabetes mellitus on medication prior to pregnancy; (xi) thyrotoxicosis requiring medication; (xii) previous thrombosis or thromboembolism requiring anticoagulant therapy through pregnancy and the early puerperium; (xiii) thrombocytopenia with platelet count of less than 100,000 prior to 20 weeks gestation; (xiv) HIV, hepatitis B or hepatitis C carrier status positive; (xv) red cell or platelet iso-immunisation; (xvi) cancer with metastatic disease; (xvii) illicit drug misuse during pregnancy (Anaes.)	$2832.60
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.)	$804.70
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.)	$604.70
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.)	$1209.40
16533	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, to a maximum of 3 services per pregnancy	$166.10
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	$166.10

Item no.	Description	Max fee (excl. GST)
16564	POST-PARTUM CARE EVACUATION OF RETAINED PRODUCTS OF CONCEPTION (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure (Anaes.)	$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.)	$778.30
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.)	$507.80
16590	Planning and management, by a practitioner, of a pregnancy if: (a) the practitioner intends to take primary responsibility for management of the pregnancy and any complications, and to be available for the birth; and (b) the patient intends to be privately admitted for the birth; and (c) the pregnancy has progressed beyond 28 weeks gestation; and (d) the practitioner has maternity privileges at a hospital or birth centre; and (e) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (f) a service to which item 16591 applies is not provided in relation to the same pregnancy Payable once only for a pregnancy	$387.40
16591	Planning and management, by a practitioner, of a pregnancy if: (a) the pregnancy has progressed beyond 28 weeks gestation; and (b) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (c) a service to which item 16590 applies is not provided in relation to the same pregnancy Payable once only for a pregnancy	$205.00
16600	INTERVENTIONAL TECHNIQUES AMNIOCENTESIS, diagnostic	$153.00
16603	Chorionic villus sampling, by any route	$233.30
16606	Fetal blood sampling, using interventional techniques from umbilical cord or fetus, including fetal neuromuscular blockade and amniocentesis (Anaes.)	$439.60
16609	FOETAL INTRAVASCULAR BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling (Anaes.)	$896.20
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.)	$705.00
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.)	$375.80
16618	AMNIOCENTESIS, THERAPEUTIC, when indicated because of polyhydramnios with at least 500ml being aspirated	$380.90
16621	AMNIOINFUSION, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios	$375.80
16624	FOETAL FLUID FILLED CAVITY, drainage of	$540.50
16627	FETO-AMNIOTIC SHUNT, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis	$1100.20

GROUP T6—ANAESTHETICS

Anaesthesia consultations

17609	Professional attendance on a patient by a specialist practising in his or her specialty of anaesthesia if: (a) the attendance is by video conference; and (b) item 17610, 17615, 17620, 17625, 17640, 17645, 17650, or 17655 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance-at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies . Derived Fee: 50% of the fee for the associated item.	DF
17610	ANAESTHETIST, PRE-ANAESTHESIA CONSULTATION (Professional attendance by a medical practitionerin the practice of ANAESTHESIA) -a BRIEF consultation involving a targeted history and limited examination (including the cardio-respiratory system) -AND of not more than 15 minutes s duration, not being a service associated with a service to which items 2801—3000 apply	$84.30
17615	Professional attendance by a medical practitioner in the practice of anaesthesia for a consultation on a patient undergoing advanced surgery or who has complex medical problems, involving a selective history and an extensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes—and of more than 15 minutes but not more than 30 minutes duration, not being a service associated with a service to which items 2801—3000 applies	$167.70
17620	Professional attendance by a medical practitioner in the practice of anaesthesia for a consultation on a patient undergoing advanced surgery or who has complex medical problems involving a detailed history and comprehensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes—and of more than 30 minutes but not more than 45 minutes duration, not being a service associated with a service to which items 2801—3000 apply	$235.00

Item no.	Description	Max fee (excl. GST)
17625	Professional attendance by a medical practitioner in the practice of anaesthesia for a consultation on a patient undergoing advanced surgery or who has complex medical problems involving an exhaustive history and comprehensive examination of multiple systems , the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of high complexity documented in the patient notes—and of more than 45 minutes duration, not being a service associated with a service to which items 2801—3000 apply	$295.00
17640	ANAESTHETIST, REFERRED CONSULTATION (other than prior to anaesthesia) (Professional attendance by a specialist anaesthetist in the practice of ANAESTHESIA where the patient is referred to him or her) -a BRIEF consultation involving a short history and limited examination -AND of not more than 15 minutesduration, 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 andthe 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.	$162.90
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	$227.80
17655	-a consultation involving an exhaustive history and comprehensive examination of multiple systems andthe formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of high complexity, -AND of more than 45 minutes duration, not being a service associated with a service to which items 2801—3000 apply.	$297.20
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 itemin the range 17615-17625 is performed in-rooms if: (a) the service is provided to a patient prior to an admitted patient episode of care involving anaesthesia; and (b) the service is not providedto an admitted patient of a hospital; and (c) the service is not provided on the day of admission to hospital for the subsequent episode of care involving anaesthesia services; and (d) the service is of more than 15 minutes duration not being a service associated with a service to which items 2801—3000 apply.	$71.80
GROUP T7—REGIONAL OR FIELD NERVE BLOCKS		
18213	Intravenous regional anaesthesia of limb by retrograde perfusion	$162.30
18216	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner Applicable once per presentation, per medical practitioner, per complete new procedure (Anaes.)	$192.00
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.)	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, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner, for a patient in labour, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday. Applicable once per presentation, per medical practitioner, per complete new procedure	$574.50
18227	Intrathecal or epidural infusion of a therapeutic substance, initial injection or commencement of, where continuous attendance by a medical practitioner extends beyond the first hour, for a patient in labour, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a saturday, a sunday or a public holiday.	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.)	$362.40
18233	Epidural injection of blood for blood patch (Anaes.)	$367.20
18234	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent (Anaes.)	$235.20
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	$68.60

Item no.	Description	Max fee (excl. GST)
18240	Retrobulbar 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 ofanaesthetic 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
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.)	$453.70
18292	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies or a service associated with the injection of botulinum toxin except those services to which item 18354 applies (Anaes.)	$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
18297	Assistance at the administration of an epidural blood patch (a service to which item 18233 applies) by another medical practitioner	$92.80
18298	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)	$319.50
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	$228.20
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	$453.70
18354	Botulinum Toxin Type A Purified Neurotixin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport), injection of, for the treatment of dynamic equinus foot deformity (including equinovarus and equinovalgus) due to spasticity in an ambulant cerebral palsy patient, if:(a) the patient is at least 2 years of age; and (b) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each lower limb), including all injections per set (Anaes.)	$240.00

Item no.	Description	Max fee (excl. GST)
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	$226.80
18361	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of moderate to severe upper limb spasticity due to cerebral palsy if: (a) the patient is at least 2 years of age; and (b) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set (Anaes.)	$222.90
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 an acute event,if: (a) the patient is at least 18 years of age; and (b) treatment is provided as: (i)second line therapy when standard treatment for the condition has failed; or (ii) an adjunct to physical therapy; and (c) the patient does not have established severe contracture in the limb that is to be treated; and (d) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set; and (e) for a patient who has received treatment on 2 previous separate occasions—the patient has responded to the treatment	$227.70
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	$485.00
18369	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of unilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.)	$92.00
18370	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of unilateral blepharospasm in a patient who is at least 12 years of age, including all such injections on any one day (Anaes.)	$86.10
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.)	$225.60
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.)	$225.60
18375	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), intravesical injection of, with cystoscopy, for the treatment of urinary incontinence, including all such injections on any one day, if: (a) the urinary incontinence is due to neurogenic detrusor overactivity as demonstrated by urodynamic study of a patient with: (i) multiple sclerosis; or (ii) spinal cord injury; or (iii) spina bifida and who is at least 18 years of age; and (b) the patient has urinary incontinence that is inadequately controlled by anti-cholinergic therapy, as manifested by having experienced at least 14 episodes of urinary incontinence per week before commencement of treatment with botulinum toxin type A; and (c) the patient is willing and able to self-catheterise; and (d) the requirements relating to botulinum toxin type A under the Pharmaceutical Benefits Scheme are complied with; and (e) treatment is not provided on the same occasion as a service described in item 104, 105, 110, 116, 119, 11900 or 11919 For each patient—applicable not more than once except if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment (Anaes.)	$395.70
18377	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of chronic migraine, including all injections in 1 day, if: (a)the patient is at least 18 years of age; and (b) the patient has experienced an inadequate response, intolerance or contraindication to at least 3 prophylactic migraine medications before commencement of treatment with botulinum toxin, as manifested by an average of 15 or more headache days per month, with at least 8 days of migraine, over a period of at least 6 months, before commencement of treatment with botulinum toxin; and (c)the requirements relating to botulinum toxin type A under the Pharmaceutical Benefits Scheme are complied with For each patient-applicable not more than twice except if the patient achieves and maintains at least a 50% reduction in the number of headache days per month from baseline after 2 treatment cycles (each of 12 weeks duration)	$214.80

Item no.	Description	Max fee (excl. GST)
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.)	$383.80
GROUP T10—RELATIVE VALUE GUIDE FOR ANAESTHESIA—WORKCOVER BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE		
	Head	
20100	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, subcutaneous tissue, muscles, salivary glands or superficial vessels of the head including biopsy, not being a service to which another item in this Subgroup applies (5 basic units)	$264.50
20102	INITIATION OF MANAGEMENT OF ANAESTHESIA for plastic repair of cleft lip (6 basic units)	$317.40
20104	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroconvulsive therapy (4 basic units)	$211.60
20120	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on external, middle or inner ear, including biopsy, not being a service to which another item in this Subgroup applies (5 basic units)	$264.50
20124	INITIATION OF MANAGEMENT OF ANAESTHESIA for otoscopy (4 basic units)	$211.60
20140	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on eye, not being a service to which another item in this Group applies (5 basic units)	$264.50
20142	INITIATION OF MANAGEMENT OF ANAESTHESIA for lens surgery (5 basic units)	$317.40
20143	INITIATION OF MANAGEMENT OF ANAESTHESIA for retinal surgery (6 basic units)	$317.40
20144	INITIATION OF MANAGEMENT OF ANAESTHESIA for corneal transplant (7 basic units)	$423.20
20145	INITIATION OF MANAGEMENT OF ANAESTHESIA for vitrectomy (7 basic units)	$423.20
20146	INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of conjunctiva (5 basic units)	$264.50
20147	INITIATION OF MANAGEMENT OF ANAESTHESIA for squint repair (6 basic units)	$317.40
20148	INITIATION OF MANAGEMENT OF ANAESTHESIA for ophthalmoscopy (4 basic units)	$211.60
20160	Initiation of the management of anaesthesia for intranasal or accessory sinuses, not being a service to which another item in this Subgroup applies (6 basic units)	$317.40
20162	Initiation of the management of anaesthesia for intranasal surgery for malignancy or for intranasal ablation (7 basic units)	$370.30
20164	INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of soft tissue of the nose and accessory sinuses (4 basic units)	$211.60
20170	INITIATION OF MANAGEMENT OF ANAESTHESIA for intraoral procedures, including biopsy, not being a service to which another item in this Subgroup applies (6 basic units)	$317.40
20172	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of cleft palate (7 basic units)	$370.30
20174	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision of retropharyngeal tumour (9 basic units)	$476.10
20176	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical intraoral surgery (10 basic units)	$529.00
20190	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on facial bones, not being a service to which another item in this Subgroup applies (5 basic units)	$264.50
20192	INITIATION OF MANAGEMENT OF ANAESTHESIA for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction) (10 basic units)	$529.00
20210	INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial procedures, not being a service to which another item in this Subgroup applies (15 basic units)	$793.50
20212	INITIATION OF MANAGEMENT OF ANAESTHESIA for subdural taps (5 basic units)	$264.50
20214	INITIATION OF MANAGEMENT OF ANAESTHESIA for burr holes of the cranium (9 basic units)	$476.10
20216	INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial vascular procedures including those for aneurysms or arterio-venous abnormalities (20 basic units)	$1058.00
20220	INITIATION OF MANAGEMENT OF ANAESTHESIA for spinal fluid shunt procedures (10 basic units)	$529.00
20222	INITIATION OF MANAGEMENT OF ANAESTHESIA for ablation of an intracranial nerve (6 basic units)	$317.40

Item no.	Description	Max fee (excl. GST)
20225	INITIATION OF MANAGEMENT OF ANAESTHESIA for all cranial bone procedures (12 basic units)	$634.80
20230	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the head or face (12 basic units)	$634.80
	Neck	
20300	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the neck not being a service to which another item in this Subgroup applies (5 basic units)	$264.50
20305	INITIATION OF MANAGEMENT OF ANAESTHESIA for incision and drainage of large haematoma, large abscess, cellulitis or similar lesion or epiglottitis causing life threatening airway obstruction (15 basic units)	$793.50
20320	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on oesophagus, thyroid, larynx, trachea, lymphatic system, muscles, nerves or other deep tissues of the neck, not being a service to which another item in this Subgroup applies (6 basic units)	$317.40
20321	INITIATION OF MANAGEMENT OF ANAESTHESIA for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy (10 basic units)	$529.00
20330	INITIATION OF MANAGEMENT OF ANAESTHESIA for laser surgery to the airway (excluding nose and mouth) (8 basic units)	$423.20
20350	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major vessels of neck, not being a service to which another item in this Subgroup applies (10 basic units)	$529.00
20352	INITIATION OF MANAGEMENT OF ANAESTHESIA for simple ligation of major vessels of neck (5 basic units)	$264.50
20355	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the neck (12 basic units)	$634.80
	Thorax	
20400	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this Subgroup applies (3 basic units)	$158.70
20401	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the breast, not being a service to which another item in this Subgroup applies (4 basic units)	$211.60
20402	INITIATION OF MANAGEMENT OF ANAESTHESIA for reconstructive procedures on breast (5 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 (5 basic units)	$264.50
20404	INITIATION OF MANAGEMENT OF ANAESTHESIA for mastectomy (6 basic units)	$317.40
20405	INITIATION OF MANAGEMENT OF ANAESTHESIA for reconstructive procedures on the breast using myocutaneous flaps (8 basic units)	$423.20
20406	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical or modified radical procedures on breast with internal mammary node dissection (13 basic units)	$687.70
20410	INITIATION OF MANAGEMENT OF ANAESTHESIA for electrical conversion of arrhythmias (4 basic units)	$264.50
20420	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the posterior part of the chest not being a service to which another item in this Subgroup applies (5 basic units)	$264.50
20440	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the sternum (4 basic units)	$211.60
20450	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on clavicle, scapula or sternum, not being a service to which another item in this Subgroup applies (5 basic units)	$264.50
20452	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical surgery on clavicle, scapula or sternum (6 basic units)	$317.40
20470	INITIATION OF MANAGEMENT OF ANAESTHESIA for partial rib resection, not being a service to which another item in this Subgroup applies (6 basic units)	$317.40
20472	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracoplasty (10 basic units)	$529.00
20474	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures on chest wall (13 basic units)	$687.70
20475	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior thorax (10 basic units)	$529.00
	Intrathoracic	
20500	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the oesophagus (15 basic units)	$793.50

Item no.	Description	Max fee (excl. GST)
20520	INITIATION OF MANAGEMENT OF ANAESTHESIA for all closed chest procedures (including rigid oesophagoscopy or bronchoscopy), not being a service to which another item in this Subgroup applies (6 basic units)	$317.40
20522	INITIATION OF MANAGEMENT OF ANAESTHESIA for needle biopsy of pleura (4 basic units)	$211.60
20524	INITIATION OF MANAGEMENT OF ANAESTHESIA for pneumocentesis (4 basic units)	$211.60
20526	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracoscopy (10 basic units)	$529.00
20528	INITIATION OF MANAGEMENT OF ANAESTHESIA for mediastinoscopy (8 basic units)	$423.20
20540	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracotomy procedures involving lungs, pleura, diaphragm, or mediastinum, not being a service to which another item in this Subgroup applies (13 basic units)	$687.70
20542	INITIATION OF MANAGEMENT OF ANAESTHESIA for pulmonary decortication (15 basic units)	$793.50
20546	INITIATION OF MANAGEMENT OF ANAESTHESIA for pulmonary resection with thoracoplasty (15 basic units)	$793.50
20548	INITIATION OF MANAGEMENT OF ANAESTHESIA for intrathoracic repair of trauma to trachea and bronchi (15 basic units)	$793.50
20560	Initiation of the management of anaesthesia for: (a) open procedures on the heart, pericardium or great vessels of the chest; or (b) percutaneous insertion of a valvular prosthesis (20 basic units)	$1058.00
	Spine and spinal cord	
20600	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on cervical spine and/or cord, not being a service to which another item in this Subgroup applies (for myelography and discography see Items 21908 and 21914) (10 basic units)	$529.00
20604	INITIATION OF MANAGEMENT OF ANAESTHESIA for posterior cervical laminectomy with the patient in the sitting position (13 basic units)	$687.70
20620	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on thoracic spine and/or cord, not being a service to which another item in this Subgroup applies (10 basic units)	$529.00
20622	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracolumbar sympathectomy (13 basic units)	$687.70
20630	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures in lumbar region, not being a service to which another item in this Subgroup applies (8 basic units)	$423.20
20632	INITIATION OF MANAGEMENT OF ANAESTHESIA for lumbar sympathectomy (7 basic units)	$370.30
20634	INITIATION OF MANAGEMENT OF ANAESTHESIA for chemonucleolysis (10 basic units)	$529.00
20670	INITIATION OF MANAGEMENT OF ANAESTHESIA for extensive spine and/or spinal cord procedures (13 basic units)	$687.70
20680	INITIATION OF MANAGEMENT OF ANAESTHESIA for manipulation of spine when performed in the operating theatre of a hospital (3 basic units)	$158.70
20690	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous spinal procedures, not being a service to which another item in this Subgroup applies (5 basic units)	$264.50
	Upper abdomen	
20700	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper anterior abdominal wall, not being a service to which another item in this Subgroup applies (3 basic units)	$158.70
20702	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units)	$211.60
20703	INITIATION OF MANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, tendons and fascia of the upper abdominal wall, not being a service to which another item in this Subgroup applies (4 basic units)	$211.60
20704	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior upper abdomen (10 basic units)	$529.00
20706	Initiation of the management of anaesthesia for laparoscopic procedures in the upper abdomen, including laparoscopic cholecystectomy, not being a service to which another item in this Subgroup applies (7 basic units)	$370.30
20730	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper posterior abdominal wall, not being a service to which another item in this Subgroup applies (5 basic units)	$264.50
20740	INITIATION OF MANAGEMENT OF ANAESTHESIA for upper gastrointestinal endoscopic procedures (5 basic units)	$264.50
20745	Initiation of the management of anaesthesia for either or both of the following:(a) upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage;(b) endoscopic retrograde cholangiopancreatography (7 basic units)	$317.40

Item no.	Description	Max fee (excl. GST)
20750	Initiation of the management of anaesthesia for hernia repairs to the upper abdominal wall, other than a service to which another item in this Subgroup applies. (5 basic units)	$211.60
20752	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional hernia and/or wound dehiscence (6 basic units)	$317.40
20754	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on an omphalocele (7 basic units)	$370.30
20756	INITIATION OF MANAGEMENT OF ANAESTHESIA for transabdominal repair of diaphragmatic hernia (9 basic units)	$476.10
20770	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major upper abdominal blood vessels (15 basic units)	$793.50
20790	Initiation of the management of anaesthesia for procedures within the peritoneal cavity in upper abdomen, including any of the following:(a) open cholecystectomy;(b) gastrectomy;(c) laparoscopically assisted nephrectomy;(d) bowel shunts (8 basic units)	$423.20
20791	Initiation of the management of anaesthesia for bariatric surgery in a patient with clinically severe obesity (10 basic units)	$529.00
20792	INITIATION OF MANAGEMENT OF ANAESTHESIA for partial hepatectomy (excluding liver biopsy) (13 basic units)	$687.70
20793	INITIATION OF MANAGEMENT OF ANAESTHESIA for extended or trisegmental hepatectomy (15 basic units)	$793.50
20794	INITIATION OF MANAGEMENT OF ANAESTHESIA for pancreatectomy, partial or total (12 basic units)	$634.80
20798	INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the upper abdomen (10 basic units)	$529.00
20799	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra-abdominal organ in the upper abdomen (6 basic units)	$317.40
	Lower abdomen	
20800	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the lower anterior abdominal walls, not being a service to which another item in this Subgroup applies (3 basic units)	$158.70
20802	INITIATION OF MANAGEMENT OF ANAESTHESIA for lipectomy of the lower abdomen (5 basic units)	$264.50
20803	INITIATION OF MANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, tendons and fascia of the lower abdominal wall, not being a service to which another item in this Subgroup applies (4 basic units)	$211.60
20804	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen (10 basic units)	$529.00
20806	INITIATION OF MANAGEMENT OF ANAESTHESIA for laparoscopic procedures in the lower abdomen (7 basic units)	$370.30
20810	INITIATION OF MANAGEMENT OF ANAESTHESIA for lowerintestinal endoscopic procedures (4 basic units)	$211.60
20815	INITIATION OF MANAGEMENT OF ANAESTHESIA for extracorporeal shock wave lithotripsy to urinary tract (6 basic units)	$317.40
20820	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or subcutaneous tissue of the lower posterior abdominal wall (5 basic units)	$264.50
20830	INITIATION OF MANAGEMENT OF ANAESTHESIA for hernia repairs in lower abdomen, not being a service to which another item in this Subgroup applies (4 basic units)	$211.60
20832	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional herniae and/or wound dehiscence of the lower abdomen (6 basic units)	$317.40
20840	Initiation of the management of anaesthesia for all open procedures within the lower abdominal peritoneal cavity, including appendicectomy, not being a service to which another item in this Subgroup applies (6 basic units)	$317.40
20841	INITIATION OF MANAGEMENT OF ANAESTHESIA for bowel resection, including laparoscopic bowel resection not being a service to which another item in this Subgroup applies (8 basic units)	$423.20
20842	INITIATION OF MANAGEMENT OF ANAESTHESIA for amniocentesis (4 basic units)	$211.60
20844	INITIATION OF MANAGEMENT OF ANAESTHESIA for abdominoperineal resection, including pull through procedures, ultra low anterior resection and formation of bowel reservoir (10 basic units)	$529.00
20845	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical prostatectomy (10 basic units)	$529.00
20846	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical hysterectomy (10 basic units)	$529.00
20847	INITIATION OF MANAGEMENT OF ANAESTHESIA for ovarian malignancy (10 basic units)	$529.00

Item no.	Description	Max fee (excl. GST)
20848	INITIATION OF MANAGEMENT OF ANAESTHESIA for pelvic exenteration (10 basic units)	$529.00
20850	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean section (12 basic units)	$634.80
20855	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean hysterectomy or hysterectomy within 24 hours of birth (15 basic units)	$793.50
20860	INITIATION OF MANAGEMENT OF ANAESTHESIA for extraperitoneal procedures in lower abdomen, including those on the urinary tract, not being a service to which another item in this Subgroup applies (6 basic units)	$317.40
20862	INITIATION OF MANAGEMENT OF ANAESTHESIA for renal procedures, including upper 1/3 of ureter (7 basic units)	$370.30
20863	INITIATION OF MANAGEMENT OF ANAESTHESIA for nephrectomy (10 basic units)	$529.00
20864	INITIATION OF MANAGEMENT OF ANAESTHESIA for total cystectomy (10 basic units)	$529.00
20866	INITIATION OF MANAGEMENT OF ANAESTHESIA for adrenalectomy (10 basic units)	$529.00
20867	INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the lower abdomen (10 basic units)	$529.00
20868	INITIATION OF MANAGEMENT OF ANAESTHESIA for renal transplantation (donor or recipient) (10 basic units)	$529.00
20880	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major lower abdominal vessels, not being a service to which another item in this subgroup applies (15 basic units)	$793.50
20882	INITIATION OF MANAGEMENT OF ANAESTHESIA for inferior vena cava ligation (10 basic units)	$529.00
20884	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous umbrella insertion (5 basic units)	$264.50
20886	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra-abdominal organ in the lower abdomen (6 basic units)	$317.40
	Perineum	
20900	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the perineum not being a service to which another item in this Subgroup applies (3 basic units)	$158.70
20902	Initiation of the management of anaesthesia for anorectal procedures (including surgical haemorrhoidectomy, but not banding of haemorrhoids) (4 basic units)	$211.60
20904	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical perineal procedures including radical perineal prostatectomy or radical vulvectomy (7 basic units)	$370.30
20905	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the perineum (10 basic units)	$529.00
20906	INITIATION OF MANAGEMENT OF ANAESTHESIA for vulvectomy (4 basic units)	$211.60
20910	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral procedures (including urethrocystoscopy), not being a service to which another item in this Subgroup applies (4 basic units)	$211.60
20911	INITIATION OF MANAGEMENT OF ANAESTHESIA for endoscopic ureteroscopic surgery including laser procedures (5 basic units)	$264.50
20912	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral resection of bladder tumour(s) (5 basic units)	$264.50
20914	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral resection of prostate (7 basic units)	$370.30
20916	INITIATION OF MANAGEMENT OF ANAESTHESIA for bleeding post-transurethral resection (7 basic units)	$370.30
20920	Initiation of management of anaesthesia for procedures on external genitalia, not being a service to which another item in this Subgroup applies. (4 basic units)	$211.60
20924	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on undescended testis, unilateral or bilateral (4 basic units)	$211.60
20926	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, inguinal approach (4 basic units)	$211.60
20928	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, abdominal approach (6 basic units)	$317.40
20930	INITIATION OF MANAGEMENT OF ANAESTHESIA for orchiopexy, unilateral or bilateral (4 basic units)	$211.60
20932	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis (4 basic units)	$211.60

Item no.	Description	Max fee (excl. GST)
20934	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal lymphadenectomy (6 basic units)	$317.40
20936	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy (8 basic units)	$423.20
20938	INITIATION OF MANAGEMENT OF ANAESTHESIA for insertion of penile prosthesis (4 basic units)	$211.60
20940	INITIATION OF MANAGEMENT OF ANAESTHESIA for per vagina and vaginal procedures (including biopsy of vagina, cervix or endometrium), not being a service to which another item in this Subgroup applies (4 basic units)	$211.60
20942	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal procedures including repair operations and urinary incontinence procedures (perineal) (5 basic units)	$264.50
20943	INITIATION OF MANAGEMENT OF ANAESTHESIA for transvaginal assisted reproductive services (4 basic units)	$211.60
20944	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal hysterectomy (6 basic units)	$317.40
20946	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal birth (8 basic units)	$423.20
20948	INITIATION OF MANAGEMENT OF ANAESTHESIA for purse string ligation of cervix, or removal of purse string ligature (4 basic units)	$211.60
20950	INITIATION OF MANAGEMENT OF ANAESTHESIA for culdoscopy (5 basic units)	$264.50
20952	INITIATION OF MANAGEMENT OF ANAESTHESIA for hysteroscopy (4 basic units)	$211.60
20954	INITIATION OF MANAGEMENT OF ANAESTHESIA for correction of inverted uterus (10 basic units)	$529.00
20956	INITIATION OF MANAGEMENT OF ANAESTHESIA for evacuation of retained products of conception, as a complication of confinement (4 basic units)	$211.60
20958	INITIATION OF MANAGEMENT OF ANAESTHESIA for manual removal of retained placenta or for repair of vaginal or perineal tear following birth (5 basic units)	$264.50
20960	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of post partum haemorrhage (blood loss > 500mls) (7 basic units)	$370.30
	Pelvis (except hip)	
21100	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior pelvic region (anterior to iliac crest), except external genitalia (3 basic units)	$158.70
21110	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum (5 basic units)	$264.50
21112	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units)	$211.60
21114	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units)	$264.50
21116	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow harvesting from the pelvis (6 basic units)	$317.40
21120	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the bony pelvis (6 basic units)	$317.40
21130	INITIATION OF MANAGEMENT OF ANAESTHESIA for body cast application or revision when performed in the operating theatre of a hospital (3 basic units)	$158.70
21140	INITIATION OF MANAGEMENT OF ANAESTHESIA for interpelviabdominal (hind-quarter) amputation (15 basic units)	$793.50
21150	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures for tumour of the pelvis, except hind-quarter amputation (10 basic units)	$529.00
21155	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior pelvis (10 basic units)	$529.00
21160	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving symphysis pubis or sacroiliac joint when performed in the operating theatre of a hospital (4 basic units)	$211.60
21170	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving symphysis pubis or sacroiliac joint (8 basic units)	$423.20
	Upper leg (except knee)	
21195	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper leg (3 basic units)	$158.70
21199	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg (4 basic units)	$211.60

Item no.	Description	Max fee (excl. GST)
21200	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving hip joint when performed in the operating theatre of a hospital (4 basic units)	$211.60
21202	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the hip joint (4 basic units)	$211.60
21210	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving hip joint, not being a service to which another item in this Subgroup applies (6 basic units)	$317.40
21212	INITIATION OF MANAGEMENT OF ANAESTHESIA for hip disarticulation (10 basic units)	$529.00
21214	INITIATION OF MANAGEMENT OF ANAESTHESIA for total hip replacement or revision (10 basic units)	$529.00
21216	INITIATION OF MANAGEMENT OF ANAESTHESIA for bilateral total hip replacement (14 basic units)	$740.60
21220	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving upper 2/3 of femur when performed in the operating theatre of a hospital (4 basic units)	$211.60
21230	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving upper 2/3 of femur, not being a service to which another item in this Subgroup applies (6 basic units)	$317.40
21232	INITIATION OF MANAGEMENT OF ANAESTHESIA for above knee amputation (5 basic units)	$264.50
21234	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection of the upper 2/3 of femur (8 basic units)	$423.20
21260	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures involving veins of upper leg, including exploration (4 basic units)	$211.60
21270	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures involving arteries of upper leg, including bypass graft, not being a service to which another item in this Subgroup applies (8 basic units)	$423.20
21272	INITIATION OF MANAGEMENT OF ANAESTHESIA for femoral artery ligation (4 basic units)	$211.60
21274	INITIATION OF MANAGEMENT OF ANAESTHESIA for femoral artery embolectomy (6 basic units)	$317.40
21275	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the upper leg (10 basic units)	$529.00
21280	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper leg (15 basic units)	$793.50
	Knee and popliteal area	
21300	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the knee and/or popliteal area (3 basic units)	$158.70
21321	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of knee and/or popliteal area (4 basic units)	$211.60
21340	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on lower 1/3 of femur when performed in the operating theatre of a hospital (4 basic units)	$211.60
21360	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on lower 1/3 of femur (5 basic units)	$264.50
21380	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on knee joint when performed in the operating theatre of a hospital (3 basic units)	$158.70
21382	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of knee joint (4 basic units)	$211.60
21390	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on upper ends of tibia, fibula, and/or patella when performed in the operating theatre of a hospital (3 basic units)	$158.70
21392	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on upper ends of tibia, fibula, and/or patella (4 basic units)	$211.60
21400	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on knee joint, not being a service to which another item in this Subgroup applies (4 basic units)	$211.60
21402	INITIATION OF MANAGEMENT OF ANAESTHESIA for knee replacement (7 basic units)	$370.30
21403	INITIATION OF MANAGEMENT OF ANAESTHESIA for bilateral knee replacement (10 basic units)	$529.00
21404	INITIATION OF MANAGEMENT OF ANAESTHESIA for disarticulation of knee (5 basic units)	$264.50
21420	INITIATION OF MANAGEMENT OF ANAESTHESIA for cast application, removal, or repair involving knee joint, undertaken in a hospital (3 basic units)	$158.70
21430	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of knee or popliteal area, not being a service to which another item in this Subgroup applies (4 basic units)	$211.60

Item no.	Description	Max fee (excl. GST)
21432	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of arteriovenous fistula of knee or popliteal area (5 basic units)	$264.50
21440	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of knee or popliteal area, not being a service to which another item in this Subgroup applies (8 basic units)	$423.20
21445	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the knee and/or popliteal area (10 basic units)	$529.00
	Lower leg (below knee)	
21460	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of lower leg, ankle, or foot (3 basic units)	$158.70
21461	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, or fascia of lower leg, ankle, or foot, not being a service to which another item in this Subgroup applies (4 basic units)	$211.60
21462	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on lower leg, ankle, or foot (3 basic units)	$158.70
21464	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedure of ankle joint (4 basic units)	$211.60
21472	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of Achilles tendon (5 basic units)	$264.50
21474	INITIATION OF MANAGEMENT OF ANAESTHESIA for gastrocnemius recession (5 basic units)	$264.50
21480	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on bones of lower leg, ankle, or foot, including amputation, not being a service to which another item in this Subgroup applies (4 basic units)	$211.60
21482	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection of bone involving lower leg, ankle or foot (5 basic units)	$264.50
21484	INITIATION OF MANAGEMENT OF ANAESTHESIA for osteotomy or osteoplasty of tibia or fibula (5 basic units)	$264.50
21486	INITIATION OF MANAGEMENT OF ANAESTHESIA for total ankle replacement (7 basic units)	$370.30
21490	INITIATION OF MANAGEMENT OF ANAESTHESIA for lower leg cast application, removal or repair, undertaken in a hospital (3 basic units)	$158.70
21500	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of lower leg, including bypass graft, not being a service to which another item in this Subgroup applies (8 basic units)	$423.20
21502	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of the lower leg (6 basic units)	$317.40
21520	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of lower leg, not being a service to which another item in this Subgroup applies (4 basic units)	$211.60
21522	INITIATION OF MANAGEMENT OF ANAESTHESIA for venous thrombectomy of the lower leg (5 basic units)	$264.50
21530	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of lower leg, ankle or foot (15 basic units)	$793.50
21532	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of toe (8 basic units)	$423.20
21535	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the lower leg (10 basic units)	$529.00
	Shoulder and axilla	
21600	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the shoulder or axilla (3 basic units)	$158.70
21610	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla including axillary dissection (5 basic units)	$264.50
21620	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, or shoulder joint when performed in the operating theatre of a hospital (4 basic units)	$211.60
21622	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of shoulder joint (5 basic units)	$264.50
21630	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint orshoulder joint, not being a service to which another item in this Subgroup applies (5 basic units)	$264.50
21632	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection involving humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint (6 basic units)	$317.40
21634	INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder disarticulation (9 basic units)	$476.10

Item no.	Description	Max fee (excl. GST)
21636	INITIATION OF MANAGEMENT OF ANAESTHESIA for interthoracoscapular (forequarter) amputation (15 basic units)	$793.50
21638	INITIATION OF MANAGEMENT OF ANAESTHESIA for total shoulder replacement (10 basic units)	$529.00
21650	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of shoulder or axilla, not being a service to which another item in this Subgroup applies (8 basic units)	$423.20
21652	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures for axillary-brachial aneurysm (10 basic units)	$529.00
21654	INITIATION OF MANAGEMENT OF ANAESTHESIA for bypass graft of arteries of shoulder or axilla (8 basic units)	$423.20
21656	INITIATION OF MANAGEMENT OF ANAESTHESIA for axillary-femoral bypass graft (10 basic units)	$529.00
21670	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of shoulder or axilla (4 basic units)	$211.60
21680	INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder cast application, removal or repair, not being a service to which another item in this Subgroup applies, when undertaken in a hospital (3 basic units)	$158.70
21682	INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder spica application when undertaken in a hospital (4 basic units)	$211.60
21685	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the shoulder or the axilla (10 basic units)	$529.00
	Upper arm and elbow	
21700	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper arm or elbow (3 basic units)	$158.70
21710	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of upper arm or elbow, not being a service to which another item in this Subgroup applies (4 basic units)	$211.60
21712	INITIATION OF MANAGEMENT OF ANAESTHESIA for open tenotomy of the upper arm orelbow (5 basic units)	$264.50
21714	INITIATION OF MANAGEMENT OF ANAESTHESIA for tenoplasty of the upper arm orelbow (5 basic units)	$264.50
21716	INITIATION OF MANAGEMENT OF ANAESTHESIA for tenodesis for rupture of long tendon of biceps (5 basic units)	$264.50
21730	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on the upper arm orelbow when performed in the operating theatre of a hospital (3 basic units)	$158.70
21732	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of elbow joint (4 basic units)	$211.60
21740	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the upper arm or elbow, not being a service to which another item in this Subgroup applies (5 basic units)	$264.50
21756	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures on the upper arm or elbow (6 basic units)	$317.40
21760	INITIATION OF MANAGEMENT OF ANAESTHESIA for total elbow replacement (7 basic units)	$370.30
21770	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of upper arm, not being a service to which another item in this Subgroup applies (8 basic units)	$423.20
21772	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of arteries of the upper arm (6 basic units)	$317.40
21780	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of upper arm, not being a service to which another item in this Subgroup applies (4 basic units)	$211.60
21785	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the upper arm or elbow (10 basic units)	$529.00
21790	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper arm (15 basic units)	$793.50
	Forearm wrist and hand	
21800	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the forearm, wrist or hand (3 basic units)	$158.70
21810	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the nerves, muscles, tendons, fascia, or bursae of the forearm, wrist or hand (4 basic units)	$211.60
21820	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on the radius, ulna, wrist, or hand bones when performed in the operating theatre of a hospital (3 basic units)	$158.70

Item no.	Description	Max fee (excl. GST)
21830	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the radius, ulna, wrist, or hand bones, not being a service to which another item in this Subgroup applies (4 basic units)	$211.60
21832	INITIATION OF MANAGEMENT OF ANAESTHESIA for total wrist replacement (7 basic units)	$370.30
21834	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the wrist joint (4 basic units)	$211.60
21840	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the arteries of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (8 basic units)	$423.20
21842	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of artery of forearm, wrist or hand (6 basic units)	$317.40
21850	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the veins of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (4 basic units)	$211.60
21860	INITIATION OF MANAGEMENT OF ANAESTHESIA for forearm, wrist, or hand cast application, removal, or repair when rendered to a patient as part of an episode of hospital treatment (3 basic units)	$158.70
21865	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the forearm, wrist or hand (10 basic units)	$529.00
21870	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of forearm, wrist or hand (15 basic units)	$793.50
21872	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of a finger (8 basic units)	$423.20
	Anaesthesia for burns	
21878	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting where the area of burn involves not more than 3% of total body surface (3 basic units)	$158.70
21879	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting,where the area of burn involves more than 3% but less than 10% of total body surface (5 basic units)	$264.50
21880	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 10% or more but less than 20% of total body surface (7 basic units)	$370.30
21881	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 20% or more but less than 30% of total body surface (9 basic units)	$476.10
21882	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 30% or more but less than 40% of total body surface (11 basic units)	$581.90
21883	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 40% or more but less than 50% of total body surface (13 basic units)	$687.70
21884	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 50% or more but less than 60% of total body surface (15 basic units)	$793.50
21885	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 60% or more but less than 70% of total body surface (17 basic units)	$899.30
21886	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 70% or more but less than 80% of total body surface (19 basic units)	$1005.10
21887	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 80% or more of total body surface (21 basic units)	$1110.90
	Anaesthesia for radiological or other diagnostic or therapeutic procedures	
21900	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for hysterosalpingography (3 basic units)	$158.70
21906	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: lumbar or thoracic (5 basic units)	$264.50
21908	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: cervical (6 basic units)	$317.40
21910	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: posterior fossa (9 basic units)	$476.10
21912	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography: lumbar or thoracic (5 basic units)	$264.50

Item no.	Description	Max fee (excl. GST)
21914	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography: cervical (6 basic units)	$317.40
21915	INITIATION OF MANAGEMENT OF ANAESTHESIA for peripheral arteriogram (5 basic units)	$264.50
21916	INITIATION OF MANAGEMENT OF ANAESTHESIA for arteriograms: cerebral, carotid or vertebral (5 basic units)	$264.50
21918	INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde arteriogram: brachial or femoral (5 basic units)	$264.50
21922	INITIATION OF MANAGEMENT OF ANAESTHESIA for computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning (6 basic units)	$370.30
21925	INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde cystography, retrograde urethrography or retrograde cystourethrography (4 basic units)	$211.60
21926	INITIATION OF MANAGEMENT OF ANAESTHESIA for fluoroscopy (4 basic units)	$264.50
21930	INITIATION OF MANAGEMENT OF ANAESTHESIA for bronchography (6 basic units)	$317.40
21935	INITIATION OF MANAGEMENT OF ANAESTHESIA for phlebography (5 basic units)	$264.50
21936	INITIATION OF MANAGEMENT OF ANAESTHESIA for heart, 2 dimensional real time transoesophageal examination (5 basic units)	$317.40
21939	INITIATION OF MANAGEMENT OF ANAESTHESIA for peripheral venous cannulation (3 basic units)	$158.70
21941	INITIATION OF MANAGEMENT OF ANAESTHESIA for cardiac catheterisation including coronary arteriography, ventriculography, cardiac mapping, insertion of automatic defibrillator or transvenous pacemaker (7 basic units)	$370.30
21942	INITIATION OF MANAGEMENT OF ANAESTHESIA for cardiac electrophysiological procedures including radio frequency ablation (10 basic units)	$529.00
21943	INITIATION OF MANAGEMENT OF ANAESTHESIA for central vein catheterisation or insertion of right heart balloon catheter (via jugular, subclavian or femoral vein) by percutaneous or open exposure (5 basic units)	$264.50
21945	INITIATION OF MANAGEMENT OF ANAESTHESIA for lumbar puncture, cisternal puncture, or epidural injection (5 basic units)	$264.50
21949	INITIATION OF MANAGEMENT OF ANAESTHESIA for harvesting of bone marrow for the purpose of transplantation (5 basic units)	$264.50
21952	Initiation of the management of anaesthesia for diagnostic muscle biopsy to assess for malignant hyperpyrexia (4 basic units)	$529.00
21955	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroencephalography (5 basic units)	$264.50
21959	INITIATION OF MANAGEMENT OF ANAESTHESIA for brain stem evoked response audiometry (5 basic units)	$264.50
21962	INITIATION OF MANAGEMENT OF ANAESTHESIA for electrocochleography by extratympanic method or transtympanic membrane insertion method (5 basic units)	$264.50
21965	INITIATION OF MANAGEMENT OF ANAESTHESIA as a therapeutic procedure if there is a clinical need for anaesthesia, not for headache of any etiology (5 basic units)	$264.50
21969	INITIATION OF MANAGEMENT OF ANAESTHESIA during hyperbaric therapy where the medical practitioner is not confined in the chamber (including the administration of oxygen) (8 basic units)	$423.20
21970	INITIATION OF MANAGEMENT OF ANAESTHESIA during hyperbaric therapy where the medical practitioner is confined in the chamber (including the administration of oxygen) (15 basic units)	$793.50
21973	INITIATION OF MANAGEMENT OF ANAESTHESIA for brachytherapy using radioactive sealed sources (5 basic units)	$264.50
21976	INITIATION OF MANAGEMENT OF ANAESTHESIA for therapeutic nuclear medicine (5 basic units)	$264.50
21980	INITIATION OF MANAGEMENT OF ANAESTHESIA for radiotherapy (5 basic units)	$264.50
	Miscellaneous	
21990	INITIATION OF MANAGEMENT OF ANAESTHESIA when no procedure ensues (3 basic units)	$158.70
21992	INITIATION OF MANAGEMENT OF ANAESTHESIA performed on a person under the age of 10 years in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic (4 basic units)	$211.60
21997	Initiation of Management of Anaesthesia in connection with a procedure covered by an item that does not include the word "(Anaes.)", other than a service to which item 21965 or 21992 applies, if there is a clinical need for anaesthesia (4 basic units)	$211.60

Item no.	Description	Max fee (excl. GST)
	Therapeutic and diagnostic services	
22002	Administration of homologous blood or bone marrow already collected, when performed in association with the management of anaesthesia (4 basic units)	$211.60
22007	ENDOTRACHEAL INTUBATION with flexible fibreoptic scope associated with difficult airway when performed in association with the administration of anaesthesia (4 basic units)	$211.60
22008	DOUBLE LUMEN ENDOBRONCHIAL TUBE OR BRONCHIAL BLOCKER, insertion of when performed in association with the administration of anaesthesia (4 basic units)	$211.60
22012	Central venous, pulmonary arterial, systemic arterial or cardiac intracavity blood pressure monitoring by indwelling catheter once per day for each type of pressure for a patient:(a) when performed in association with the management of anaesthesia for the patient; and(b) other than a service to which item 13876 applies(c) is categorised as having a high risk of complications or during the procedure develops either complications or a high risk of complications (3 basic units)	$158.70
22014	Central venous, pulmonary arterial, systemic arterial or cardiac intracavity blood pressure monitoring by indwelling catheter once per day for each type of pressure for a patient:(a) when performed in association with the management of anaesthesia for the patient; and(b) relating to another discrete operation on the same day for the patient; and(c) other than a service to which item 13876 applies(d) who is categorised as having a high risk of complications or develops during the current procedure either complications or a high risk of complications (3 basic units)	$158.70
22015	RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and cardiac output measurement, when performed in association with the administration of anaesthesia (6 basic units)	$317.40
22020	CENTRAL VEIN CATHETERISATION by percutaneous or open exposure, not being a service to which item 13318 applies, when performed in association with the administration of anaesthesia (4 basic units)	$211.60
22025	Intra-arterial cannulation when performed in association with the management of anaesthesia in a patient who:(a) is categorised as having a high risk of complications; or(b) develops a high risk of complications during the procedure (4 basic units)	$211.60
22031	Intrathecal or epidural injection (initial) of a therapeutic substance or substances, with or without insertion of a catheter, in association with anaesthesia and surgery, for post-operative pain management, not being a service to which 22036 applies (5 basic units)	$264.50
22036	INTRATHECAL or EPIDURAL INJECTION (subsequent) of a therapeutic substance or substances, using an in-situ catheter, in association with anaesthesia and surgery, for postoperative pain management, not being a service associated with a service to which 22031 applies (3 basic units)	$158.70
22041	Perioperative introduction of a plexus or nerve block proximal to the lower leg or forearm for post operative pain management (2 basic units)	$105.80
22042	Introduction of a nerve block performed via a retrobulbar, peribulbar, or sub Tenon s approach, or other complex eye block, when administered by an anaesthetist perioperatively (1 basic units)	$52.90
22051	INTRA-OPERATIVE TRANSOESOPHAGEAL ECHOCARDIOGRAPHY—Monitoring in real time of the structure and function of the heart chambers, valves and surrounding structures, including assessment of blood flow, with appropriate permanent recording during procedures on the heart, pericardium or great vessels of the chest (not in association with items 55130, 55135 or 21936) (9 basic units)	$476.10
22055	PERFUSION OF LIMB OR ORGAN using heart-lung machine or equivalent, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (12 basic units)	$634.80
22060	WHOLE BODY PERFUSION, CARDIAC BYPASS, where the heart-lung machine or equivalent is continuously operated by a medical perfusionist, other than a service associated with anaesthesia to which an item in Subgroup 21 applies (Anaes.) (30 basic units)	$1058.00
22065	INDUCED CONTROLLED HYPOTHERMIA total body, being a service to which item 22060 applies, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (5 basic units)	$264.50
22075	DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22°c, including management of retrograde cerebral perfusion if performed, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (15 basic units)	$793.50
	Administration of anaesthesia in connection with a dental service	
22900	INITIATION OF MANAGEMENT BY A MEDICAL PRACTITIONER OF ANAESTHESIA for extraction of tooth or teeth with or without incision of soft tissue or removal of bone (6 basic units)	$317.40
22905	INITIATION OF MANAGEMENT OF ANAESTHESIA for restorative dental work (6 basic units)	$317.40
	Anaesthesia/perfusion time units	
23010	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA (a) administration of anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or (b) perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 25205 For a period of: (FIFTEEN MINUTES OR LESS) (1 basic units)	$52.90

Item no.	Description	Max fee (excl. GST)
23025	16 MINUTES TO 30 MINUTES (2 basic units)	$105.80
23035	31 MINUTES to 45 MINUTES (3 basic units)	$158.70
23045	46 MINUTES to 1:00 HOUR (4 basic units)	$211.60
23055	1:01 HOURS to 1:15 HOURS (5 basic units)	$264.50
23065	1:16 HOURS to 1:30 HOURS (6 basic units)	$317.40
23075	1:31 HOURS to 1:45 HOURS (7 basic units)	$370.30
23085	1:46 HOURS to 2:00 HOURS (8 basic units)	$423.20
23091	2:01 HOURS TO 2:10 HOURS (9 basic units)	$476.10
23101	2:11 HOURS TO 2:20 HOURS (10 basic units)	$529.00
23111	2:21 HOURS TO 2:30 HOURS (11 basic units)	$581.90
23112	2:31 HOURS TO 2:40 HOURS (12 basic units)	$634.80
23113	2:41 HOURS TO 2:50 HOURS (13 basic units)	$687.70
23114	2:51 HOURS TO 3:00 HOURS (14 basic units)	$740.60
23115	3:01 HOURS TO 3:10 HOURS (15 basic units)	$793.50
23116	3:11 HOURS TO 3:20 HOURS (16 basic units)	$846.40
23117	3:21 HOURS TO 3:30 HOURS (17 basic units)	$899.30
23118	3:31 HOURS TO 3:40 HOURS (18 basic units)	$952.20
23119	3:41 HOURS TO 3:50 HOURS (19 basic units)	$1005.10
23121	3:51 HOURS TO 4:00 HOURS (20 basic units)	$1058.00
23170	4:01 HOURS TO 4:10 HOURS (21 basic units)	$1110.90
23180	4:11 HOURS TO 4:20 HOURS (22 basic units)	$1163.80
23190	4:21 HOURS TO 4:30 HOURS (23 basic units)	$1216.70
23200	4:31 HOURS TO 4:40 HOURS (24 basic units)	$1269.60
23210	4:41 HOURS TO 4:50 HOURS (25 basic units)	$1322.50
23220	4:51 HOURS TO 5:00 HOURS (26 basic units)	$1375.40
23230	5:01 HOURS TO 5:10 HOURS (27 basic units)	$1428.30
23240	5:11 HOURS TO 5:20 HOURS (28 basic units)	$1481.20
23250	5:21 HOURS TO 5:30 HOURS (29 basic units)	$1534.10
23260	5:31 HOURS TO 5:40 HOURS (30 basic units)	$1587.00
23270	5:41 HOURS TO 5:50 HOURS (31 basic units)	$1639.90
23280	(5:51 HOURS TO 6:00 HOURS (32 basic units)	$1692.80
23290	6:01 HOURS TO 6:10 HOURS (33 basic units)	$1745.70
23300	6:11 HOURS TO 6:20 HOURS (34 basic units)	$1798.60
23310	6:21 HOURS TO 6:30 HOURS (35 basic units)	$1851.50
23320	6:31 HOURS TO 6:40 HOURS (36 basic units)	$1904.40
23330	6:41 HOURS TO 6:50 HOURS (37 basic units)	$1957.30
23340	6:51 HOURS TO 7:00 HOURS (38 basic units)	$2010.20
23350	7:01 HOURS TO 7:10 HOURS (39 basic units)	$2063.10
23360	7:11 HOURS TO 7:20 HOURS (40 basic units)	$2116.00
23370	7:21 HOURS TO 7:30 HOURS (41 basic units)	$2168.90
23380	7:31 HOURS TO 7:40 HOURS (42 basic units)	$2221.80
23390	7:41 HOURS TO 7:50 HOURS (43 basic units)	$2274.70
23400	7:51 HOURS TO 8:00 HOURS (44 basic units)	$2327.60
23410	8:01 HOURS TO 8:10 HOURS (45 basic units)	$2380.50
23420	8:11 HOURS TO 8:20 HOURS (46 basic units)	$2433.40
23430	8:21 HOURS TO 8:30 HOURS (47 basic units)	$2486.30
23440	8:31 HOURS TO 8:40 HOURS (48 basic units)	$2539.20

Item no.	Description	Max fee (excl. GST)
23450	8:41 HOURS TO 8:50 HOURS (49 basic units)	$2592.10
23460	8:51 HOURS TO 9:00 HOURS (50 basic units)	$2645.00
23470	9:01 HOURS TO 9:10 HOURS (51 basic units)	$2697.90
23480	9:11 HOURS TO 9:20 HOURS (52 basic units)	$2750.80
23490	9:21 HOURS TO 9:30 HOURS (53 basic units)	$2803.70
23500	9:31 HOURS TO 9:40 HOURS (54 basic units)	$2856.60
23510	9:41 HOURS TO 9:50 HOURS (55 basic units)	$2909.50
23520	9:51 HOURS TO 10:00 HOURS (56 basic units)	$2962.40
23530	10:01 HOURS TO 10:10 HOURS (57 basic units)	$3015.30
23540	10:11 HOURS TO 10:20 HOURS (58 basic units)	$3068.20
23550	10:21 HOURS TO 10:30 HOURS (59 basic units)	$3121.10
23560	10:31 HOURS TO 10:40 HOURS (60 basic units)	$3174.00
23570	10:41 HOURS TO 10:50 HOURS (61 basic units)	$3226.90
23580	10:51 HOURS TO 11:00 HOURS (62 basic units)	$3279.80
23590	11:01 HOURS TO 11:10 HOURS (63 basic units)	$3332.70
23600	11:11 HOURS TO 11:20 HOURS (64 basic units)	$3385.60
23610	11:21 HOURS TO 11:30 HOURS (65 basic units)	$3438.50
23620	11:31 HOURS TO 11:40 HOURS (66 basic units)	$3491.40
23630	11:41 HOURS TO 11:50 HOURS (67 basic units)	$3544.30
23640	11:51 HOURS TO 12:00 HOURS (68 basic units)	$3597.20
23650	12:01 HOURS TO 12:10 HOURS (69 basic units)	$3650.10
23660	12:11 HOURS TO 12:20 HOURS (70 basic units)	$3703.00
23670	12:21 HOURS TO 12:30 HOURS (71 basic units)	$3755.90
23680	12:31 HOURS TO 12:40 HOURS (72 basic units)	$3808.80
23690	12:41 HOURS TO 12:50 HOURS (73 basic units)	$3861.70
23700	12:51 HOURS TO 13:00 HOURS (74 basic units)	$3914.60
23710	13:01 HOURS TO 13:10 HOURS (75 basic units)	$3967.50
23720	13:11 HOURS TO 13:20 HOURS (76 basic units)	$4020.40
23730	13:21 HOURS TO 13:30 HOURS (77 basic units)	$4073.30
23740	13:31 HOURS TO 13:40 HOURS (78 basic units)	$4126.20
23750	13:41 HOURS TO 13:50 HOURS (79 basic units)	$4179.10
23760	13:51 HOURS TO 14:00 HOURS (80 basic units)	$4232.00
23770	14:01 HOURS TO 14:10 HOURS (81 basic units)	$4284.90
23780	14:11 HOURS TO 14:20 HOURS (82 basic units)	$4337.80
23790	14:21 HOURS TO 14:30 HOURS (83 basic units)	$4390.70
23800	14:31 HOURS TO 14:40 HOURS (84 basic units)	$4443.60
23810	14:41 HOURS TO 14:50 HOURS (85 basic units)	$4496.50
23820	14:51 HOURS TO 15:00 HOURS (86 basic units)	$4549.40
23830	15:01 HOURS TO 15:10 HOURS (87 basic units)	$4602.30
23840	15:11 HOURS TO 15:20 HOURS (88 basic units)	$4655.20
23850	15:21 HOURS TO 15:30 HOURS (89 basic units)	$4708.10
23860	15:31 HOURS TO 15:40 HOURS (90 basic units)	$4761.00
23870	15:41 HOURS TO 15:50 HOURS (91 basic units)	$4813.90
23880	15:51 HOURS TO 16:00 HOURS (92 basic units)	$4866.80
23890	16:01 HOURS TO 16:10 HOURS (93 basic units)	$4919.70
23900	16:11 HOURS TO 16:20 HOURS (94 basic units)	$4972.60
23910	16:21 HOURS TO 16:30 HOURS (95 basic units)	$5025.50

Item no.	Description	Max fee (excl. GST)
23920	16:31 HOURS TO 16:40 HOURS (96 basic units)	$5078.40
23930	16:41 HOURS TO 16:50 HOURS (97 basic units)	$5131.30
23940	16:51 HOURS TO 17:00 HOURS (98 basic units)	$5184.20
23950	17:01 HOURS TO 17:10 HOURS (99 basic units)	$5237.10
23960	17:11 HOURS TO 17:20 HOURS (100 basic units)	$5290.00
23970	17:21 HOURS TO 17:30 HOURS (101 basic units)	$5342.90
23980	17:31 HOURS TO 17:40 HOURS (102 basic units)	$5395.80
23990	17:41 HOURS TO 17:50 HOURS (103 basic units)	$5448.70
24100	17:51 HOURS TO 18:00 HOURS (104 basic units)	$5501.60
24101	18:01 HOURS TO 18:10 HOURS (105 basic units)	$5554.50
24102	18:11 HOURS TO 18:20 HOURS (106 basic units)	$5607.40
24103	18:21 HOURS TO 18:30 HOURS (107 basic units)	$5660.30
24104	18:31 HOURS TO 18:40 HOURS (108 basic units)	$5713.20
24105	18:41 HOURS TO 18:50 HOURS (109 basic units)	$5766.10
24106	18:51 HOURS TO 19:00 HOURS (110 basic units)	$5819.00
24107	19:01 HOURS TO 19:10 HOURS (111 basic units)	$5871.90
24108	19:11 HOURS TO 19:20 HOURS (112 basic units)	$5924.80
24109	19:21 HOURS TO 19:30 HOURS (113 basic units)	$5977.70
24110	19:31 HOURS TO 19:40 HOURS (114 basic units)	$6030.60
24111	19:41 HOURS TO 19:50 HOURS (115 basic units)	$6083.50
24112	19:51 HOURS TO 20:00 HOURS (116 basic units)	$6136.40
24113	20:01 HOURS TO 20:10 HOURS (117 basic units)	$6189.30
24114	20:11 HOURS TO 20:20 HOURS (118 basic units)	$6242.20
24115	20:21 HOURS TO 20:30 HOURS (119 basic units)	$6295.10
24116	20:31 HOURS TO 20:40 HOURS (120 basic units)	$6348.00
24117	20:41 HOURS TO 20:50 HOURS (121 basic units)	$6400.90
24118	20:51 HOURS TO 21:00 HOURS (122 basic units)	$6453.80
24119	21:01 HOURS TO 21:10 HOURS (123 basic units)	$6506.70
24120	21:11 HOURS TO 21:20 HOURS (124 basic units)	$6559.60
24121	21:21 HOURS TO 21:30 HOURS (125 basic units)	$6612.50
24122	21:31 HOURS TO 21:40 HOURS (126 basic units)	$6665.40
24123	21:41 HOURS TO 21:50 HOURS (127 basic units)	$6718.30
24124	21:51 HOURS TO 22:00 HOURS (128 basic units)	$6771.20
24125	22:01 HOURS TO 22:10 HOURS (129 basic units)	$6824.10
24126	22:11 HOURS TO 22:20 HOURS (130 basic units)	$6877.00
24127	22:21 HOURS TO 22:30 HOURS (131 basic units)	$6929.90
24128	22:31 HOURS TO 22:40 HOURS (132 basic units)	$6982.80
24129	22:41 HOURS TO 22:50 HOURS (133 basic units)	$7035.70
24130	22:51 HOURS TO 23:00 HOURS (134 basic units)	$7088.60
24131	23:01 HOURS TO 23:10 HOURS (135 basic units)	$7141.50
24132	23:11 HOURS TO 23:20 HOURS (136 basic units)	$7194.40
24133	23:21 HOURS TO 23:30 HOURS (137 basic units)	$7247.30
24134	23:31 HOURS TO 23:40 HOURS (138 basic units)	$7300.20
24135	23:41 HOURS TO 23:50 HOURS (139 basic units)	$7353.10
24136	23:51 HOURS TO 24:00 HOURS (140 basic units)	$7406.00

Item no.	Description	Max fee (excl. GST)
	Anaesthesia/perfusion modifying units—physical status	
25000	ANAESTHESIA, PERFUSION or ASSISTANCE AT ANAESTHESIA (a) for anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or (b) for perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 25205 Where the patient has severe systemic disease equivalent to ASA physical status indicator 3 (1 basic units)	$52.90
25005	Where the patient has severe systemic disease which is a constant threat to life equivalent to ASA physical status indicator 4 (2 basic units)	$105.80
25010	For a patient who is not expected to survive for 24 hours with or without the operation, equivalent to ASA physical status indicator 5 (3 basic units)	$158.70
	Anaesthesia/perfusion modifying units—other	
25014	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is aged 75 years or more (Anaes.) (1 basic units)	$52.90
25020	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA—where the patient requires immediate treatment without which there would be significant threat to life or body part—not being a service associated with a service to which item 25025 or 25030 or 25050 applies (2 basic units)	$105.80
	Anaesthesia after hours emergency modifier	
25025	Anaesthesia, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday (0 basic units) Derived fee: An additional amount of 50% of fee for the anaesthetic service. That is:(a) an anaesthesia item/s range 20100—21997 or 22900, plus (b) an item range 23010—24136, plus(c) if applicable,an item range 25000-25014, plus(d) where performed, any assoc therapeutic or diagnostic service range 22002-22051	DF
25030	Assistance in the management of anaesthesia, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday (0 basic units) Derived fee: 50% of the fee for assistance at anaesthesia. That is: (a) an assistant anaesthesia item in the range 25200—25205, plus (b) an item range 23010-24136, plus (c) where applicable, an item range 25000-25014, plus (d) where performed, any associated therapeutic or diagnostic service 22002 -22051	DF
	Perfusion after hours emergency modifier	
25050	Perfusion, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday. (0 basic units) Derived fee: An additional amount of 50% of the fee for the perfusion service. That is: (a) item 22060, plus (b) an item range 23010—24136, plus (c) where applicable, an item range 25000—25014, plus (d) where performed, any associated therapeutic or diagnostic service in the range 22002-22051 or 22065-22075	DF
	Assistance at anaesthesia	
25200	Assistance in the administration of anaesthesia requiring continuous anaesthesia on a patient in imminent danger of death requiring continuous life saving emergency treatment, to the exclusion of all other patients (005) (basic units) Derived fee: An amount of $264.50 (5 basic units) plus an item in the range 23010—24136 plus, where applicable, an item in the range 25000—25020, plus, where performed, any associated therapeutic or diagnostic service/s in the range 22001—22051	DF
25205	Assistance in the administration of elective anaesthesia, where: (i) the patient has complex airway problems; or (ii) the patient is a neonate or a complex paediatric case; or (iii) there is anticipated to be massive blood loss (greater than 50% of blood volume) during the procedure; or (iv) the patient is critically ill, with multiple organ failure; or (v)where the anaesthesia time exceeds 6 hours and the assistance is provided to the exclusion of all other patients (005) (basic units) Derived fee: An amount of $264.50 (5 basic units), plus an item in the range 23010—24136, plus, where applicable, an item in the range 25000—25020 plus, where performed, any associated therapeutic or diagnostic service/s in the range 22001—22051	DF
GROUP T8—SURGICAL OPERATIONS		
	General	
30001	Operative procedure, not being a service to which any other item i n this Group applies, being a service to which an item in this Group would have applied had the procedure not been discontinued on medical grounds Derived fee : 50% of the fee which would have applied had the procedure not been discontinued.	DF
30003	LOCALISED BURNS, dressing of, (not involving grafting)each attendance at which the procedure is performed, including any associated consultation	$56.90
30006	EXTENSIVE BURNS, dressing of, without anaesthesia (not involving grafting)each attendance at which the procedure is performed, including any associated consultation	$84.50
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

Item no.	Description	Max fee (excl. GST)
30017	BURNS, excision of, under general anaesthesia, involving not more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.)	$592.00
30020	BURNS, excision of, under general anaesthesia, involving more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$627.80
30026	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OFWOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.)	$94.90
30029	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OFWOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.)	$163.40
30032	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OFWOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes.)	$149.70
30035	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OFWOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue (Anaes.)	$213.60
30038	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.)	$163.40
30042	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OFWOUND OF, other than wound closure at time of surgery, other than on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue, other than a service to which another item in Group T4 applies (Anaes.)	$359.10
30045	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OFWOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes.)	$213.60
30049	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OFWOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes.)	$355.70
30052	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.)	$484.10
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.)	$43.90
30062	Etonogestrel subcutaneous implant, removal of, as an independent procedure (Anaes.)	$109.90
30064	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.)	$199.70
30068	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.)	$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.)	$83.50
30075	DIAGNOSTIC BIOPSY OF LYMPH NODE, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure,if the biopsy specimen is sent for pathological examination (Anaes.)	$290.30
30078	DIAGNOSTIC DRILL BIOPSY OF LYMPH NODE, DEEP TISSUE OR ORGAN, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.)	$93.70
30081	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using open approach, where the biopsy specimen is sent for pathological examination (Anaes.)	$200.50
30084	Diagnostic biopsy of bone marrow by trephine using percutaneous approach where the biopsy is sent for pathological examination (Anaes.)	$112.90

Item no.	Description	Max fee (excl. GST)
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.)	$309.40
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.)	$333.80
30097	Personal performance of a Synacthen Stimulation Test, including associated consultation; by a medical practitioner with resuscitation training and access to facilities where life support procedures can be implemented, if: serum cortisol at 0830-0930 hours on any dayin 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 unwelland adrenal insufficiency is suspected.	$186.50
30099	Sinus, excision of, involving superficial tissue only (Anaes.)	$174.40
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.)	$269.20
30107	GANGLION OR SMALL BURSA, excision of,other thana 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 (Anaes.) (Assist.)	$711.60
30114	BURSA, SEMIMEMBRANOSUS (Baker's cyst), excision of (Anaes.) (Assist.)	$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, 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.)	$1395.00
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.)	$1129.00
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.)	$1608.90
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

Item no.	Description	Max fee (excl. GST)
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.)	$1979.90
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.)	$392.30
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
30191	Angiofibromas, trichoepithelioma, epidermal naevi, xanthelasma, pyogenic granuloma, genital angiokeratomas, hereditary haemorrhagic telangiectasia and other severely disfiguring or recurrently bleeding tumours (excluding melanocytic naevi, sebaceous hyperplasia, dermatosis papulosa nigra, Campbell De Morgan angiomas and seborrheic or viral warts), treatment of, with carbon dioxide/erbium or other appropriate laser (or curettage and fine point diathermy for pyogenic granuloma only), if confirmed by the opinion of a specialist in the specialty of dermatology, one or more lesions.	$97.80
30192	PREMALIGNANT SKIN LESIONS (including solar keratoses), treatment of, by ablative technique (10 or more lesions) (Anaes.)	$72.40
30196	Malignant neoplasm of skin or mucous membrane that has been: (a) proven by histopathology; or (b) confirmed by the opinion of a specialist in the specialty of dermatology or plastic surgerywhere a specimen has been submitted for histologic confirmation; removal of, by serial curettage, or carbon dioxide laser or erbium laser excision ablation, including any associated cryotherapy or diathermy (Anaes.)	$228.30
30202	Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by the opinion of a specialist in the specialty of dermatology or plastic surgery removal of, by liquid nitrogen cryotherapy using repeat freeze thaw cycles	$87.20
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.)	$48.30
30219	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital—INCISION WITH DRAINAGE OF (excluding aftercare)	$48.30
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
30229	MUSCLE, excision of (EXTENSIVE) (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$690.60
30244	STYLOID PROCESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.)	$730.00
30246	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.)	$1326.40
30247	PAROTID GLAND, total extirpation of (Anaes.) (Assist.)	$1425.50

Item no.	Description	Max fee (excl. GST)
30250	PAROTID GLAND, total extirpation of, with preservation of facial nerve (Anaes.) (Assist.)	$2562.20
30251	RECURRENT PAROTID TUMOUR, excision of, withpreservation of facial nerve (Anaes.) (Assist.)	$3690.30
30253	PAROTID GLAND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anaes.) (Assist.)	$1784.60
30255	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.)	$2495.00
30256	SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$573.50
30275	RADICAL EXCISION OF INTRAORAL TUMOUR INVOLVING RESECTION OF MANDIBLE AND LYMPH NODES OF NECK (commandotype operation) (Anaes.) (Assist.)	$3417.20
30278	Tongue tie, repair of, not being a service to which another item in this Group applies (Anaes.)	$88.80
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.)	$381.70
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.)	$844.10
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 (Anaes.) (Assist.)	$855.00
30294	CERVICAL OESOPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction (Anaes.) (Assist.)	$3184.90
30296	THYROIDECTOMY, total (Anaes.) (Assist.)	$2101.60
30297	THYROIDECTOMY following previous thyroid surgery (Anaes.) (Assist.)	$1984.10
30299	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level I axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30300, 30302 or 30303 applies (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1176.80
30306	TOTAL HEMITHYROIDECTOMY (Anaes.) (Assist.)	$1575.70
30310	Partial or subtotal thyroidectomy (Anaes.) (Assist.)	$901.60
30314	THYROGLOSSAL CYST or FISTULA or both, on a person 10 years of age or over.Radical removal of, including thyroglossal duct and portion of hyoid bone (Anaes.) (Assist.)	$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 item30318, 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. 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.)	$1783.50

Item no.	Description	Max fee (excl. GST)
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.)	$970.40
30329	LYMPH NODES of GROIN, limited excision of (Anaes.)	$482.90
30330	LYMPH NODES of GROIN, radical excision of (Anaes.) (Assist.)	$1380.60
30332	LYMPH NODES of AXILLA, limited excision of (sampling) (Anaes.) (Assist.)	$677.90
30335	LYMPH NODES of AXILLA, complete excision of, to level I (Anaes.) (Assist.)	$1647.40
30336	LYMPH NODES of AXILLA, complete excision of, to level II or level III (Anaes.) (Assist.)	$2019.70
30373	LAPAROTOMY (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1779.00
30382	ENTEROCUTANEOUS FISTULA, radical repair of, involving extensive dissection and resection of bowel (Anaes.) (Assist.)	$2508.80
30384	LAPAROTOMY FOR GRADING OF LYMPHOMA, including splenectomy, liver biopsies, lymph node biopsies and oophoropexy (Anaes.) (Assist.)	$2104.80
30385	LAPAROTOMY FOR CONTROL OF POSTOPERATIVE HAEMORRHAGE, where no other procedure is performed (Anaes.) (Assist.)	$1081.60
30387	LAPAROTOMY INVOLVING OPERATION ON ABDOMINAL VISCERA (including pelvic viscera), not being a service to which another item in this Group applies (Anaes.) (Assist.)	$1275.10
30388	LAPAROTOMY for trauma involving 3 or more organs (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$557.60
30392	RADICAL OR DEBULKING OPERATION for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (Anaes.) (Assist.)	$1244.70
30393	LAPAROSCOPIC DIVISION OF ADHESIONS in association with another intra-abdominal procedure where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$612.10
30400	LAPAROTOMY WITH INSERTION OF PORTACATH for administration of cytotoxic therapy including placement of reservoir (Anaes.) (Assist.)	$1215.20
30402	RETROPERITONEAL ABSCESS, drainage of, not involving laparotomy (Anaes.) (Assist.)	$889.50
30403	VENTRAL, INCISIONAL, OR RECURRENT HERNIA OR BURST ABDOMEN, repair of with or without mesh (Anaes.) (Assist.)	$998.60

Item no.	Description	Max fee (excl. GST)
30405	VENTRAL OR INCISIONAL HERNIA, (excluding recurrent inguinal or femoral hernia), repair of, requiring muscle transposition, mesh hernioplasty or resection of strangulated bowel (Anaes.) (Assist.)	$1756.40
30406	Paracentesis abdominis (Anaes.)	$100.10
30408	PERITONEOVENOUS shunt, insertion of (Anaes.) (Assist.)	$752.40
30409	Liver biopsy, percutaneous (Anaes.)	$337.20
30411	LIVER BIOPSY by wedge excision when performed in conjunction with another intraabdominal procedure (Anaes.)	$200.00
30412	LIVER BIOPSY by core needle, when performed in conjunction with another intra-abdominal procedure (Anaes.)	$100.30
30414	LIVER, subsegmental resection of, (local excision), other than for trauma (Anaes.) (Assist.)	$1325.10
30415	LIVER, segmental resection of, other than for trauma (Anaes.) (Assist.)	$2641.50
30416	LIVER CYST, laparoscopic marsupialisation of, where the size of the cyst is greater than 5cm in diameter (Anaes.) (Assist.)	$1435.50
30417	LIVER CYSTS, laparoscopic marsupialisation of 5 or more, including any cyst greater than 5cm in diameter (Anaes.) (Assist.)	$2152.90
30418	LIVER, lobectomy of, other than for trauma (Anaes.) (Assist.)	$3065.10
30419	LIVER TUMOURS, destruction of, by hepatic cryotherapy, not being a service associated with a service to which item 50950 or 50952 applies (Anaes.) (Assist.)	$1598.00
30421	LIVER, TRI-SEGMENTAL RESECTION (extended lobectomy) of, other than for trauma (Anaes.) (Assist.)	$3826.30
30422	LIVER, repair of superficial laceration of, for trauma (Anaes.) (Assist.)	$1293.50
30425	LIVER, repair of deep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.)	$2508.80
30427	LIVER, segmental resection of, for trauma (Anaes.) (Assist.)	$2834.80
30428	LIVER, lobectomy of, for trauma (Anaes.) (Assist.)	$3032.90
30430	LIVER, extended lobectomy (tri-segmental resection) of, for trauma (Anaes.) (Assist.)	$4453.60
30431	LIVER ABSCESS, open abdominal drainage of (Anaes.) (Assist.)	$998.60
30433	LIVER ABSCESS (multiple), open abdominal drainage of (Anaes.) (Assist.)	$1419.20
30434	HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1186.60
30437	HYDATID CYST OF LIVER, total excision of, by cysto-pericystectomy (membrane plus fibrous wall) (Anaes.) (Assist.)	$1567.60
30438	HYDATID CYST OF LIVER, excision of, with drainage and excision of liver tissue (Anaes.) (Assist.)	$2208.70
30439	OPERATIVE CHOLANGIOGRAPHY OR OPERATIVE PANCREATOGRAPHY OR INTRA OPERATIVE ULTRASOUND of the biliary tract (including 1 or more examinations performed during the 1 operation) (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1011.50
30441	INTRA OPERATIVE ULTRASOUND for staging of intra abdominal tumours (Anaes.)	$261.40
30442	Choledochoscopy in conjunction with another procedure (Anaes.)	$359.10
30443	CHOLECYSTECTOMY (Anaes.) (Assist.)	$1418.80
30445	LAPAROSCOPIC CHOLECYSTECTOMY (Anaes.) (Assist.)	$1433.00
30446	LAPAROSCOPIC CHOLECYSTECTOMY when procedure is completed by laparotomy (Anaes.) (Assist.)	$1428.90
30448	LAPAROSCOPIC CHOLECYSTECTOMY, involving removal of common duct calculi via the cystic duct (Anaes.) (Assist.)	$1866.50
30449	LAPAROSCOPIC CHOLECYSTECTOMY with removal of common duct calculi via laparoscopic choledochotomy (Anaes.) (Assist.)	$2077.50
30450	Calculus of biliary or renal tract, extraction of, using interventional imaging techniques—other than a service associated with a service to which items 36627 or 36645 applies (Anaes.) (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 (Anaes.) (Assist.)	$513.20

Item no.	Description	Max fee (excl. GST)
30452	CHOLEDOCHOSCOPY with balloon dilation of a stricture or passage of stent or extraction of calculi (Anaes.) (Assist.)	$732.10
30454	CHOLEDOCHOTOMY (with or without cholecystectomy), with or without removal of calculi (Anaes.) (Assist.)	$1672.50
30455	CHOLEDOCHOTOMY (with or without cholecystectomy), with removal of calculi including biliary intestinal anastomosis (Anaes.) (Assist.)	$1942.60
30457	CHOLEDOCHOTOMY, intrahepatic, involving removal of intrahepatic bile duct calculi (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1949.70
30460	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2866.00
30463	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, with 2 duct anastomoses (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$4179.40
30466	INTRAHEPATIC biliary bypass of left hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.)	$2406.30
30467	INTRAHEPATIC BYPASS of right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.)	$3036.60
30469	BILIARY STRICTURE, repair of, after 1 or more operations on the biliary tree (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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.)	$643.60
30478	Oesophagoscopy (other than a service to which item41816, 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 item30473 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 INTUBATIONas 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

Item no.	Description	Max fee (excl. GST)
30492	BILE DUCT, PERCUTANEOUS STENTING OF (including dilatation when performed), using interventional imaging techniques—but not including imaging (Anaes.)	$1524.90
30494	Endoscopic biliary dilatation (Anaes.)	$808.10
30495	PERCUTANEOUS BILIARY DILATATION for biliary stricture, using interventional imaging techniques—but not including imaging (Anaes.)	$1524.90
30496	VAGOTOMY, truncal or selective, with or without pyloroplasty or gastroenterostomy (Anaes.) (Assist.)	$1068.20
30497	VAGOTOMY and ANTRECTOMY (Anaes.) (Assist.)	$1273.50
30499	VAGOTOMY, highly selective (Anaes.) (Assist.)	$1602.10
30500	VAGOTOMY, highly selective with duodenoplasty for peptic stricture (Anaes.) (Assist.)	$1709.60
30502	VAGOTOMY, highly selective, with dilatation of pylorus (Anaes.) (Assist.)	$1790.20
30503	VAGOTOMY or ANTRECTOMY, or both, for peptic ulcer following previous operation for peptic ulcer (Anaes.) (Assist.)	$2004.40
30505	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision (Anaes.) (Assist.)	$1095.50
30506	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy (Anaes.) (Assist.)	$1753.70
30508	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and highly selective vagotomy (Anaes.) (Assist.)	$1952.50
30509	BLEEDING PEPTIC ULCER, control of, involving gastric resection (other than wedge resection) (Anaes.) (Assist.)	$1952.50
30515	Gastroenterostomy (including gastroduodenostomy) or enterocolostomy or enteroenterostomy, not being a service to which any of items 31569 to 31581 apply (Anaes.) (Assist.)	$1354.50
30517	GASTROENTEROSTOMY, PYLOROPLASTY or GASTRODUODENOSTOMY, reconstruction of (Anaes.) (Assist.)	$1780.30
30518	Partial gastrectomy, not being a service associated with a service to which any of items 31569 to 31581 apply (Anaes.) (Assist.)	$2240.00
30520	GASTRIC TUMOUR, removal of, by local excision, not being a service to which item 30518 applies (Anaes.) (Assist.)	$1293.50
30521	GASTRECTOMY, TOTAL, for benign disease (Anaes.) (Assist.)	$2615.00
30523	GASTRECTOMY, SUBTOTAL RADICAL, for carcinoma, (including splenectomy when performed) (Anaes.) (Assist.)	$2852.70
30524	GASTRECTOMY, TOTAL RADICAL, for carcinoma (including extended node dissection and distal pancreatectomy and splenectomy when performed) (Anaes.) (Assist.)	$3218.90
30526	GASTRECTOMY, TOTAL, and including lower oesophagus, performed by left thoraco-abdominal incision or opening of diaphragmatic hiatus, (including splenectomy when performed) (Anaes.) (Assist.)	$4131.00
30527	ANTIREFLUX OPERATION by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatusnot being a service to which item 30601 applies (Anaes.) (Assist.)	$1679.80
30529	ANTIREFLUX operation by fundoplasty, with OESOPHAGOPLASTY for stricture or short oesophagus (Anaes.) (Assist.)	$2508.80
30530	ANTIREFLUX operation by cardiopexy, with or without fundoplasty (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2053.80
30535	OESOPHAGECTOMY with gastric reconstruction by abdominal mobilisation and thoracotomy (Anaes.) (Assist.)	$3260.90
30536	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest—1 surgeon (Anaes.) (Assist.)	$3300.20
30538	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest- conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2908.10

Item no.	Description	Max fee (excl. GST)
30542	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement—conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$3520.40
30547	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis)—conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.)	$2294.40
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 (Anaes.) (Assist.)	$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) (Anaes.) (Assist.)	$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.)	$1911.70
30554	OESOPHAGECTOMY with reconstruction by free jejunal graft—1 surgeon (Anaes.) (Assist.)	$4166.80
30556	OESOPHAGECTOMY with reconstruction by free jejunal graft—conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.)	$2937.20
30557	OESOPHAGECTOMY with reconstruction by free jejunal graft—conjoint surgery, co-surgeon (Assist.)	$2122.80
30559	OESOPHAGUS, local excision for tumour of (Anaes.) (Assist.)	$1631.10
30560	OESOPHAGEAL PERFORATION, repair of, by thoracotomy (Anaes.) (Assist.)	$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
30563	Colostomy or ileostomy, refashioning of, on a person 10 years of age or over (Anaes.) (Assist.)	$1144.20
30564	SMALL BOWEL STRICTUREPLASTY for chronic inflammatory bowel disease (Anaes.) (Assist.)	$1481.20
30565	SMALL INTESTINE, resection of, without anastomosis (including formation of stoma) (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1396.10
30569	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed at laparotomy, with or without biopsies (Anaes.) (Assist.)	$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	NOTE: Multiple Operation and Multiple Anaesthetic rules apply to this item APPENDICECTOMY, when performed in conjunction with any other intraabdominal procedure through the same incision (Anaes.)	$264.20
30575	PANCREATIC ABSCESS, laparotomy and external drainage of, not requiring retro-pancreatic dissection (Anaes.) (Assist.)	$984.00
30577	PANCREATIC NECROSECTOMY for PANCREATIC NECROSIS or ABSCESS FORMATION requiring major pancreatic or retro-pancreatic dissection, excluding aftercare (Anaes.) (Assist.)	$2084.90
30578	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of pancreatic tumour (Anaes.) (Assist.)	$2202.60
30580	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of duodenal tumour (Anaes.) (Assist.)	$2006.90
30581	ENDOCRINE TUMOUR, exploration of pancreas or duodenum for, but no tumour found (Anaes.) (Assist.)	$1384.50
30583	DISTAL PANCREATECTOMY (Anaes.) (Assist.)	$2317.60
30584	PANCREATICO-DUODENECTOMY, WHIPPLE'S OPERATION, with or without preservation of pylorus (Anaes.) (Assist.)	$3386.20
30586	PANCREATIC CYSTANASTOMOSIS TO STOMACH OR DUODENUM—by open or endoscopic means (Anaes.) (Assist.)	$1347.90
30587	PANCREATIC CYST, anastomosis to Roux loop of jejunum (Anaes.) (Assist.)	$1396.10

Item no.	Description	Max fee (excl. GST)
30589	PANCREATICO-JEJUNOSTOMY for pancreatitis or trauma (Anaes.) (Assist.)	$2398.60
30590	PANCREATICO-JEJUNOSTOMY following previous pancreatic surgery (Anaes.) (Assist.)	$2641.50
30593	PANCREATECTOMY, near total or total (including duodenum), with or without splenectomy (Anaes.) (Assist.)	$3621.30
30594	PANCREATECTOMY for pancreatitis following previously attempted drainage procedure or partial resection (Anaes.) (Assist.)	$4179.40
30596	SPLENORRHAPHY OR PARTIAL SPLENECTOMY (Anaes.) (Assist.)	$1724.80
30597	SPLENECTOMY (Anaes.) (Assist.)	$1379.50
30599	SPLENECTOMY, for massive spleen (weighing more than 1500 grams) or involving thoraco-abdominal incision (Anaes.) (Assist.)	$2508.80
30600	DIAPHRAGMATIC HERNIA, TRAUMATIC, repair of (Anaes.) (Assist.)	$1492.80
30601	Diaphragmatic hernia, congential repair of, by thoracic or abdominal approach, not being a service to which any of items 31569 to 31581 apply, on a person 10 years of age or over (Anaes.) (Assist.)	$1841.00
30602	PORTAL HYPERTENSION, porto-caval shunt for (Anaes.) (Assist.)	$2974.90
30603	PORTAL HYPERTENSION, meso-caval shunt for (Anaes.) (Assist.)	$2980.20
30605	PORTAL HYPERTENSION, selective spleno-renal shunt for (Anaes.) (Assist.)	$3574.80
30606	PORTAL HYPERTENSION, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (Anaes.) (Assist.)	$2131.70
30608	Small intestine, resection of, with anastomosis, on a person under 10 years of age (Anaes.) (Assist.)	$2053.30
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.)	$919.30
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.)	$852.40
30619	Laparoscopic splenectomy, on a person under 10 years of age (Anaes.) (Assist.)	$1528.00
30621	Repair of symptomatic umbilical, epigastric or linea alba hernia requiring mesh or other formal repair of, in a person 10 years of age or over, other than a service to which item 30403 or 30405 applies (Anaes.) (Assist.)	$782.20
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.)	$1105.90
30623	LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESIONS (where no other intraabdominal procedure is performed) on a person under 10 years of age (Anaes.) (Assist.)	$1105.90
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.)	$1111.00
30627	LAPAROSCOPY, diagnostic, not being a service associated with any other laparoscopic procedure, on a person under 10 years of age (Anaes.)	$466.60
30628	Hydrocele, tapping of	$67.20
30629	Orchidectomy, radical, including spermatic cord, unilateral, for tumour, inguinal approach, without insertion of testicular prosthesis, other than a service associated with a service to which item 30631, 30635, 30641, 30643 or 30644 applies (Anaes.) (Assist.)	$806.30
30630	Insertion of testicular prosthesis,at least 6 months following orchidectomy (Anaes.) (Assist.)	$366.50
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, including microsurgical techniques, other than a service associated with a service to which item 30390, 30627, 30641, 30642 or 30644 applies one procedure (Anaes.) (Assist.)	$605.10

Item no.	Description	Max fee (excl. GST)
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.)	$380.50
30637	ENTEROSTOMY or COLOSTOMY, closure of not involving resection of bowel, on a person under 10 years of age (Anaes.) (Assist.)	$1262.60
30639	COLOSTOMY OR ILEOSTOMY, refashioning of, on a person under 10 years of age (Anaes.) (Assist.)	$1262.60
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.)	$1462.60
30641	ORCHIDECTOMY, simple or subscapsular, unilateral with or without insertion of testicular prosthesis (Anaes.) (Assist.)	$789.10
30642	Orchidectomy, radical, including spermatic cord, unilateral, for tumour, inguinal approach, with insertion of testicular prosthesis, other than a service associated with a service to which item 30631, 30635, 30641, 30643, 30644 or 45051 applies (Anaes.) (Assist.)	$820.10
30643	Exploration of spermatic cord, inguinal approach, with or without testicular biopsy, with or without excision of spermatic cord lesion, for a patient under 10 years of age, other than a service associated with a service to which item 30629, 30630 or 30642 applies (Anaes.) (Assist.)	$1105.90
30644	Exploration of spermatic cord, inguinal approach, with or without testicular biopsy, with or without excision of spermatic cord lesion, for a patient at least 10 years of age, other than a service associated with a service to which item 30629, 30630 or 30642 applies (Anaes.) (Assist.)	$1019.70
30645	Appendicectomy, not being a service to which item 30574 applies, on a person under 10 years of age (Anaes.) (Assist.)	$945.00
30646	Laparoscopic appendicectomy, on a person under 10 years of age (Anaes.) (Assist.)	$945.00
30649	Haemorrhage, arrest of, following circumcision requiring general anaesthesia on a person under 10 years of age (Anaes.)	$306.30
30654	Circumcision of the penis, with topical or local analgesia, other than a service to which item 30658 applies	$74.40
30658	Circumcision of the penis, when performed under general or regional anaesthesia and in conjunction with a service to which an item in Group T7 or Group T10 applies (Anaes.)	$223.40
30663	Haemorrhage, arrest of, following circumcision requiring general anaesthesia on a person 10 years of age or over (Anaes.)	$260.70
30666	Paraphimosis or phimosis, reduction of, under general anaesthesia, with or without dorsal incision, not being a service associated with a service to which another item in this Group applies (Anaes.)	$91.20
30672	COCCYX, excision of (Anaes.) (Assist.)	$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.)	$187.40
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.)	$2140.60
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 ofthe bleeding. (Anaes.)	$2140.60
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.)	$2634.60

Item no.	Description	Max fee (excl. GST)
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.)	$2634.60
30687	Endoscopy with radiofrequency ablation of mucosal metaplasia for the treatment of barrett's oesophagus in a single course of treatment, following diagnosis of high grade dysplasia confirmed by histological examination (Anaes.)	$838.40
30688	Endoscopicultrasound(endoscopy with ultrasound imaging), with or without biopsy, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup (other thanitem30484, 30485, 30491 or 30494) andother thana service associated with the routine monitoring of chronic pancreatitis. (Anaes.)	$667.60
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 item30484, 30485, 30491 or 30494)and other thana service associated with the routine monitoring of chronic pancreatitis. (Anaes.)	$1030.70
30692	Endoscopic ultrasound(endoscopy with ultrasound imaging), with or without biopsy, for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup (other than item30484, 30485, 30491 or 30494)and other thana service associated with the routine monitoring of chronic pancreatitis. (Anaes.)	$667.60
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 item30484, 30485, 30491 or 30494)and other thana service associated with the routine monitoring of chronic pancreatitis. (Anaes.)	$1030.70
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.)	$1423.30
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.)	$1691.10
31003	Mohs surgery of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon 6 or fewer sections Not applicable to a service performed in association with a service to which item31000 applies (Anaes.)	$893.90
31004	Mohs surgery of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon 7 to 12 sections (inclusive) Not applicable to a service performed in association with a service to which item31001 applies (Anaes.)	$1117.20
31005	Mohs surgery of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon 13 or more sections Not applicable to a service performed in association with a service to which item31002 applies (Anaes.)	$1340.70
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.)	$152.60
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.)	$196.90

Item no.	Description	Max fee (excl. GST)
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.)	$229.40
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.)	$399.30
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.)	$342.90
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.)	$713.20
31245	SKIN AND SUBCUTANEOUS TISSUE, extensive excision of, in the treatment of SUPPURATIVE HIDRADENITIS (excision from axilla, groin or natal cleft) or SYCOSIS BARBAE or NUCHAE (excision from face or neck) (Anaes.)	$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.)	$716.50
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.)	$383.00
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 TUMOURof SOFT TISSUE, excluding tumours of skin, cartilage and bone, removal of by surgical excision, where histological proof of malignancy has been obtained, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$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.)	$353.80
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.)	$175.40
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.)	$433.00
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.)	$527.70

Item no.	Description	Max fee (excl. GST)
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.)	$268.70
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.)	$298.50
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.)	$214.10
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.)	$390.60
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.)	$268.70
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.)	$253.10
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.)	$152.60
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.)	$341.40
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.)	$200.60
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.)	$393.10
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.)	$229.40

Item no.	Description	Max fee (excl. GST)
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.)	$570.70
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.)	$493.50
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.)	$570.30
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.)	$450.70
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.)	$485.00
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.)	$562.00
31400	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR up to and including 20mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.)	$564.50
31403	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 20mm and up to and including 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.)	$650.90
31406	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.)	$1020.00
31409	PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.)	$3255.40
31412	RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.)	$3686.30
31420	Lymph node of neck, biopsy of (Anaes.)	$332.30
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 (Anaes.) (Assist.)	$1875.00
31429	LYMPH NODES OF NECK, selective dissection of 4 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes.) (Assist.)	$2404.10
31432	LYMPH NODES OF NECK, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections) (Anaes.) (Assist.)	$3120.00
31435	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$3305.00
31450	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken is 1 hour or less (Anaes.) (Assist.)	$775.70

Item no.	Description	Max fee (excl. GST)
31452	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken in more than 1 hour (Anaes.) (Assist.)	$1365.40
31454	LAPAROSCOPY with drainage of pus, bile or blood, as an independent procedure (Anaes.) (Assist.)	$1091.60
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.)	$443.80
31458	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition, and where the use of imaging intensification is clinically indicated (Anaes.)	$532.50
31460	PERCUTANEOUS GASTROSTOMY TUBE, jejunal extension to, including any associated imaging services (Anaes.) (Assist.)	$678.70
31462	OPERATIVE FEEDING JEJUNOSTOMY performed in conjunction with major upper gastro-intestinal resection (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2113.70
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 (Anaes.) (Assist.)	$671.90
31506	BREAST, ABNORMALITY detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of (Anaes.) (Assist.)	$747.80
31509	BREAST, MALIGNANT TUMOUR, open surgical biopsy of, with or without frozen section histology (Anaes.)	$659.80
31512	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology (Anaes.) (Assist.)	$1249.20
31515	BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excision of malignant tumour (Anaes.) (Assist.)	$853.80
31516	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology when targeted intraoperative radiation therapy(using an Intrabeam or Xoft Axxent device) is performed concurrently, if the patient satisfies the requirements mentioned in paragraphs(a) to (g) of item15900 Applicable only once per breast per lifetime (H) (Anaes.) (Assist.)	$1415.00
31519	BREAST, total mastectomy (H) (Anaes.) (Assist.)	$1229.00
31524	BREAST, subcutaneous mastectomy (H) (Anaes.) (Assist.)	$2036.80
31525	BREAST, mastectomy for gynecomastia, with or without liposuction (suction assisted lipolysis), not being a service associated with a service to which item 45585 applies (H) (Anaes.) (Assist.)	$868.10
31530	Breast, biopsy of solid tumour or tissue of, using a vacuum-assisted breast biopsy device under imaging guidance, for histological examination, if imaging has demonstrated:(a) microcalcification of lesion; or(b) impalpable lesion less than one cm in diameter;including pre-operative localisation of lesion, if performed, other than a service associated with a service to which item 31548 applies	$1102.40
31533	FINE NEEDLE ASPIRATION of an impalpable breast lesion detected by mammography or ultrasound, imaging guided—but not including imaging (Anaes.)	$255.10
31536	Breast, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques, but not including imaging (Anaes.) (Anaes.)	$350.50
31548	Breast, biopsy of solid tumour or tissue of, using mechanical biopsy device, for histological examination, other than a service associated with a service to which item 31530 applies (Anaes.) (Anaes.)	$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.)	$401.10
31554	BREAST, microdochotomy of, for benign or malignant condition (Anaes.) (Assist.)	$837.10
31557	BREAST CENTRAL DUCTS, excision of, for benign condition (Anaes.) (Assist.)	$664.50

Item no.	Description	Max fee (excl. GST)
31560	ACCESSORY BREAST TISSUE, excision of (Anaes.) (Assist.)	$665.20
31563	Inverted nipple, surgical eversion of (Anaes.)	$452.00
31566	Accessory nipple, excision of (Anaes.)	$264.70
31569	Adjustable gastric band, placement of, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.)	$1462.40
31572	Gastric bypass by Roux-en-Y including associated anastomoses, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity not being associated with a service to which item 30515 applies (Anaes.) (Assist.)	$1799.50
31575	Sleeve gastrectomy, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.)	$1462.40
31578	Gastroplasty (excluding by gastric plication), with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.)	$1462.40
31581	Gastric bypass by biliopancreatic diversion with or without duodenal switch including gastric resection and anastomoses, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.)	$1799.50
31584	Surgical reversal of adjustable gastric banding (removal or replacement of gastric band), gastric bypass, gastroplasty (excluding by gastric plication) or biliopancreatic diversion being services to which items 31569 to 31581 apply (Anaes.) (Assist.)	$2649.30
31587	Adjustment of gastric band as an independent procedure including any associated consultation	$168.60
31590	Adjustment of gastric band reservoir, repair, revision or replacement of (Anaes.) (Assist.)	$433.40
	Colorectal	
32000	LARGE INTESTINE, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Anaes.) (Assist.)	$1996.40
32003	LARGE INTESTINE, resection of, with anastomosis, including right hemicolectomy (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2493.70
32006	LEFT HEMICOLECTOMY, including the descending and sigmoid colon (including formation of stoma) (Anaes.) (Assist.)	$2202.60
32009	TOTAL COLECTOMY AND ILEOSTOMY (Anaes.) (Assist.)	$2632.70
32012	TOTAL COLECTOMY AND ILEORECTAL ANASTOMOSIS (Anaes.) (Assist.)	$2908.40
32015	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY1 surgeon (Anaes.) (Assist.)	$3619.50
32018	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; ABDOMINAL RESECTION (including aftercare) (Anaes.) (Assist.)	$3040.00
32021	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; PERINEAL RESECTION (Assist.)	$1022.60
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.)	$978.00
32024	RECTUM, HIGH RESTORATIVE ANTERIOR RESECTION WITH INTRAPERITONEAL ANASTOMOSIS (of the rectum) greater than 10 centimetres from the anal vergeexcluding resection of sigmoid colon alone not being a service associated with a service to which item 32103, 32104 or 32106 applies (Anaes.) (Assist.)	$2648.20
32025	RECTUM, LOW RESTORATIVE ANTERIOR RESECTION WITH EXTRAPERITONEAL ANASTOMOSIS (of the rectum) less than 10 centimetres from the anal verge, with or without covering stoma not being a service associated with a service to which item 32103, 32104 or 32106 applies (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$3800.00
32028	RECTUM, LOW OR ULTRA LOW RESTORATIVE RESECTION, with peranal sutured coloanal anastomosis, with or without covering stoma (Anaes.) (Assist.)	$4040.30
32029	COLONIC RESERVOIR, construction of, being a service associated with a service to which any other item in this Subgroup applies (Anaes.) (Assist.)	$811.70
32030	RECTOSIGMOIDECTOMY(Hartmann's operation) (Anaes.) (Assist.)	$1975.10

Item no.	Description	Max fee (excl. GST)
32033	RESTORATION OF BOWEL following Hartmann's or similar operation, including dismantling of the stoma (Anaes.) (Assist.)	$2893.10
32036	SACROCOCCYGEAL AND PRESACRAL TUMOURexcision of (Anaes.) (Assist.)	$3699.80
32039	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF1 surgeon (Anaes.) (Assist.)	$2951.10
32042	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATIONabdominal resection (Anaes.) (Assist.)	$2501.00
32045	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATIONperineal 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 (Anaes.) (Assist.)	$1670.60
32051	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy1 surgeon (Anaes.) (Assist.)	$4473.90
32054	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomyconjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.)	$4461.10
32057	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoirconjoint surgery, perineal surgeon (Assist.)	$1088.40
32060	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy1 surgeon (Anaes.) (Assist.)	$4473.90
32063	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomyconjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.)	$3861.40
32066	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomyconjoint surgery, perineal surgeon (Assist.)	$1022.60
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	Sigmoidoscopy or colonoscopy up to the hepatic flexure, with or without biopsy,other thana service associated with a service to whichany of items 32222 to 32228applies. (Anaes.)	$213.70
32087	Endoscopic examination of the colon up to the hepatic flexure by sigmoidoscopy or colonoscopy for the removal of one or more polyps, other than a service associated with a service to which any of items 32222 to 32228 applies (Anaes.) (Anaes.)	$393.00
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 (Anaes.) (Assist.)	$512.20
32099	RECTAL TUMOUR of 5 centimetres or less in diameter, per anal submucosal excision of (Anaes.) (Assist.)	$639.20
32102	RECTAL TUMOUR of greater than 5 centimetres in diameter, indicated by pathological examination, per anal submucosal excision of (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1938.30
32105	ANORECTAL CARCINOMAper anal full thickness excision of (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2630.00

Item no.	Description	Max fee (excl. GST)
32108	RECTAL TUMOUR, transsphincteric excision of (Kraske or similar operation) (Anaes.) (Assist.)	$1940.00
32111	RECTAL PROLAPSEDelorme procedure for (Anaes.) (Assist.)	$1222.10
32112	RECTAL PROLAPSE, perineal recto-sigmoidectomy for (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1940.00
32120	RECTAL PROLAPSE, perineal repair of (Anaes.) (Assist.)	$496.80
32123	ANAL STRICTURE, anoplasty for (Anaes.) (Assist.)	$644.00
32126	ANAL INCONTINENCE, Parks' intersphincteric procedure for (Anaes.) (Assist.)	$926.40
32129	ANAL SPHINCTER, direct repair of (Anaes.) (Assist.)	$1222.10
32131	RECTOCELE, transanal repair of rectocele (Anaes.) (Assist.)	$1029.60
32132	HAEMORRHOIDS OR RECTAL PROLAPSEsclerotherapy for (Anaes.)	$86.60
32135	HAEMORRHOIDS OR RECTAL PROLAPSErubber 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 (Anaes.) (Assist.)	$704.70
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.)	$86.90
32150	OPERATION FOR FISSUREINANO, including excision or sphincterotomy, but excluding dilatation only (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$677.50
32162	ANAL FISTULA, treatment of, by excision or by insertion of a Seton, or by a combination of both procedures, involving the upper half of the anal sphincter mechanism (Anaes.) (Assist.)	$937.30
32165	ANAL FISTULA, repair of, by mucosal flap advancement (Anaes.) (Assist.)	$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	INTR-AANAL, perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.)	$169.40
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 (Anaes.) (Assist.)	$1081.70
32186	COLONIC LAVAGE, total, intra operative (Anaes.) (Assist.)	$1081.70
32200	DISTAL MUSCLE, devascularisation of (Anaes.) (Assist.)	$537.00
32203	ANAL OR PERINEAL GRACILOPLASTY (Anaes.) (Assist.)	$1222.10
32206	STIMULATOR AND ELECTRODES, insertion of, following previous graciloplasty (Anaes.) (Assist.)	$1104.90
32209	ANAL OR PERINEAL GRACILOPLASTY with insertion of stimulator and electrodes (Anaes.) (Assist.)	$1674.20

Item no.	Description	Max fee (excl. GST)
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	$228.20
32216	Sacral nerve lead or leads, percutaneous surgical repositioning of, using fluoroscopic guidance (or open surgical repositioning of) and interoperative test stimulation, to correct displacement or unsatisfactory positioning, if the lead was inserted to manage faecal incontinence in a patient who:a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or i) has functional effects of previous pelvic irradiation; or j) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months other than a service to which item 32213 applies (Anaes.)	$1143.20
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 enage in receptive anal intercourse (Anaes.) (Assist.)	$1641.40
32221	Removal or revision of an artificial bowel sphincter (with or without replacement) for severe faecal incontinence in the treatment of a patient for whom conservative and other less invasive forms of treatment are contraindicated or have failed.Contraindicated in: (a)patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases or a scarred or fragile perineum; and (b)patients who have had an adverse reaction to radiopaque solution; and (c)patients who engage in receptive anal intercourse (Anaes.) (Assist.)	$1670.60

Item no.	Description	Max fee (excl. GST)
32222	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient: (a) following a positive faecal occult blood test; or (b) who has symptoms consistent with pathology of the colonic mucosa; or (c) with anaemia or iron deficiency; or (d) for whom diagnostic imaging has shown an abnormality of the colon; or (e) who is undergoing the first examination following surgery for colorectal cancer; or (f) who is undergoing pre operative evaluation; or (g) for whom a repeat colonoscopy is required due to inadequate bowel preparation for the patient s previous colonoscopy; or (h) for the management of inflammatory bowel disease Applicable only once on a day under a single episode of anaesthesia or other sedation (Anaes.)	$509.60
32223	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient: (a) who has had a colonoscopy that revealed: (i) 1 to 4 adenomas, each of which was less than 10 mm in diameter, had no villous features and had no high grade dysplasia; or (ii) 1 or 2 sessile serrated lesions, each of which was less than 10 mm in diameter, and without dysplasia; or (b) with a moderate risk of colorectal cancer due to family history; or (c) with a history of colorectal cancer, who has had an initial post operative colonoscopy that did not reveal any adenomas or colorectal cancer Applicable only once in any 5 year period.	$509.60
32224	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient with a moderate risk of colorectal cancer due to: (a) a history of adenomas, including an adenoma that: (i) was 10 mm or greater in diameter; or (ii) had villous features; or (iii) had high grade dysplasia; or (b) having had a previous colonoscopy that revealed: (i) 5 to 9 adenomas, each of which was less than 10 mm in diameter, had no villous features and had no high grade dysplasia; or (ii) 1 or 2 sessile serrated lesions, each of which was 10 mm or greater in diameter or had dysplasia; or (iii) a hyperplastic polyp that was 10 mm or greater in diameter; or (iv) 3 or more sessile serrated lesions, each of which was less than 10 mm in diameter and had no dysplasia; or (v) 1 or 2 traditional serrated adenomas, of any size Applicable only once in any 3 year period (Anaes.)	$509.60
32225	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient with a high risk of colorectal cancer due to having had a previous colonoscopy that: (a) revealed 10 or more adenomas; or (b) included a piecemeal, or possibly incomplete, excision of a large, sessile polyp Applicable not more than 4 times in any 12 month period (Anaes.)	$509.60
32226	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient who has a high risk of colorectal cancer due to: (a) having either: (i) a known or suspected familial condition, such as familial adenomatous polyposis, Lynch syndrome or serrated polyposis syndrome; or (ii) a genetic mutation associated with hereditary colorectal cancer; or (b) having had a previous colonoscopy that revealed: (i) 5 or more sessile serrated lesions, each of which was less than 10 mm in diameter and had no dysplasia; or (ii) 3 or more sessile serrated lesions, 1 or more of which was 10 mm or greater in diameter or had dysplasia; or (iii) 3 or more traditional serrated adenomas, of any size Applicable only once in any 12 month period (Anaes.)	$509.60
32227	Endoscopic examination of the colon to the caecum by colonoscopy: (a) for the treatment of bleeding, including one or more of the following: (i) radiation proctitis; (ii) angioectasia; (iii) post polypectomy bleeding; or (b) for the treatment of colonic strictures with balloon dilatation Applicable only once on a day under a single episode of anaesthesia or other sedation (Anaes.)	$715.10
32228	Endoscopic examination of the colon to the caecum by colonoscopy, other that a service to which item 32222, 32223, 32224, 32225, or 32226 applies. Applicable only once (Anaes.)	$509.60
32229	Removal of one or more polyps during colonoscopy, in association with a service to which item 32222, 32223, 32224, 32225, 32226, or 32228 applies (Anaes.)	$411.00
	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 after-care)—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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1786.70

Item no.	Description	Max fee (excl. GST)
32517	VARICOSE VEINS, ligation of the long and short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in either territory—1 leg—including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.)	$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.)	$972.00
32522	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) and small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a laser probe introduced by an endovenous catheter, if it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including radiofrequency diathermy, radiofrequency ablation or cyanoacrylate embolisation, and not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.)	$1445.00
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.)	$939.60
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.)	$1397.10
32528	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using cyanoacrylate adhesive, if it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; and (c) not provided on the same occasion as a service described in any of items32500, 32504 and 32507 (Anaes.)	$839.50
32529	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) and small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using cyanoacrylate adhesive, if it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; and (c) not provided on the same occasion as a service described in any of items32500, 32504 and 32507 (Anaes.)	$1248.20
32700	ARTERY OF NECK, bypass using vein or synthetic material (Anaes.) (Assist.)	$2778.40
32703	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of small length and reanastomosis of—with or without endarterectomy (Anaes.) (Assist.)	$2283.20
32708	AORTIC BYPASS for occlusive disease using a straight non-bifurcated graft (Anaes.) (Assist.)	$2721.70
32710	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac arteries (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$3367.70
32712	ILIO-FEMORAL BYPASS GRAFTING (Anaes.) (Assist.)	$2432.70
32715	AXILLARY or SUBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL ARTERIES (Anaes.) (Assist.)	$2280.60
32718	FEMORO-FEMORAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.)	$2302.20
32721	RENAL ARTERY, bypass grafting to (Anaes.) (Assist.)	$3649.40
32724	RENAL ARTERIES (both), bypass grafting to (Anaes.) (Assist.)	$4150.10
32730	MESENTERIC VESSEL (single), bypass grafting to (Anaes.) (Assist.)	$3149.60

Item no.	Description	Max fee (excl. GST)
32733	MESENTERIC VESSELS (multiple), bypass grafting to (Anaes.) (Assist.)	$3649.40
32736	INFERIOR MESENTERIC ARTERY, operation on, when performed in conjunction with another intra-abdominal vascular operation (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$3544.20
32751	FEMORAL ARTERY BYPASS GRAFTING using synthetic graft, with lower anastomosis above or below the knee (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$838.80
32760	VEIN, HARVESTING OF, FROM LEG OR ARM for bypass or replacement graft when not performed on the limb which is the subject of the bypass or graft—each vein (Anaes.) (Assist.)	$778.30
32763	ARTERIAL BYPASS GRAFTING, using vein or synthetic material, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.)	$2302.20
32766	ARTERIAL OR VENOUS ANASTOMOSIS, not being a service to which another item in this Sub-group applies, as an independent procedure (Anaes.) (Assist.)	$2383.00
32769	ARTERIAL OR VENOUS ANASTOMOSIS not being a service to which another item in this Sub-group applies, when performed in combination with another vascular operation (including graft to graft anastomosis) (Anaes.) (Assist.)	$523.90
33050	BYPASS GRAFTING to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (Anaes.) (Assist.)	$2821.00
33055	BYPASS GRAFTING to replace a popliteal aneurysm using a synthetic graft (Anaes.) (Assist.)	$2264.20
33070	ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)	$1631.00
33075	ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)	$2076.80
33080	INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)	$2533.00
33100	ANEURYSM OF COMMON OR INTERNAL CAROTID ARTERY, OR BOTH, replacement by graft of vein or synthetic material (Anaes.) (Assist.)	$2778.40
33103	THORACIC ANEURYSM, replacement by graft (Anaes.) (Assist.)	$3899.40
33109	THORACO-ABDOMINAL ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.)	$4725.20
33112	SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.)	$4081.50
33115	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft, not being a service associated with a service to which item 33116 applies (Anaes.) (Assist.)	$2728.30
33116	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.)	$2652.50
33118	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision of common iliac aneurysms) not being a service associated with a service to which item 33119 applies (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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) (Anaes.) (Assist.)	$3520.90

Item no.	Description	Max fee (excl. GST)
33124	ANEURYSM OF ILIAC ARTERY (common, external or internal), replacement by graft—unilateral (Anaes.) (Assist.)	$2340.20
33127	ANEURYSMS OF ILIAC ARTERIES (common, external or internal), replacement by graft—bilateral (Anaes.) (Assist.)	$2881.60
33130	ANEURYSM OF VISCERAL ARTERY, excision and repair by direct anastomosis or replacement by graft (Anaes.) (Assist.)	$2671.60
33133	ANEURYSM OF VISCERAL ARTERY, dissection and ligation of arteries without restoration of continuity (Anaes.) (Assist.)	$2006.50
33136	FALSE ANEURYSM, repair of, at aortic anastomosis following previous aortic surgery (Anaes.) (Assist.)	$5066.00
33139	FALSE ANEURYSM, repair of, in iliac artery and restoration of arterial continuity (Anaes.) (Assist.)	$3075.10
33142	FALSE ANEURYSM, repair of, in femoral artery and restoration of arterial continuity (Anaes.) (Assist.)	$2871.80
33145	RUPTURED THORACIC AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.)	$4914.60
33148	RUPTURED THORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.)	$5749.20
33151	RUPTURED SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.)	$5823.20
33154	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft (Anaes.) (Assist.)	$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) (Anaes.) (Assist.)	$4815.70
33160	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (Anaes.) (Assist.)	$6165.00
33163	RUPTURED ILIAC ARTERY ANEURYSM, replacement by graft (Anaes.) (Assist.)	$4034.60
33166	RUPTURED ANEURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (Anaes.) (Assist.)	$3824.20
33169	RUPTURED ANEURYSM OF VISCERAL ARTERY, simple ligation of (Anaes.) (Assist.)	$2977.20
33172	ANEURYSM OF MAJOR ARTERY, replacement by graft, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.)	$2468.20
33175	RUPTURED ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)	$2281.70
33178	RUPTURED ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)	$2905.20
33181	RUPTURED INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)	$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) (Anaes.) (Assist.)	$2174.30
33506	INNOMINATE OR SUBCLAVIAN ARTERY, endarterectomy of, including closure by suture (Anaes.) (Assist.)	$2307.90
33509	AORTIC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the aorta (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$3093.30
33515	AORTO-FEMORAL ENDARTERECTOMY (1 or both femoral arteries) or BILATERAL ILIO-FEMORAL ENDARTERECTOMY, including closure by suture, not being a service associated with a service to which item 33512 applies (Anaes.) (Assist.)	$3345.70
33518	ILIAC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the iliac artery (Anaes.) (Assist.)	$2446.30
33521	ILIO-FEMORAL ENDARTERECTOMY (1 side), including closure by suture (Anaes.) (Assist.)	$2650.20
33524	RENAL ARTERY, endarterectomy of (Anaes.) (Assist.)	$3149.60
33527	RENAL ARTERIES (both), endarterectomy of (Anaes.) (Assist.)	$3649.40
33530	COELIAC OR SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.)	$3149.60
33533	COELIAC AND SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.)	$3427.70
33536	INFERIOR MESENTERIC ARTERY, endarterectomy of, not being a service associated with a service to which another item in this Sub-group applies (Anaes.) (Assist.)	$2444.50

Item no.	Description	Max fee (excl. GST)
33539	ARTERY OF EXTREMITIES, endarterectomy of, including closure by suture (Anaes.) (Assist.)	$1861.00
33542	EXTENDED DEEP FEMORAL ENDARTERECTOMY where the endarterectomy is at least 7cms long (Anaes.) (Assist.)	$2673.50
33545	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is less than 3cm long (Anaes.) (Assist.)	$525.30
33548	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is 3cm long or greater (Anaes.) (Assist.)	$1077.90
33551	VEIN, harvesting of from leg or arm for patch when not performed through same incision as operation (Anaes.) (Assist.)	$525.30
33554	ENDARTERECTOMY, in conjunction with an arterial bypass operation to prepare the site for anastomosis—each site (Anaes.) (Assist.)	$521.60
33800	EMBOLUS, removal of, from artery of neck (Anaes.) (Assist.)	$2278.80
33803	EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an artery or bypass graft of trunk (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1575.60
33810	INFERIOR VENA CAVA OR ILIAC VEIN, closed thrombectomy by catheter via the femoral vein (Anaes.) (Assist.)	$1119.50
33811	INFERIOR VENA CAVA OR ILIAC VEIN, open removal of thrombus or tumour (Anaes.) (Assist.)	$3388.40
33812	THROMBUS, removal of, from femoral or other similar large vein (Anaes.) (Assist.)	$1802.60
33815	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.)	$1644.10
33818	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2234.70
33824	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.)	$2093.10
33827	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.)	$2444.10
33830	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.)	$3079.30
33833	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by lateral suture (Anaes.) (Assist.)	$2574.40
33836	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by direct anastomosis (Anaes.) (Assist.)	$3075.10
33839	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by means of interposition graft (Anaes.) (Assist.)	$3582.20
33842	ARTERY OF NECK, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (Anaes.) (Assist.)	$1756.00
33845	LAPAROTOMY for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (Anaes.) (Assist.)	$1239.50
33848	EXTREMITY, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no other procedure is performed (Anaes.) (Assist.)	$1239.50
34100	MAJOR ARTERY OF NECK, elective ligation or exploration of, not being a service associated with any other vascular procedure (Anaes.) (Assist.)	$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, 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.)	$792.80
34106	ARTERY OR VEIN (including brachial, radial, ulnar or tibial), ligation of, by elective operation, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508, 32511, 32514 or 32517 apply (Anaes.) (Assist.)	$685.00
34109	TEMPORAL ARTERY, biopsy of (Anaes.) (Assist.)	$648.70
34112	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and ligation (Anaes.) (Assist.)	$1658.50
34115	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and ligation (Anaes.) (Assist.)	$1861.00

Item no.	Description	Max fee (excl. GST)
34118	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and ligation (Anaes.) (Assist.)	$2512.70
34121	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and repair of, with restoration of continuity (Anaes.) (Assist.)	$2143.50
34124	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and repair of, with restoration of continuity (Anaes.) (Assist.)	$2198.80
34127	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of continuity (Anaes.) (Assist.)	$2881.60
34130	SURGICALLY CREATED ARTERIO-VENOUS FISTULA OF AN EXTREMITY, closure of (Anaes.) (Assist.)	$952.70
34133	SCALENOTOMY (Anaes.) (Assist.)	$1079.50
34136	FIRST RIB, resection of portion of (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1727.10
34142	COELIAC ARTERY, decompression of, for coeliac artery compression syndrome, as an independent procedure (Anaes.) (Assist.)	$2331.00
34145	POPLITEAL ARTERY, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$3380.00
34151	CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is greater than 4cm in maximum diameter (Anaes.) (Assist.)	$3786.00
34154	RECURRENT CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Anaes.) (Assist.)	$4534.40
34157	NECK, excision of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.)	$2157.90
34160	AORTO-DUODENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes.) (Assist.)	$4042.40
34163	AORTO-DUODENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum (Anaes.) (Assist.)	$5189.50
34166	AORTO-DUODENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo-bifemoral grafting (Anaes.) (Assist.)	$5587.00
34169	INFECTED BYPASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.) (Assist.)	$3075.10
34172	INFECTED AXILLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of arteries (Anaes.) (Assist.)	$2506.10
34175	INFECTED BYPASS GRAFT FROM EXTREMITIES, excision of including closure of arteries (Anaes.) (Assist.)	$2302.20
34500	ARTERIOVENOUS SHUNT, EXTERNAL, insertion of (Anaes.) (Assist.)	$559.90
34503	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, in conjunction with another venous or arterial operation (Anaes.) (Assist.)	$794.60
34506	ARTERIOVENOUS SHUNT, EXTERNAL, removal of (Anaes.) (Assist.)	$403.70
34509	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, not in conjunctionwith another venous or arterial operation (Anaes.) (Assist.)	$1885.80
34512	ARTERIOVENOUS ACCESS DEVICE, insertion of (Anaes.) (Assist.)	$2082.20
34515	ARTERIOVENOUS ACCESS DEVICE, thrombectomy of (Anaes.) (Assist.)	$1483.80
34518	STENOSIS OF ARTERIOVENOUS FISTULA OR PROSTHETIC ARTERIOVENOUS ACCESS DEVICE, correction of (Anaes.) (Assist.)	$2491.50
34521	INTRA-ABDOMINAL ARTERY OR VEIN, cannulation of, for infusion chemotherapy, by open operation (excluding aftercare) (Anaes.) (Assist.)	$1137.50
34524	ARTERIAL CANNULATION for infusion chemotherapy by open operation, not being a service to which item 34521 applies (excluding after-care) (Anaes.) (Assist.)	$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.)	$991.60
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.)	$1170.40
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.)	$379.50
34533	ISOLATED LIMB PERFUSION, including cannulation of artery and vein at commencement of procedure, regional perfusion for chemotherapy, or other therapy, repair of arteriotomy and venotomy at conclusion of procedure (excluding aftercare) (Anaes.) (Assist.)	$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.)	$578.00
34538	CENTRAL VEIN CATHERTERISATION by percutaneous technique, using subcutaneous tunnelled cuffed catheter or similar device, for the administration of haemodialysis or parenteral nutrition (Anaes.)	$516.70
34539	Tunnelled cuffed catheter, or similar device, removal of, by open surgical procedure (Anaes.)	$387.60
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.)	$433.40
34800	INFERIOR VENA CAVA, plication, ligation, or application of caval clip (Anaes.) (Assist.)	$1827.60
34803	INFERIOR VENA CAVA, reconstruction of or bypass by vein or synthetic material (Anaes.) (Assist.)	$3563.50
34806	CROSS LEG BYPASS GRAFTING, saphenous to iliac or femoral vein (Anaes.) (Assist.)	$1761.80
34809	SAPHENOUS VEIN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (Anaes.) (Assist.)	$1761.80
34812	VENOUS STENOSIS OR OCCLUSION, vein bypass for, using vein or synthetic material, not being a service associated with a service to which item 34806 or 34809 applies (Anaes.) (Assist.)	$2294.80
34815	VEIN STENOSIS, patch angioplasty for, (excluding vein graft stenosis)-using vein or synthetic material (Anaes.) (Assist.)	$1861.00
34818	VENOUS VALVE, plication or repair to restore valve competency (Anaes.) (Assist.)	$2067.80
34821	VEIN TRANSPLANT to restore valvular function (Anaes.) (Assist.)	$2635.80
34824	EXTERNAL STENT, application of, to restore venous valve competency to superficial vein—1 stent (Anaes.) (Assist.)	$1175.00
34827	EXTERNAL STENTS, application of, to restore venous valve competency to superficial vein or veins—more than 1 stent (Anaes.) (Assist.)	$1288.40
34830	EXTERNAL STENT, application of, to restore venous valve competency to deep vein (1 stent) (Anaes.) (Assist.)	$1283.90
34833	EXTERNAL STENTS, application of, to restore venous valve competency to deep vein or veins (more than 1 stent) (Anaes.) (Assist.)	$1666.00
35000	LUMBAR SYMPATHECTOMY (Anaes.) (Assist.)	$1370.30
35003	CERVICAL OR UPPER THORACIC SYMPATHECTOMY by any surgical approach (Anaes.) (Assist.)	$1943.90
35006	CERVICAL OR UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (Anaes.) (Assist.)	$2205.50
35009	LUMBAR SYMPATHECTOMY, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (Anaes.) (Assist.)	$1714.20
35012	SACRAL or PRE-SACRAL SYMPATHECTOMY (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1269.40

Item no.	Description	Max fee (excl. GST)
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 (Anaes.) (Assist.)	$2159.40
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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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) (Anaes.) (Assist.)	$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) (Anaes.) (Assist.)	$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) (Anaes.) (Assist.)	$1616.90
35321	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION to administer agents to occlude arteries, veins or arterio-venous fistulae or to arrest haemorrhage, (but not for the treatment of uterine fibroids or varicose veins) percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.)	$1558.90
35324	ANGIOSCOPY not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	$585.00
35327	ANGIOSCOPY combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	$742.20
35330	INSERTION of INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	$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.)	$1147.50
35360	Retrieval of foreign body in PULMONARY ARTERY, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (foreign body does not include an instrument inserted for the purpose of a service being rendered) (Anaes.) (Assist.)	$1504.00
35361	Retrieval of foreign body in RIGHT ATRIUM, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (foreign body does not include an instrument inserted for the purpose of a service being rendered) (Anaes.) (Assist.)	$1375.90
35362	Retrieval of foreign body in INFERIOR VENA CAVA or AORTA, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (foreign body does not include an instrument inserted for the purpose of a service being rendered) (Anaes.) (Assist.)	$1147.50
35363	Retrieval of foreign body in PERIPHERAL VEIN or PERIPHERAL ARTERY, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (foreign body does not include an instrument inserted for the purpose of a service being rendered) (Anaes.) (Assist.)	$918.50

Item no.	Description	Max fee (excl. GST)
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.	$626.30
35406	Trans-femoral catheterisation of the hepatic artery to administer SIR-Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	$1469.60
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 (Anaes.) (Assist.)	$1102.30
35410	UTERINE ARTERY CATHETERISATION with percutaneous administration of occlusive agents, for the treatment of symptomatic uterine fibroids in a patient who has been referred for uterine artery embolisation by a specialist gynaecologist, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	$1469.60
35412	Intracranial aneurysm, ruptured or unruptured, endovascular occlusion with detachable coils, and assisted coiling if performed, with parent artery preservation, not for use with liquid embolics only, including aftercare, including intra-operative imaging, but in association with the following pre-operative diagnostic imaging items:—either 60009 or 60010; and—either 60072, 60073, 60075, 60076, 60078 or 60079 (Anaes.) (Assist.)	$5163.20
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.)	$5506.60
	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.)	$100.40
35507	VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is less than or equal to 45 minutes—not being a service associated with a service to which item 32177 or 32180 applies (Anaes.)	$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 (Anaes.) (Assist.)	$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.)	$386.70
35520	Bartholin's abscess, incision of (Anaes.)	$114.10
35523	Urethra or urethral caruncle, cauterisation of (Anaes.)	$126.00
35527	Urethral caruncle, excision of (Anaes.)	$308.20

Item no.	Description	Max fee (excl. GST)
35530	CLITORIS, amputation of, where medically indicated (Anaes.) (Assist.)	$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 item35536, 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.)	$584.20
35536	VULVA, wide local excision of suspected malignancy or hemivulvectomy, 1 or both procedures (Anaes.) (Assist.)	$668.00
35539	COLPOSCOPICALLY DIRECTED CO² LASER THERAPY for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies1 anatomical site (Anaes.)	$523.50
35542	COLPOSCOPICALLY DIRECTED CO² LASER THERAPY for previously confirmed intraepithelial neoplasticchanges of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies2 or more anatomical sites (Anaes.) (Assist.)	$658.00
35545	COLPOSCOPICALLY DIRECTED CO² LASER THERAPY for condylomata, unsuccessfully treated by other methods (Anaes.)	$331.90
35548	VULVECTOMY, radical, for malignancy (Anaes.) (Assist.)	$1611.80
35551	Pelvic lymph nodes, radical excision of,unilateral, or sentinel node dissection (including any pre-operative injection) (Anaes.) (Assist.)	$1427.00
35552	Pelvic lymph nodes, radical excision of, unilateral, following similar previous dissection, radiation or chemotherapy (Anaes.) (Assist.)	$2151.90
35554	VAGINA, DILATATION OF, as an independent procedure including any associated consultation (Anaes.)	$78.50
35557	Vagina, removal of simple tumour (including Gartner duct cyst) (Anaes.)	$411.60
35560	VAGINA, partial or complete removal of (Anaes.) (Assist.)	$1314.00
35561	VAGINECTOMY, radical, for proven invasive malignancy—1 surgeon (Anaes.) (Assist.)	$2646.40
35562	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery—abdominal surgeon (including aftercare) (Anaes.) (Assist.)	$2046.50
35564	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery—perineal surgeon (Assist.)	$1225.00
35565	VAGINAL RECONSTRUCTION for congenital absence, gynatresia or urogenital sinus (Anaes.) (Assist.)	$1531.00
35566	VAGINAL SEPTUM, excision of, for correction of double vagina (Anaes.) (Assist.)	$769.40
35568	SACROSPINOUS COLPOPEXY FOR MANAGEMENT OF UPPER VAGINAL PROLAPSE (Anaes.) (Assist.)	$1200.20
35569	Plastic repair to enlarge vaginal orifice (Anaes.)	$311.50
35570	Anterior vaginal compartment repair by vaginal approach for pelvic organ prolapse: (a) involving repair of urethrocele and cystocele; and (b) using native tissue without graft; other than a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.)	$1063.80
35571	Posterior vaginal compartment repair by vaginal approach for pelvic organ prolapse: (a) involving repair of one or more of the following: (i) perineum; (ii) rectocoele; (iii) enterocoele; and (b) using native tissue without graft; other than a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.)	$1060.60
35572	COLPOTOMYnot 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: (a) involving anterior and posterior compartment defects; and (b) using native tissue without graft; other than a service associated with a service to which item 35577 or 35578 applies (Anaes.) (Assist.)	$1606.00
35577	Manchester (Donald Fothergill) operation for pelvic organ prolapse, involving either or both of the following: (a) cervical amputation; (b) anterior and posterior native tissue vaginal wall repairs without graft (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1308.90
35581	Vaginal procedure for excision of graft material in symptomatic patients with graft related complications (including graft related pain or discharge and bleeding related to graft exposure), less than 2cm2 in its maximum area, either singly or in multiple pieces, other than a service associated with a service to which item 35582 or 35585 applies (Anaes.) (Assist.)	$871.40

Item no.	Description	Max fee (excl. GST)
35582	Vaginal procedure for excision of graft material in symptomatic patients with graft related complications (including graft related pain or discharge and bleeding related to graft exposure),2cm2 or more in its maximum area, either singly or in multiple pieces, other than a service associated with a service to which item 35581 or 35585 applies (Anaes.) (Assist.)	$1307.30
35585	Abdominal procedure, by open, laparoscopic or robot assisted approach, if the service: (a) is for the removal of graft material: (i) in symptomatic patients with graft related complications (including graft related pain or discharge and bleeding related to graft exposure); or (ii) where the graft has penetrated adjacent organs such as the bladder (including urethra) or bowel; and (b) if required includes retroperitoneal dissection, and mobilisation, of either or both of the bladder and bowel; other than a service associated with a service to which item 35581 or 35582 applies (Anaes.) (Assist.)	$2317.80
35595	LAPAROSCOPIC OR ABDOMINAL PELVIC FLOOR REPAIR INCORPORATING THE FIXATION OF THE UTEROSACRAL AND CARDINAL LIGAMENTS TO RECTOVAGINAL AND PUBOCERVICAL FASCIA for symptomatic upper vaginal vault prolapse (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2938.60
35599	Stress incontinence, procedure using a female synthetic mid-urethral sling, with diagnostic cystoscopy to assess the integrity of the lower urinary tract, other than a service associated with a service to which item 30405 or 36812 applies (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1465.00
35605	STRESS INCONTINENCE, combined synchronous ABDOMINOVAGINAL operation for; vaginal procedure, with or without mesh, (including aftercare), not being a service associated with a service to which item 30405 applies (Assist.)	$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 (Anaes.) (Assist.)	$980.60
35613	CERVIX, RESIDUAL STUMP, removal of, by vaginal approach (Anaes.) (Assist.)	$756.30
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 35614 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 refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage, not being a service associated with a service to which item 30390 applies (Anaes.)	$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 35626 or 35630 applies (Anaes.)	$212.80
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.)	$1248.70

Item no.	Description	Max fee (excl. GST)
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, ventrosuspension, division of adhesions or similar procedure—1 or more procedures with or without biopsy—not being a service associated with any other laparoscopic procedure or hysterectomy (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 2 cms in diameter, dissection of bowel from uterus from the level of the endocervical junction or above: where the operating time exceeds 90 minutes (Anaes.) (Assist.)	$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.)	$393.80
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.)	$368.00
35645	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative therapy of additional areas of intraepithelial change in 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35648 applies (Anaes.)	$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	HYSTEROTOMY or UTERINE MYOMECTOMY, abdominal (Anaes.) (Assist.)	$1055.00
35653	HYSTERECTOMY, ABDOMINAL, SUBTOTAL or TOTAL, with or without removal of uterine adnexae (Anaes.) (Assist.)	$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. (Anaes.) (Assist.)	$1307.20
35658	UTERUS (at least equivalent in size to a 10 week gravid uterus), debulking of, prior to vaginal removal at hysterectomy (Anaes.) (Assist.)	$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 the ovaries (Anaes.) (Assist.)	$1712.40
35664	RADICAL HYSTERECTOMY with radical excision of pelvic lymph nodes (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2374.10
35670	HYSTERECTOMY, abdominal, with radical excision of pelvic lymph nodes, with or without removal of uterine adnexae (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1454.90
35674	Ultrasound guided needling and injection of ectopic pregnancy	$375.80

Item no.	Description	Max fee (excl. GST)
35677	ECTOPIC PREGNANCY, removal of (Anaes.) (Assist.)	$1032.20
35678	ECTOPIC PREGNANCY, laparoscopic removal of (Anaes.) (Assist.)	$1240.40
35680	BICORNUATE UTERUS, plastic reconstruction for (Anaes.) (Assist.)	$1219.10
35684	UTERUS, SUSPENSION OR FIXATION OF, as an independent procedure (Anaes.) (Assist.)	$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. (Anaes.) (Assist.)	$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 explantory note before submitting a claim. (Anaes.) (Assist.)	$306.50
35694	TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.)	$1224.00
35697	MICROSURGICAL TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.)	$1827.30
35700	FALLOPIAN TUBES, unilateral microsurgical anastomosis of, using operating microscope (Anaes.) (Assist.)	$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	FALLOPOSCOPY, unilateral or bilateral, including hysteroscopy and tubal catheterization (Anaes.) (Assist.)	$926.60
35713	LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGO-OOPHORECTOMY, removal of OVARIAN, PARAOVARIAN, FIMBRIAL or BROAD LIGAMENT CYST—one such procedure,other than a serviceassociated 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 thana service associated with hysterectomy (anaes.) (assist.)	$1044.50
35720	RADICAL OR DEBULKING OPERATION for advanced gynaecological malignancy, with or without omentectomy (Anaes.) (Assist.)	$1315.00
35723	RETROPERITONEAL LYMPH NODE BIOPSIES from above the level of the aortic bifurcation, for staging or restaging of gynaecological malignancy (Anaes.) (Assist.)	$943.50
35726	INFRACOLIC OMENTECTOMY with multiple peritoneal biopsies for staging or restaging of gynaecological malignancy (Anaes.) (Assist.)	$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.)	$342.70
35750	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, including any associated laparoscopy (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2416.50
35756	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, when procedure is completed by open hysterectomy, including any associated laparoscopy (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1086.50

Item no.	Description	Max fee (excl. GST)
	Urological	
36502	PELVIC LYMPHADENECTOMY, open or laparoscopic, or both, unilateral or bilateral (Anaes.) (Assist.)	$1475.00
36503	RENAL TRANSPLANT (not being a service to which item 36506 or 36509 applies) (Anaes.) (Assist.)	$2708.70
36504	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with biopsy of bladder, not being a service associated with a service to which item 36505, 36507, 36508, 36812, 36830, 36836, 36840, 36845, 36848, 36854, 37203, 37206, 37215, 37230 or 37233 applies. (Anaes.)	$453.70
36505	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with urethroscopy with or without urethral dilatation, not being a service associated with any other urological endoscopic procedure on the lower urinary tract except a service to which item 37327 applies. (Anaes.)	$356.60
36506	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating togethervascular anastomosis including aftercare (Anaes.) (Assist.)	$1803.30
36507	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with resection, diathermy or visual laser destruction of bladder tumour or other lesion of the bladder, not being a service to which item 36840 or 36845 applies. (Anaes.)	$597.30
36508	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with diathermy, resection or visual laser destruction of multiple tumours in more than 2 quadrants of the bladder or solitary tumour greater than 2cm in diameter, not being a service to which item 36845 applies. (Anaes.)	$1163.90
36509	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating togetherureterovesical anastomosis including aftercare (Assist.)	$1499.70
36516	Nephrectomy, complete, by open, laparoscopic or robot-assisted approach, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$1773.70
36519	Nephrectomy, complete, by open, laparoscopic or robot-assisted approach, complicated by previous surgery on the same kidney, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$2477.70
36522	Nephrectomy, partial,by open, laparoscopic or robot-assisted approach, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$2285.00
36525	Nephrectomy, partial, by open, laparoscopic or robot assisted approach: (a) if complicated by previous surgery or ablative procedure on the same kidney; or (b) for a patient with a solitary functioning kidney; or (c) for a patient with an estimated glomerular filtration rate (eGFR) of less than 60ml/min/1.73m2; other than a service associated with a service to which item30390 or 30627 applies (Anaes.) (Assist.)	$3235.00
36528	Nephrectomy, radical, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10 cm in diameter, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$2665.00
36529	Nephrectomy, radical, by open, laparoscopic or robot assisted approach, with or without en bloc dissection of lymph nodes, with or without adrenalectomy: (a) for a tumour 10 cm or more in diameter; or (b) if complicated by previous open or laparoscopic surgery on the same kidney; other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$3224.10
36531	Nephroureterectomy, complete, by open, laparoscopic or robot-assisted approach, including associated bladder repair and any associated endoscopic procedure, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$2370.60
36532	Nephroureterectomy, for tumour, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures, other than a service to which item 36533 applies or a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$3348.30
36533	Nephroureterectomy, for tumour, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures, if complicated by previous open or laparoscopic surgery on the same kidney or ureter, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1332.10
36543	Nephrolithotomy or pyelolithotomy, or both, extended, for one or more renal stones, including one or more of nephrostomy, pyelostomy, pedicle control with or without freezing, calyorrhaphy or pyeloplasty (Anaes.) (Assist.)	$2506.60
36546	EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY (ESWL) to urinary tract and posttreatment care for 3 days, including pretreatment consultation, unilateral (Anaes.)	$1324.80
36549	Ureterolithotomy, by open, laparoscopic or robot-assisted approach (Anaes.) (Assist.)	$1609.30
36552	NEPHROSTOMY or pyelostomy, open, as an independent procedure (Anaes.) (Assist.)	$1444.50
36558	RENAL CYST OR CYSTS, excision or unroofing of (Anaes.) (Assist.)	$1335.00

Item no.	Description	Max fee (excl. GST)
36561	Renal biopsy, performed under image guidance (closed) (Anaes.)	$328.50
36564	Pyeloplasty, (plastic reconstruction of the pelvi-ureteric junction) by open, laparoscopic or robot-assisted approach, with or without the use of a retroperitoneal approach (Anaes.) (Assist.)	$1905.00
36567	Pyeloplasty in a kidney that is congenitally abnormal (in addition to the presence of pelvi-ureteric junction obstruction), or in a solitary kidney, by open, laparoscopic or robot-assisted approach, with or without the use of a retroperitoneal approach (Anaes.) (Assist.)	$1982.30
36570	Pyeloplasty, complicated by previous surgery on the same kidney, by open,laparoscopic or robot-assisted approach, with or without the use of a retroperitoneal approach (Anaes.) (Assist.)	$2665.00
36573	DIVIDED URETER, repair of (Anaes.) (Assist.)	$1783.20
36576	Kidney, exposure and exploration of, including repair or nephrectomy, for trauma, by open, laparoscopic or robot assisted approach, other than a service associated with: (a) any other procedure performed on the kidney, renal pelvis or renal pedicle; or (b) a service to which item30390 or 30627 applies (Anaes.) (Assist.)	$2380.00
36579	Ureterectomy, complete or partial: (a) for a tumour within the ureter, proven by histopathology at the time of surgery; or (b) for congenital anomaly; with or without associated bladder repair (Anaes.) (Assist.)	$1525.00
36585	URETER, transplantation of, into skin (Anaes.) (Assist.)	$1346.80
36588	URETER, reimplantation into bladder (Anaes.) (Assist.)	$1803.30
36591	URETER, reimplantation into bladder with psoas hitch or Boari flap or both (Anaes.) (Assist.)	$2167.50
36594	URETER, transplantation of, into intestine (Anaes.) (Assist.)	$1796.40
36597	URETER, transplantation of, into another ureter (Anaes.) (Assist.)	$1783.30
36600	URETER, transplantation of, into isolated intestinal segment, unilateral (Anaes.) (Assist.)	$2149.20
36603	URETERS, transplantation of, into isolated intestinal segment, bilateral (Anaes.) (Assist.)	$2473.50
36604	Ureteric stent, passage of through percutaneous nephrostomy tube, using interventional radiology techniques, but not including imaging (Anaes.)	$516.00
36606	INTESTINAL URINARY RESERVOIR, continent, formation of, including formation of nonreturn valves and implantation of ureters (1 or both) into reservoir (Anaes.) (Assist.)	$4496.20
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 interventionalradiology techniques, but not including imaging (Anaes.)	$1351.20
36608	Ureteric stent, exchange of, percutaneously through either the ileal conduit or bladder, using interventional radiology techniques, but not including imaging, not being a service associated with a service to which items 36811 to 36854 apply (Anaes.)	$516.10
36609	Intestinal urinary conduit, reservoir or ureterostomy, revision of (Anaes.) (Assist.)	$1434.30
36610	Intestinal urinary conduit, incontinent, formation of (including associated small bowel resection and anastomosis), including implantation of one or both ureters into reservoir (Anaes.) (Assist.)	$2745.80
36611	Intestinal urinary reservoir, continent, formation of (including associated small bowel resection and anastomosis), including formation of non-return valves and implantation of one or both ureters into reservoir, performed by open, laparoscopic or robot-assisted approach (Anaes.) (Assist.)	$4330.80
36612	URETER, exploration of, with or without drainage of, as an independent procedure (Anaes.) (Assist.)	$1259.50
36615	Ureterolysis, unilateral, with or without repositioning of the ureter, for obstruction of the ureter, if: (a) the obstruction: (i) is evident either radiologically or by proximal ureteric dilatation at operation; and (ii) is secondary to retroperitoneal fibrosis; and (b) there is biopsy proven fibrosis, endometriosis or cancer at the site of the obstruction at time of surgery (Anaes.) (Assist.)	$1439.90
36618	REDUCTION URETEROPLASTY (Anaes.) (Assist.)	$1180.20
36621	CLOSURE OF CUTANEOUS URETEROSTOMY (Anaes.) (Assist.)	$860.30
36624	Nephrostomy, percutaneous, using interventional radiology techniques, but not including imaging (Anaes.) (Assist.)	$1084.80
36627	Nephroscopy, percutaneous, with or without any one or more of; stone extraction, biopsy or diathermy, not being a service to which item 36639 or 36645 applies (Anaes.)	$1330.00
36633	Nephroscopy, percutaneous, with incision of any one or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, not being a service associated with a service to which item 36627, 36639 or 36645 applies (Anaes.) (Assist.)	$1444.50
36636	Nephroscopy, percutaneous, with incision of any one or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, being a service associated with a service to which item 36627, 36639 or 36645 applies (Anaes.) (Assist.)	$820.00
36639	Nephroscopy, percutaneous, with destruction and extraction of one or two stones using ultrasound or electrohydraulic shock waves orlasers, other than a service to which item 36645 applies (Anaes.)	$1613.60

Item no.	Description	Max fee (excl. GST)
36645	NEPHROSCOPY, percutaneous, with removal or destruction of a stone greater than 3 cm in any dimension, or for 3 or more stones (Anaes.) (Assist.)	$2053.70
36649	Nephrostomy drainage tube, exchange of, using interventional radiology techniques, but not including imaging (Anaes.) (Assist.)	$516.00
36650	Nephrostomy tube, removal of, using interventionalradiology techniques, but not including imaging, if the ureter has been stented with a double J ureteric stent and that stent is left in place (Anaes.)	$290.00
36652	PYELOSCOPY, retrograde, of one collecting system, with or without any one or more of, cystoscopy, ureteric meatotomy, ureteric dilatation, not being a service associated with a service to which item 36803, 36812 or 36824 applies (Anaes.) (Assist.)	$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 (Anaes.) (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 (Anaes.) (Assist.)	$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.)	$1077.70
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	$227.70
36666	Pulse generator, subcutaneous placement of, and placement and connection of extension wire or wires to sacral nerve electrode or electrodes, for the management of:(a) detrusor over activity that has been refractory to at least 12 months conservative non surgical treatment; or (b) non obstructive urinary retention that has been refractory to at least 12 months conservative non surgical treatment (Anaes.)	$759.00
36667	Sacral nerve lead or leads, removal of, if the lead was inserted to manage:(a) detrusor over activity that has been refractory to at least 12 months conservative non surgical treatment; or (b) non obstructive urinary retention that has been refractory to at least 12 months conservative non surgical treatment (Anaes.)	$284.00
36668	Pulse generator, removal of, if the pulse generator was inserted to manage:(a) detrusor over activity that has been refractory to at least 12 months conservative non surgical treatment; or (b) non obstructive urinary retention that has been refractory to at least 12 months conservative non surgical treatment (Anaes.)	$284.00
36671	Percutaneous tibial nerve stimulation, initial treatment protocol, for the treatment of overactive bladder, by a specialist urologist, gynaecologist or urogynaecologist, if: (a) the patient has been diagnosed with idiopathic overactive bladder; and (b) the patient has been refractory to, is contraindicated or otherwise not suitable for conservative treatments (including anti cholinergic agents); and (c) the patient is contraindicated or otherwise not a suitable candidate for botulinum toxin type A therapy; and (d) the patient is contraindicated or otherwise not a suitable candidate for sacral nerve stimulation; and (e) the patient is willing and able to comply with the treatment protocol; and (f) the initial treatment protocol comprises 12 sessions, delivered over a 3 month period; and (g) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts for 30 minutes. For each patient applicable only once, unless the patient achieves at least a 50% reduction in overactive bladder symptoms from baseline at any time during the 3 month treatment period. Not applicable for a service associated with a service to which item 36672 or 36673 applies	$307.70
36672	Percutaneous tibial nerve stimulation, tapering treatment protocol, for the treatment of overactive bladder, including any associated consultation at the time the percutaneous tibial nerve stimulation treatment is administered, if: (a) the patient responded to the percutaneous tibial nerve stimulation initial treatment protocol and has achieved at least a 50% reduction in overactive bladder symptoms from baseline at any time during the treatment period for the initial treatment protocol; and (b) the tapering treatment protocol comprises no more than 5 sessions, delivered over a 3 month period, and the interval between sessions is adjusted with the aim of sustaining therapeutic benefit of the treatment; and (c) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts for 30 minutes. Not applicable for a service associated with a service to which item 36671 or 36673 applies	$307.70

Item no.	Description	Max fee (excl. GST)
36673	Percutaneous tibial nerve stimulation, maintenance treatment protocol, for the treatment of overactive bladder, including any associated consultation at the time the percutaneous tibial nerve stimulation treatment is administered, if: (a) the patient responded to the percutaneous tibial nerve stimulation initial treatment protocol and to the tapering treatment protocol, and has achieved at least a 50% reduction in overactive bladder symptoms from baseline at any time during the treatment period for the initial treatment protocol; and (b) the maintenance treatment protocol comprises no more than 12 sessions, delivered over a 12 month period, and the interval between sessions is adjusted with the aim of sustaining therapeutic benefit of the treatment; and (c) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts for 30 minutes. Not applicable for service associated with a service to which item 36671 or 36672 applies	$307.70
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 or 36848 applies (Anaes.) (Assist.)	$893.80
36806	Ureteroscopy, of one ureter: (a) with or without one or more of the following: (i) cystoscopy; (ii) endoscopic incision of pelviureteric junction or ureteric stricture; (iii) ureteric meatotomy; (iv) ureteric dilatation; and (b) with either or both of the following: (i) extraction of stone from the ureter; (ii) biopsy or diathermy of the ureter; other than: (c) a service associated with a service to which item36803 or 36812 applies; or (d) a service associated with a service, performed on the same ureter, to which item36809, 36824 or 36848 applies (Anaes.) (Assist.)	$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 or 36848 applies to a procedure performed on the same ureter (Anaes.) (Assist.)	$1595.60
36811	Cystoscopy, with insertion of one or more urethral or prostatic prostheses, other than a service associated with a service to which item 37203, 37207 or 37230 applies (Anaes.)	$621.00
36812	Either or both of cystoscopy and urethroscopy, with or without urethral dilatation, other than a service associated with any other urological endoscopic procedure on the lower urinary tract (Anaes.)	$319.50
36815	CYSTOSCOPY, with or without urethroscopy, for the treatment of penile warts or uretheral warts, not being a service associated with a service to which item 30189 applies (Anaes.)	$456.80
36818	Cystoscopy, with ureteric catheterisation, unilateral or bilateral, guided by fluoroscopic imaging of the upper urinary tract, other than a service associated with a service to which item 36824 or 36830 applies (Anaes.)	$529.70
36821	Cystoscopy with one or more of; ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or renal pelvis, unilateral (Anaes.) (Assist.)	$621.20
36822	Cystoscopy, with ureteric catheterisation, unilateral: (a) guided by fluoroscopic imaging of the upper urinary tract; and (b) including one or more of ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or of renal pelvis; other than a service associated with a service to which item 36818, 36821 or 36830 applies (Anaes.) (Assist.)	$713.90
36823	Cystoscopy, with removal of ureteric stent and ureteric catheterisation, unilateral: (a) guided by fluoroscopic imaging of the upper urinary tract; and (b) including either or both of the following: (i) ureteric dilatation; or (ii) insertion of ureteric stent of ureter or of renal pelvis; other than a service associated with a service to which item 36818, 36821, 36830 or 36833 applies (Anaes.) (Assist.)	$820.90
36824	Cystoscopy, with ureteric catheterisation, unilateral or bilateral,other than a service associated with a service to which item 36818 applies (Anaes.)	$440.00
36827	Cystoscopy, with controlled hydrodilatation of the bladder,other than a service associated with a service to which item 37011 or 37245 applies (Anaes.)	$444.90
36830	Cystoscopy, with ureteric meatotomy (Anaes.)	$389.90
36833	Cystoscopy, with removal of ureteric stent or other foreign body in the lower urinary tract, unilateral (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, 37215, 37230 or 37233 applies (Anaes.)	$440.00
36840	Cystoscopy, with diathermy, resection or visual laser destruction of bladder tumour or other lesion of the bladder, for: (a) a tumour or lesion in only one quadrant of the bladder; or (b) a solitary tumour of not more than 2 cm in diameter; other than a service associated with a service to which item 36845 applies (Anaes.)	$620.70
36842	Cystoscopy, with lavage of blood clots from bladder, including any associated cautery of prostate or bladder, other than a service associated with a service to which any of items 36812, 36827 to 36863, 37203, 37206, 37230 and 37233 apply (Anaes.)	$628.00
36845	Cystoscopy, with diathermy, resection or visual laser destruction of: (a) multiple tumours in 2 or more quadrants of the bladder; or (b) a solitary bladder tumour of more than 2 cm in diameter (Anaes.)	$1340.60
36848	CYSTOSCOPY, with resection of ureterocele (Anaes.)	$440.70

Item no.	Description	Max fee (excl. GST)
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
36860	Endoscopic examination of intestinal conduit or reservoir (Anaes.)	$323.80
36863	Litholapaxy, with or without cystoscopy (Anaes.)	$903.00
37000	BLADDER, partial excision of (Anaes.) (Assist.)	$1509.80
37004	BLADDER, repair of rupture (Anaes.) (Assist.)	$1265.90
37008	Open cystostomy or cystotomy, suprapubic, other than: (a) a service to which item 37011 applies; or (b) a service associated with a service to which item 37245 applies; or (c) another open bladder procedure (Anaes.) (Assist.)	$799.00
37011	Suprapubic stab cystotomy, other than a service associated with a service to which item 36827 applies (Anaes.)	$190.00
37014	BLADDER, total excision of (Anaes.) (Assist.)	$2156.10
37015	Bladder, total excision of, following previous open, laparoscopic or robot-assisted surgery, or radiation therapy or chemotherapy to the pelvis (Anaes.) (Assist.)	$1979.30
37016	Cystectomy, including prostatectomy and pelvic lymph node dissection, other than a service associated with a service to which items 37000, 37014, 37015, 37209, 35551 or 36502 applies (Anaes.) (Assist.)	$3086.30
37018	Cystectomy, including prostatectomy and pelvic lymph node dissection, following previous open, laparoscopic or robot-assisted surgery, or radiation therapy or chemotherapy to the pelvis, other than a service associated with a service to which items 37000, 37014, 37015, 37016, 37209, 35551 or 36502 applies (Anaes.) (Assist.)	$4629.50
37019	Cystectomy, including anterior exenteration and pelvic lymph node dissection, other than a service associated with a service to which any of items 37000, 37014, 37015, 35551, 36502, and 35653 to 35756 apply (Anaes.) (Assist.)	$3082.80
37020	BLADDER DIVERTICULUM, excision or obliteration of (Anaes.) (Assist.)	$1422.10
37021	Cystectomy, including anterior exenteration and pelvic lymph node dissection, following previous open, laparoscopic or robot-assisted surgery, radiation therapy or chemotherapy to the pelvis, other than a service associated with a service to which any of items 37000, 37014, 37015, 35551, 36502 and 35653 to 35756 apply (Anaes.) (Assist.)	$4624.20
37023	Vesical fistula, cutaneous, operation for (Anaes.)	$855.00
37026	CUTANEOUS VESICOSTOMY, establishment of (Anaes.) (Assist.)	$756.20
37029	VESICOVAGINAL FISTULA, closure of, by abdominal approach (Anaes.) (Assist.)	$1791.50
37038	VESICOINTESTINAL FISTULA, closure of, excluding bowel resection (Anaes.) (Assist.)	$1327.60
37039	Bladder stress incontinence, sling procedure for, using a non-autologous biological sling (Anaes.) (Assist.)	$1043.40
37040	Bladder stress incontinence, sling procedure for, using a non-adjustable synthetic male sling system, other than a service associated with a service to which item 30405 or 37042 applies (Anaes.) (Assist.)	$1456.80
37041	BLADDER ASPIRATION by needle	$89.60
37042	Bladder stress incontinence, sling procedure for, using autologous fascial sling, including harvesting of sling, other than a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.)	$1752.20
37043	Bladder stress incontinence, Stamey or similar type needle colposuspension, other than a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.)	$1306.20
37044	Bladder stress incontinence, suprapubic procedure for, eg Burch colposuspension,other than a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.)	$1346.50
37045	Continent catheterisation bladder stomas (eg. mitrofanoff), formation of (Anaes.) (Assist.)	$2756.10
37046	Suprapubic or perineal procedure for excision of graft material, either singly or in multiple pieces, for a symptomatic patient with graft related complications (including graft related pain or discharge and bleeding related to graft exposure), if not more than one service to which this item applies has been provided to the patient by the same practitioner in the preceding 12 months (Anaes.) (Assist.)	$1071.10
37047	BLADDER ENLARGEMENT using intestine (Anaes.) (Assist.)	$3247.90
37048	Bladder neck closure for the management of urinary incontinence (Anaes.) (Assist.)	$1430.40
37050	BLADDER EXSTROPHY CLOSURE, not involving sphincter reconstruction (Anaes.) (Assist.)	$1444.50
37053	BLADDER TRANSECTION AND RE-ANASTOMOSIS TO TRIGONE (Anaes.) (Assist.)	$1555.80
37200	Prostatectomy, by open, laparoscopic or robot-assisted approach (Anaes.) (Assist.)	$2095.00

Item no.	Description	Max fee (excl. GST)
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.)	$755.50
37203	Prostatectomy, transurethral resection using cautery, 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 other ablative techniques: (a) with or without cystoscopy and with or without urethroscopy; and (b) including services to which one or more of items36854, 37303, 37321 and 37324 apply; continuation, within 10 days, of treatment of benign prostatic hyperplasia that 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, 37303, 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.)	$808.60
37209	PROSTATE, and/or SEMINAL VESICLE/AMPULLA OF VAS, unilateral or bilateral, total excision of, not being a service associated with a service to which item number 37210 or 37211 applies (Anaes.) (Assist.)	$2665.00
37210	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated) with or without bladder neck reconstruction, other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.)	$3275.00
37211	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated): (a) with or without bladder neck reconstruction; and (b) with pelvic lymphadenectomy; other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.)	$3980.00
37213	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated): (a) complicated by: (i) previous radiation therapy (including brachytherapy) on the prostate; or (ii) previous ablative procedures on the prostate; and (b) with bladder neck reconstruction; other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.)	$3697.00
37214	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated): (a) complicated by: (i) previous radiation therapy (including brachytherapy) on the prostate; or (ii) previous ablative procedures on the prostate; and (b) with bladder neck reconstruction and pelvic lymphadenectomy; other than a service associated with a service to which item30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.)	$4490.60
37215	Prostate, biopsy of, endoscopic, with or without cystoscopy (Anaes.)	$800.10
37216	Prostate or prostatic bed, needle biopsy of, by the transrectal route, using prostatic ultrasound guidance and obtaining one or more prostatic specimens, being a service associated with a service to which item 55603 applies (Anaes.)	$217.30
37217	Prostate, implantation of radio-opaque fiducial markers into the prostate gland or prostate surgical bed, under ultrasound guidance, being an item associated with a service to which item 55603 applies (Anaes.)	$247.00
37218	Prostate, injection into, one or more, excluding insertion of fiduciary markers (Anaes.)	$265.00
37219	Prostate or prostatic bed, needle biopsy of, by the transperineal route, using prostatic ultrasound guidance and obtaining one or more prostatic specimens, being a service associated with a service to which item 55600 or 55603 applies (Anaes.)	$537.80
37220	Prostate, radioactive seed implantation of, urological component, using transrectal ultrasound guidance: (a) for a patient with: (i) localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate); and (ii) a Gleason score of less than or equal to 7 (Grade Group 1 to Grade Group 3); and (iii) a prostate specific antigen (PSA) of not more than 10ng/ml at the time of diagnosis; and (b) performed by a urologist at an approved site in association with a radiation oncologist; and (c) being a service associated with: (i) services to which items 15338 and 55603 apply; and (ii) a service to which item 60506 or 60509 applies (Anaes.)	$2185.00
37221	Prostatic abscess, endoscopic drainage of (Anaes.)	$950.00

Item no.	Description	Max fee (excl. GST)
37223	Prostatic coil, insertion of, under ultrasound control (Anaes.)	$403.10
37224	Prostate, diathermy or cauterisation,other than a service associated with a service to which item 37201, 37202, 37203, 37206, 37207, 37208 or 37215 applies (Anaes.)	$627.00
37226	Prostate or prostatic bed, needle biopsy of, using prostatic magnetic resonance imaging techniques and obtaining 1 or more prostatic specimens. (Anaes.) (Anaes.)	$428.00
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, ablation by electrocautery or high-energy transurethral microwave thermotherapy, with or without cystoscopy and with or without urethroscopy (Anaes.)	$2380.00
37233	Prostate, ablation by electrocautery or high-energy transurethral microwave thermotherapy, with or without cystoscopy and with or without urethroscopy, continuation, within 10 days, of a urological procedure of the prostate that had to be discontinued for medical reasons (Anaes.)	$1008.40
37245	Prostate, endoscopic enucleation of, for the treatment of benign prostatic hyperplasia: (a) with morcellation, including mechanical morcellation or by an endoscopic technique; and (b) with or without cystoscopy; and (c) with or without urethroscopy; and other than a service associated with a service to which item 36827, 36854, 37008, 37201, 37202, 37203, 37206, 37207, 37208, 37303, 37321 or 37324 applies (Anaes.)	$2222.50
37300	Urethral sounds, passage of, as an independent procedure (Anaes.)	$89.70
37303	Urethral stricture, dilatation of (Anaes.)	$141.90
37306	URETHRA, repair of rupture of distal section (Anaes.) (Assist.)	$1251.00
37309	URETHRA, repair of rupture of prostatic or membranous segment (Anaes.) (Assist.)	$1783.60
37318	Urethroscopy, with or without cystoscopy, with one or more of biopsy, diathermy, visual laser destruction of urethral calculi or removal of foreign body or calculi (Anaes.)	$530.30
37321	Urethral meatotomy, external (Anaes.)	$180.10
37324	Urethrotomy or urethrostomy, internal or external (Anaes.) (Assist.)	$440.00
37327	URETHROTOMY, optical, for urethral stricture (Anaes.) (Assist.)	$619.30
37330	URETHRECTOMY, partial or complete, for removal of tumour (Anaes.) (Assist.)	$1243.70
37333	URETHROVAGINAL FISTULA, closure of (Anaes.) (Assist.)	$1013.50
37336	URETHRORECTAL FISTULA, closure of (Anaes.) (Assist.)	$1444.50
37338	Urethral synthetic male sling system, division or removal of, for urethral obstruction, sling erosion, pain or infection, following previous surgery for urinary incontinence, other than a service associated with a service to which item 37340 or 37341 applies (Anaes.) (Assist.)	$1456.80
37339	Periurethral or transurethral injection of urethral bulking agents for the treatment of urinary incontinence, including cystoscopy and urethroscopy, other than a service associated with a service to which item 18375 or 18379 applies (Anaes.)	$461.30
37340	Urethral synthetic sling, division or removal of, for urethral obstruction, sling erosion, pain or infection following previous surgery for urinary incontinence, vaginal approach, other than a service associated with a service to which item 37341 or 37344 applies (Anaes.) (Assist.)	$820.10
37341	Urethral sling, division or removal of, for urethral obstruction, sling erosion, pain or infection following previous surgery for urinary incontinence, suprapubic, combined suprapubic and vaginal or combined suprapubic and perineal approach, other than a service associated with a service to which item 37340 or 37344 applies (Anaes.) (Assist.)	$1745.00
37342	URETHROPLASTYsingle stage operation (Anaes.) (Assist.)	$1715.00
37343	URETHROPLASTY, single stage operation, transpubic approach via separate incisions above and below the symphysis pubis, excluding laparotomy, symphysectomy and suprapubic cystotomy, with or without re-routing of the urethra around the crura (Anaes.) (Assist.)	$2666.00
37344	Urethral autologous fascial sling (or other biological sling), division or removal of, for urethral obstruction, sling erosion, pain or infection following previous surgery for urinary incontinence, vaginal approach, other than a service to which 37340 or 37341 applies (Anaes.) (Assist.)	$1409.70
37345	URETHROPLASTY2 stage operationfirst stage (Anaes.) (Assist.)	$1430.00
37348	URETHROPLASTY2 stage operationsecond stage (Anaes.) (Assist.)	$1430.00
37351	URETHROPLASTY, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$536.90
37354	HYPOSPADIAS, meatotomy and hemicircumcision (Anaes.) (Assist.)	$670.00
37369	Urethra, excision of prolapse of (Anaes.)	$362.40
37372	URETHRAL DIVERTICULUM, excision of (Anaes.) (Assist.)	$904.80

Item no.	Description	Max fee (excl. GST)
37375	URETHRAL SPHINCTER, reconstruction by bladder tubularisation technique or similar procedure (Anaes.) (Assist.)	$2380.00
37381	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, perineal approach (Anaes.) (Assist.)	$1525.00
37384	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, abdominal approach (Anaes.) (Assist.)	$2380.00
37387	ARTIFICIAL URINARY SPHINCTER, insertion of pressure regulating balloon and pump (Anaes.) (Assist.)	$665.00
37388	Artificial urinary sphincter, sterile, percutaneous adjustment of filling volume	$151.50
37390	ARTIFICIAL URINARY SPHINCTER, revision or removal of, with or without replacement (Anaes.) (Assist.)	$1771.40
37393	PRIAPISM, decompression by glanular stab cavernosospongiosum 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 (Anaes.) (Assist.)	$1346.80
37402	PENIS, partial amputation of (Anaes.) (Assist.)	$950.00
37405	PENIS, complete or radical amputation of (Anaes.) (Assist.)	$1905.00
37408	PENIS, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.)	$950.00
37411	PENIS, repair of avulsion (Anaes.) (Assist.)	$1679.20
37415	Penis, injection of, for the investigation and treatment of erectile dysfunction. Applicable not more than twice in a 36 month period	$90.30
37417	Penis, correction of chordee by plication techniques including Nesbit s corporoplasty (Anaes.) (Assist.)	$1140.00
37418	Penis, correction of chordee with incision or excision of fibrous plaque or plaques, with or without mobilisation of one or both of the neuro-vascular bundle and urethra (Anaes.) (Assist.)	$1525.00
37423	Penis, lengthening by translocation of corpora, in conjunction with partial penectomy or penile epispadias secondary repair, either as primary or secondary procedures (Anaes.) (Assist.)	$1905.00
37426	PENIS, artificial erection device, insertion of, into 1 or both corpora (Anaes.) (Assist.)	$2000.00
37429	PENIS, artificial erection device, insertion of pump and pressure regulating reservoir (Anaes.) (Assist.)	$665.00
37432	PENIS, artificial erection device, complete or partial revision or removal of components, with or without replacement (Anaes.) (Assist.)	$1769.80
37435	Penis, frenuloplasty as an independent procedure (Anaes.)	$190.00
37438	Scrotum, partial excision of, for histologically proven malignancy or infection (Anaes.) (Assist.)	$533.40
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 or bilateral, other than a service associated with sperm harvesting for IVF (Anaes.)	$565.00
37605	Transcutaneous sperm retrieval, unilateral, from either the testis or the epididymis, for the purposes ofintracytoplasmic sperm injection, for male factor infertility, excluding a service to which item 13218 applies. (Anaes.)	$715.50
37606	Open surgical sperm retrieval, unilateral, including the exploration of scrotal contents, with our without biopsy, for the purposes of intracytoplasmic sperm injection, for male factor infertility, performed in a hospital, excluding a service to which item13218 or 37604 applies. (Anaes.)	$1062.70
37607	Bilateral retroperitoneal lymph node dissection, for testicular tumour, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$1778.80
37610	Bilateral retroperitoneal lymph node dissection, for testicular tumour, following previous similar retroperitoneal dissection, retroperitoneal radiation therapy or chemotherapy, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.)	$2700.20
37613	Epididymectomy (Anaes.)	$570.00
37616	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, using operating microscope, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.)	$2050.50
37619	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.)	$1176.10
37623	VASOTOMY OR VASECTOMY, unilateral or bilateral NOTE:Strict legal requirements apply in relation to sterilisation procedures on minors.Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law.Observe the explanatory note before submitting a claim. (Anaes.)	$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.)	$1105.90

Item no.	Description	Max fee (excl. GST)
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.)	$1105.90
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.)	$1177.80
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.)	$1277.80
37809	Undescended testis, revision orchidopexy for, on a person 10 years of age or over. (Anaes.) (Assist.)	$1148.60
37810	Undescended testis, revision orchidopexy for, on a person under 10 years of age (Anaes.) (Assist.)	$1277.80
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.)	$1179.70
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.)	$196.90
37818	Hypospadias, glanuloplasty incorporating meatal advancement, on a person 10 years of age or over (Anaes.) (Assist.)	$906.40
37819	Hypospadias, glanuloplasty incorporating meatal advancement, on a person under 10 years of age (Anaes.) (Assist.)	$1042.80
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.)	$1767.60
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.)	$2457.50
37827	Hypospadias, staged repair, first stage, on a person 10 years of age or over. (Anaes.) (Assist.)	$964.00
37828	Hypospadias, staged repair, first stage, on a person under 10 years of age (Anaes.) (Assist.)	$1132.30
37830	HYPOSPADIAS, staged repair, second stage, on a person 10 years of age or over. (Anaes.) (Assist.)	$1249.20
37831	HYPOSPADIAS, staged repair, second stage, on a person under 10 years of age. (Anaes.) (Assist.)	$1467.10
37833	Hypospadias, repair of urethral fistula, on a person 10 years of age or over (Anaes.) (Assist.)	$668.60
37834	Hypospadias, repair of urethral fistula, on a person under 10 years of age (Anaes.) (Assist.)	$700.00
37836	EPISPADIAS, staged repair, first stage (Anaes.) (Assist.)	$1255.90
37839	EPISPADIAS, staged repair, second stage (Anaes.) (Assist.)	$1423.10
37842	Exstrophy of bladder or epispadias, primary or secondary repair with or without bladder neck tightening, with or without ureteric reimplantation (Anaes.) (Assist.)	$2940.90
37845	Congenital disorder of sexual differentiation with urogenital sinus, external genitoplasty, with or without endoscopy (Anaes.) (Assist.)	$1255.90
37848	Congenital disorder of sexual differentiation with urogenital sinus, external genitoplasty with endoscopy and vaginoplasty (Anaes.) (Assist.)	$2260.20
37851	Congenital disorder of sexual differentiation, vaginoplasty for, with or without endoscopy (Anaes.) (Assist.)	$1674.40
37854	Urethral valve, destruction of, including cystoscopy and urethroscopy (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.)	$778.10
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.)	$998.50
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

Item no.	Description	Max fee (excl. GST)
38209	CARDIAC ELECTROPHYSIOLOGICAL STUDYup to and including 3 catheter investigation of any 1 or more ofsyncope, 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.)	$1356.10
38212	CARDIAC ELECTROPHYSIOLOGICAL STUDY4 or more catheter supraventricular tachycardia investigation; or complex tachycardia inductions, or multiple catheter mapping, or acute intravenous antiarrhythmic drug testing with pre and post drug inductions; or catheter ablation to intentionally induce complete AV block; or intraoperative mapping; or electrophysiological services during defibrillator implantationnot being a service associated with a service to which item 38209 or 38213 applies (Anaes.)	$2320.40
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 associated with a service to which item 38215, 38218, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)	$340.80
38222	SELECTIVE CORONARY GRAFT ANGIOGRAPHY, placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)	$644.30
38225	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)	$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 (Anaes.)	$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 (Anaes.)	$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 (Anaes.)	$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 (Anaes.)	$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 (Anaes.)	$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 (Anaes.)	$858.90

Item no.	Description	Max fee (excl. GST)
38246	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography followed by placement of catheters prior to any coronary interventional procedure, not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38243 applies (Anaes.)	$1704.40
38256	Temporary transvenous pacemaking electrode, insertion of (Anaes.)	$473.80
38270	BALLOON VALVULOPLASTY OR ISOLATED ATRIAL SEPTOSTOMY, including cardiac catheterisations before and after balloon dilatation (Anaes.) (Assist.)	$1786.60
38272	ATRIAL SEPTAL DEFECT closure, with septal occluder or other similar device, by transcatheter approach (Anaes.) (Assist.)	$1766.80
38273	Patent ductus arteriosus, transcatheter closure of, including cardiac catheterisation and any imaging associated with the service (Anaes.) (Assist.)	$1523.30
38274	Ventricular septal defect, transcatheter closure of, with imaging and cardiac catheterisation (Anaes.) (Assist.)	$1523.30
38275	Myocardial biopsy, by cardiac catheterisation (Anaes.)	$575.20
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.)	$1435.40
38285	IMPLANTABLE ECG LOOP RECORDER, insertion of, for diagnosis of primary disorder in patients with recurrent unexplained syncope where: -a diagnosis has not been achieved through all other available cardiac investigations; and -a neurogenic cause is not suspected; and -it has been determined that the patient does not have structural heart disease associated with a high risk of sudden cardiac death. including initial programming and testing, as an admitted patient in an approved hospital (Anaes.)	$334.60
38286	IMPLANTABLE ECG LOOP RECORDER, removal of, as an admitted patient in an approved hospital (Anaes.)	$303.70
38287	ABLATION OF ARRHYTHMIA CIRCUIT OR FOCUS or isolation procedure involving 1 atrial chamber (Anaes.) (Assist.)	$4056.30
38288	Implantable loop recorder, insertion of, for diagnosis of atrial fibrillation, if: (a) the patient to whom the service is provided has been diagnosed as having had an embolic stroke of undetermined source; and (b) the bases of the diagnosis included the following: (i) the medical history of the patient; (ii) physical examination; (iii) brain and carotid imaging; (iv) cardiac imaging; (v) surface ECG testing including 24 hour Holter monitoring; and (c) atrial fibrillation is suspected; and (d) the patient: (i) does not have a permanent indication for oral anticoagulants; or (ii) does not have a permanent oral anticoagulants contraindication; including initial programming and testing (Anaes.)	$303.50
38290	ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Anaes.) (Assist.)	$5162.50
38293	VENTRICULAR ARRHYTHMIA with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes.) (Assist.)	$5543.80
38300	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1272.70
38306	Transluminal insertion of stent or stents into one occlusional site, including associated balloon dilatation of coronary artery, percutaneous or by open exposure, excluding associated radiological services, radiological preparation and after care (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1678.00
38312	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of 1 coronary artery, including balloon angioplasty with insertion of 1 or more stents, where: -no lesion of the coronary artery has been stented; and -each lesion of the coronary artery is complex and heavily calcified; and -balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	$2096.10

Item no.	Description	Max fee (excl. GST)
38315	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty with no stent insertion, where: -no lesion of the coronary arteries has been stented; and -each lesion of the coronary arteries is complex and heavily calcified; and -balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	$2369.10
38318	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty, with insertion of 1 or more stents, where: -no lesion of the coronary arteries has been stented; and -each lesion of the coronary arteries is complex and heavily calcified; and -balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	$2971.10
38350	Single chamber permanent transvenous electrode, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.)	$1150.00
38353	Permanent cardiac pacemaker, insertion, removal or replacement of, not for cardiac resynchronisation therapy, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.)	$481.40
38356	Dual chamber permanent transvenous electrodes, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.)	$1502.50
38358	Extraction of chronically implanted transvenous pacing or defibrillator lead or leads, by percutaneous method where the leads have been in situ for greater than six months and require removal with locking stylets, snares and/or extraction sheaths in a facility where cardiac surgery is available, in association with item 61109 or 60509 (Anaes.) (Assist.)	$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
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 associatedwith a service to which item 38213 applies (Anaes.) (Assist.)	$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—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 associatedwith a service to which item 38213 applies, not for defibrillators capable of cardiac resynchronisation therapy (Anaes.) (Assist.)	$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 associatedwith a service to which item 38213 applies (Anaes.) (Assist.)	$2036.20

Item no.	Description	Max fee (excl. GST)
38393	AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of for—not for patients with heart failure or as primaryprevention for tachycardia arrhythmias. Not being a service associated with a service to which item 38213 applies. (Anaes.) (Assist.)	$558.90
38415	EMPYEMA, radical operation for, involving resection of rib (Anaes.) (Assist.)	$765.10
38416	Endoscopic ultrasound guided fine needle aspiration biopsy or biopsies (endoscopy with ultrasound imaging) to obtain one or more specimens from either or both of the following: (a) mediastinal masses; (b) locoregional nodes to stage non-small cell lung carcinoma; other than a service associated with a service to which an item in Subgroup 1 of this Group, or item 38417 or 55054, applies (Anaes.)	$999.60
38417	Endobronchial ultrasound guided biopsy or biopsies (bronchoscopy with ultrasound imaging, with or without associated fluoroscopic imaging) to obtain one or more specimens by: (a) transbronchial biopsy or biopsies of peripheral lung lesions; or (b) fine needle aspirations of one or more mediastinal masses; or (c) fine needle aspirations of locoregional nodes to stage non-small cell lung carcinoma; other than a service associated with a service to which an item in Subgroup 1 of this Group, item 38416, 38420 or 38423, or an item in Subgroup I5 of Group I3, applies (Anaes.)	$999.60
38418	THORACOTOMY, exploratory, with or without biopsy (Anaes.) (Assist.)	$1856.80
38419	Bronchoscopy, as an independent procedure (Anaes.)	$341.70
38420	Bronchoscopy with one or more endobronchial biopsies or other diagnostic or therapeutic procedures (Anaes.)	$450.30
38421	THORACOTOMY, with pulmonary decortication (Anaes.) (Assist.)	$2999.60
38422	Bronchus, removal of foreign body in (Anaes.) (Assist.)	$719.80
38423	Fibreoptic bronchoscopy with one or more transbronchial lung biopsies, with or without bronchial or broncho-alveolar lavage, with or without the use of interventional imaging (Anaes.) (Assist.)	$491.80
38424	THORACOTOMY, with pleurectomy or pleurodesis, OR ENUCLEATION OF HYDATID cysts (Anaes.) (Assist.)	$1841.00
38425	Endoscopic laser resection of endobronchial tumours for relief of obstruction including any associated endoscopic procedures (Anaes.) (Assist.)	$1164.10
38426	Trachea or bronchus, dilatation of stricture and endoscopic insertion of stent (Anaes.) (Assist.)	$838.80
38427	THORACOPLASTY (complete)—3 or more ribs (Anaes.) (Assist.)	$2265.90
38430	THORACOPLASTY (in stages)each stage (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2935.50
38440	LUNG, wedge resection of (Anaes.) (Assist.)	$2248.30
38441	RADICAL LOBECTOMY or PNEUMONECTOMY including resection of chest wall, diaphragm, pericardium, or formal mediastinal node dissection (Anaes.) (Assist.)	$3480.80
38446	THORACOTOMY or STERNOTOMY, for removal of thymus or mediastinal tumour (Anaes.) (Assist.)	$2264.70
38447	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (Anaes.) (Assist.)	$2941.10
38448	MEDIASTINUM, cervical exploration of, with or without biopsy (Anaes.) (Assist.)	$773.40
38449	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass (Anaes.) (Assist.)	$4100.90
38450	PERICARDIUM, transthoracic open surgical drainage of (Anaes.) (Assist.)	$1675.80
38452	PERICARDIUM, subxiphoid open surgical drainage of (Anaes.) (Assist.)	$1111.20
38453	TRACHEAL excision and repair without cardiopulmonary bypass (Anaes.) (Assist.)	$3303.10
38455	TRACHEAL EXCISION AND REPAIR OF, with cardiopulmonary bypass (Anaes.) (Assist.)	$4227.20
38456	INTRATHORACIC OPERATION on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than 1 of those organs, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$2958.40
38457	PECTUS EXCAVATUM or PECTUS CARINATUM, repair or radical correction of (Anaes.) (Assist.)	$2770.30
38458	PECTUS EXCAVATUM, repair of, with implantation of subcutaneous prosthesis (Anaes.) (Assist.)	$1620.00
38460	STERNAL WIRE 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

Item no.	Description	Max fee (excl. GST)
38466	STERNUM, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring (Anaes.) (Assist.)	$1849.00
38468	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps or greater omentum (Anaes.) (Assist.)	$2852.00
38469	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps and greater omentum (Anaes.) (Assist.)	$3125.20
38470	PERMANENT MYOCARDIAL ELECTRODE, insertion of, by thoracotomy or sternotomy (Anaes.) (Assist.)	$1839.70
38473	PERMANENT PACEMAKER ELECTRODE, insertion by open surgical approach (Anaes.) (Assist.)	$1119.10
38475	VALVE ANNULOPLASTY without insertion of ring, not being a service associated with a service to which item 38480 or 38481 applies (Anaes.) (Assist.)	$1599.20
38477	VALVE ANNULOPLASTY with insertion of ring not being a service to which item 38478 applies (Anaes.) (Assist.)	$3852.00
38478	VALVE ANNULOPLASTY with insertion of ring performed in conjunction with item 38480 or 38481 (Anaes.) (Assist.)	$1865.70
38480	VALVE REPAIR, 1 leaflet (Anaes.) (Assist.)	$3844.60
38481	VALVE REPAIR, 2 or more leaflets (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$3125.20
38485	MITRAL ANNULUS, reconstruction of, after decalcification, when performed in association with valve surgery (Anaes.) (Assist.)	$1568.40
38487	MITRAL VALVE, open valvotomy of (Anaes.) (Assist.)	$3125.20
38488	VALVE REPLACEMENT with BIOPROSTHESIS OR MECHANICAL PROSTHESIS (Anaes.) (Assist.)	$3663.60
38489	VALVE REPLACEMENT with allograft (subcoronary or cylindrical implant), or unstented xenograft (Anaes.) (Assist.)	$4389.10
38490	SUB-VALVULAR STRUCTURES, reconstruction and re-implantation of, associated with mitral and tricuspid valve replacement (Anaes.) (Assist.)	$1063.70
38493	OPERATIVE MANAGEMENT of acute infective endocarditis, in association with heart valve surgery (Anaes.) (Assist.)	$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.)	$2253.30
38496	ARTERY HARVESTING (other than internal mammary), for coronary artery bypass (Anaes.) (Assist.)	$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 asociated with a service to which items 38498, 38500, 38501, 38503 or 38504 apply (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 38600 apply (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$4597.80

Item no.	Description	Max fee (excl. GST)
38504	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38498, 38500, 38501, 38503 or 38600 apply (Anaes.) (Assist.)	$4584.60
38505	CORONARY ENDARTERECTOMY, by open operation, including repair with 1 or more patch grafts, each vessel (Anaes.) (Assist.)	$554.00
38506	LEFT VENTRICULAR ANEURYSM, plication of (Anaes.) (Assist.)	$2953.40
38507	LEFT VENTRICULAR ANEURYSM resection with primary repair (Anaes.) (Assist.)	$3699.10
38508	LEFT VENTRICULAR ANEURYSM resection with patch reconstruction of the left ventricle (Anaes.) (Assist.)	$4621.60
38509	ISCHAEMIC VENTRICULAR SEPTAL RUPTURE, repair of (Anaes.) (Assist.)	$4674.60
38512	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving 1 atrial chamber only (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$5151.60
38518	VENTRICULAR ARRHYTHMIA with mapping and muscle ablation, with or without aneurysmeotomy (Anaes.) (Assist.)	$5614.50
38550	ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.)	$3994.40
38553	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.)	$5249.30
38556	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.)	$6052.40
38559	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.)	$4846.10
38562	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.)	$5995.40
38565	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.)	$6735.20
38568	DESCENDING THORACIC AORTA, repair or replacement of, without shunt or cardiopulmonary bypass, by open exposure, percutaneous or endovascular means (Anaes.) (Assist.)	$3609.10
38571	DESCENDING THORACIC AORTA, repair or replacement of, using shunt or cardiopulmonary bypass (Anaes.) (Assist.)	$3791.80
38572	OPERATIVE MANAGEMENT OF ACUTE RUPTURE OR DISSECTION, in conjunction with procedures on the thoracic aorta (Anaes.) (Assist.)	$3853.00
38577	CANNULATION FOR, and supervision and monitoring of, the administration of retrograde 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 (Anaes.) (Assist.)	$2999.40
38603	PERIPHERAL CANNULATION for cardiopulmonary bypass excluding post-operative management (Anaes.) (Assist.)	$1855.60
38609	INTRA-AORTIC BALLOON PUMP, insertion of, by arteriotomy (Anaes.) (Assist.)	$921.60
38612	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by direct suture (Anaes.) (Assist.)	$975.20
38613	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by patch graft (Anaes.) (Assist.)	$1224.20
38615	Insertion of a left or right ventricular assist device, for use as: (a) a bridge to cardiac transplantation in patients with refractory heart failure who are: (i) currently on a heart transplant waiting list, or (ii) expected to be suitable candidates for cardiac transplantation following a period of support on the ventricular assist device; or (b) acute post cardiotomy support for failure to wean from cardiopulmonary transplantation; or (c) cardio-respiratory support for acute cardiac failure which is likely to recover with short term support of less than 6 weeks; not being a service associated with the use of a ventricular assist device as destination therapy in the management of patients with heart failure who are not expected to be suitable candidates for cardiac transplantation (Anaes.) (Assist.)	$2999.40

Item no.	Description	Max fee (excl. GST)
38618	Insertion of a left and right ventricular assist device, for use as: (a) a bridge to cardiac transplantation in patients with refractory heart failure who are: (i) currently on a heart transplant waiting list, or (ii) expected to be suitable candidates for cardiac transplantation following a period of support on the ventricular assist device; or (b) acute post cardiotomy support for failure to wean from cardiopulmonary transplantation; or (c) cardio-respiratory support for acute cardiac failure which is likely to recover with short term support of less than 6 weeks; not being a service associated with the use of a ventricular assist device as destination therapy in the management of patients with heart failure who are not expected to be suitable candidates for cardiac transplantation (Anaes.) (Assist.)	$3734.60
38621	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.)	$1483.10
38624	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.)	$1674.70
38627	EXTRA-CORPOREAL MEMBRANE OXYGENATION, BYPASS OR VENTRICULAR ASSIST DEVICE CANNULAE, adjustment and re-positioning of, by open operation, in patients supported by these devices (Anaes.) (Assist.)	$1353.60
38637	PATENT DISEASED coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of (Anaes.) (Assist.)	$1086.80
38640	RE-OPERATION via median sternotomy, for any procedure, including any divisions of adhesions where the time taken to divide the adhesions is 45 minutes or less (Anaes.) (Assist.)	$1835.50
38643	THORACOTOMY OR STERNOTOMY involving division of adhesions where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.)	$2052.00
38647	THORACOTOMY OR STERNOTOMY involving division of extensive adhesions where the time taken to divide the adhesions exceeds 2 hours (Anaes.) (Assist.)	$4173.00
38650	MYOMECTOMY or MYOTOMY for hypertrophic obstructive cardiomyopathy (Anaes.) (Assist.)	$3735.40
38653	OPEN HEART SURGERY, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$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 chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 120 ms; or (b) has: (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and (ii)sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 150 ms; or (c)satisfied the requirements mentioned in paragraph (a) or (b) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode (Anaes.) (Assist.)	$2364.60
38656	THORACOTOMY or median sternotomy for post-operative bleeding (Anaes.) (Assist.)	$1841.40
38670	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, without patch or conduit reconstruction (Anaes.) (Assist.)	$3689.90
38673	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit (Anaes.) (Assist.)	$4158.20
38677	CARDIAC TUMOUR arising from ventricular myocardium, partial thickness excision of (Anaes.) (Assist.)	$3931.20
38680	CARDIAC TUMOUR arising from ventricular myocardium, full thickness excision of including repair or reconstruction (Anaes.) (Assist.)	$4663.20
38700	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)	$2041.30
38703	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)	$3768.80
38706	AORTA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)	$3563.30
38709	AORTA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)	$4179.70
38712	AORTIC INTERRUPTION, repair of, for congenital heart disease (Anaes.) (Assist.)	$4960.00
38715	MAIN PULMONARY ARTERY, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)	$3098.60
38718	MAIN PULMONARY ARTERY, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)	$4112.10
38721	VENA CAVA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)	$2924.70
38724	VENA CAVA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)	$4179.70

Item no.	Description	Max fee (excl. GST)
38727	INTRATHORACIC VESSELS, anastomosis or repair of, without cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Anaes.) (Assist.)	$2932.00
38730	INTRATHORACIC VESSELS, anastomosis or repair of, with cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Anaes.) (Assist.)	$4179.70
38733	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)	$2716.30
38736	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)	$3876.50
38739	ATRIAL SEPTECTOMY, with or without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)	$3494.40
38742	ATRIAL SEPTAL DEFECT, closure by open exposure direct suture or patch, for congenital heart disease (Anaes.) (Assist.)	$3695.80
38745	INTRA-ATRIAL BAFFLE, insertion of, for congenital heart disease (Anaes.) (Assist.)	$4091.50
38748	VENTRICULAR SEPTECTOMY, for congenital heart disease (Anaes.) (Assist.)	$4405.00
38751	Ventricular septal defect, closure by direct suture or patch (Anaes.) (Assist.)	$4116.30
38754	INTRAVENTRICULAR BAFFLE OR CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.)	$4852.80
38757	EXTRACARDIAC CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.)	$4405.00
38760	EXTRACARDIAC CONDUIT, replacement of, for congenital heart disease (Anaes.) (Assist.)	$3876.50
38763	VENTRICULAR MYECTOMY, for relief of ventricular obstruction, right or left, for congenital heart disease (Anaes.) (Assist.)	$4101.10
38766	VENTRICULAR AUGMENTATION, right or left, for congenital heart disease (Anaes.) (Assist.)	$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	$150.50
38806	INTERCOSTAL DRAIN, insertion of, not involving resection of rib (excluding aftercare) (Anaes.)	$257.90
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
39007	Procedure to obtain access to intracranial space (including subdural space, ventricle or basal cistern), percutaneously or by burr-hole (Anaes.)	$246.60
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	Intracranial parenchymal pressure monitoring device, insertion of including burr hole (excluding after care) (Anaes.)	$721.00
39018	Cerebrospinal reservoir, ventricular reservoir or external ventricular drain, insertion of, with or without stereotaxy (Anaes.) (Assist.)	$722.90
39100	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.)	$431.60
39109	Trigeminal gangliotomy by radiofrequency, balloon or glycerol, including stereotaxy (Anaes.) (Assist.)	$1022.10
39113	Cranial nerve, neurectomy or intracranial decompression of, using microsurgical techniques, including stereotaxy and cranioplasty (Anaes.) (Assist.)	$3678.60
39115	PERCUTANEOUS NEUROTOMY of posterior divisions (or rami) of spinal nerves by any method, including any associated spinal, epidural or regional nerve block (payable once only in a 30 day period) (Anaes.)	$180.20
39118	PERCUTANEOUS NEUROTOMY for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.) (Assist.)	$570.30
39121	PERCUTANEOUS CORDOTOMY (Anaes.) (Assist.)	$1147.20
39124	CORDOTOMY OR MYELOTOMY, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes.) (Assist.)	$3775.00

Item no.	Description	Max fee (excl. GST)
39125	Intrathecal or epidural SPINAL CATHETER insertion or replacement of, and connection to a subcutaneous implanted infusion pump, for the management of chronic intractable pain (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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	$239.70
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 (Anaes.) (Assist.)	$659.20
39135	NEUROSTIMULATOR or RECEIVER, that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, removal of, performed in the operating theatre of a hospital (Anaes.)	$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, 39138 or 39139 applies (Anaes.)	$1172.70
39138	PERIPHERAL NERVE LEAD, surgical placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a maximum of 4 leads (Anaes.) (Assist.)	$1295.80
39139	Epidural lead, surgical placement of one or more by partial or total laminectomy, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris to a maximum of 4 leads (H) (Anaes.) (Assist.)	$1961.90
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 (Anaes.) (Assist.)	$676.50
39303	CUTANEOUS NERVE (including digital nerve), secondary repair of, using microsurgical techniques (Anaes.) (Assist.)	$929.90
39306	NERVE TRUNK, primary repair of, using microsurgical techniques (Anaes.) (Assist.)	$1323.90
39309	NERVE TRUNK, secondary repair of, using microsurgical techniques (Anaes.) (Assist.)	$1568.70
39312	NERVE TRUNK, (interfascicular), neurolysis of, using microsurgical techniques (Anaes.) (Assist.)	$815.30
39315	NERVE TRUNK, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.)	$1977.80
39318	CUTANEOUS NERVE (including digital nerve), nerve graft to, using microsurgical techniques (Anaes.) (Assist.)	$1308.70
39321	NERVE, transposition of (Anaes.) (Assist.)	$950.10
39323	PERCUTANEOUS NEUROTOMY by cryotherapy or radiofrequency lesion generator, not being a service to which another item applies (Anaes.) (Assist.)	$530.70
39324	NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve, by open operation (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$946.10
39330	NEUROLYSIS by open operation without transposition, not being a service associated with a service to which item 39312 applies (Anaes.) (Assist.)	$583.00

Item no.	Description	Max fee (excl. GST)
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 (Anaes.) (Assist.)	$764.00
39503	FACIO-HYPOGLOSSAL nerve or FACIO-ACCESSORY nerve, anastomosis of (Anaes.) (Assist.)	$1853.80
39604	Any of the following procedures for intracranial haemorrhage or swelling:(a) craniotomy, craniectomy or burr-holes for removal of intracranial haemorrhage, including stereotaxy;(b) craniotomy or craniectomy for brain swelling, stroke, or raised intracranial pressure, including for subtemporal decompression, including stereotaxy; or(c) post-operative re-opening, including for swelling or post-operative cerebrospinal fluid leak. (Anaes.) (Assist.)	$2774.40
39610	Fractured skull, without brain laceration or dural penetration, repair of (Anaes.) (Assist.)	$1477.30
39612	Fractured skull, with brain laceration or dural penetration but without cerebrospinal fluid, rhinorrhoea or otorrhoea, repair of (Anaes.) (Assist.)	$2270.10
39615	Fractured skull, after trauma, with cerebrospinal fluid rhinorrhoea or otorrhoea, repair of, including stereotaxy and dermofat graft (Anaes.) (Assist.)	$2317.30
39638	Anterior or middle cranial fossa or cavernous sinus, tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty conjoint surgery, principal surgeon (Anaes.) (Assist.)	$6585.20
39639	Anterior or middle cranial fossa or cavernous sinus, tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty conjoint surgery, co surgeon (Assist.)	$5262.30
39641	Anterior or middle cranial fossa or cavernous sinus, tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty—one surgeon (Anaes.) (Assist.)	$6945.80
39651	Petro-clival, clival or foramen magnum tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty—one surgeon (Anaes.) (Assist.)	$8569.30
39654	Petro-clival, clival or foramen magnum tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty conjoint surgery, principal surgeon (Anaes.) (Assist.)	$6630.20
39656	Petro clival, clival or foramen magnum tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty conjoint surgery, co surgeon (Assist.)	$6600.00
39700	Skull tumour, benign or malignant, excision of, including stereotaxy and cranioplasty (Anaes.) (Assist.)	$1232.00
39703	Intracranial tumour, cyst or other brain tissue, either or both of: (a) burr hole and biopsy of; (b) drainage of; including stereotaxy (Anaes.) (Assist.)	$1100.90
39710	Intracranial tumour, one or more, biopsy, drainage, decompression or removal of, through a single craniotomy, including stereotaxy and cranioplasty (Anaes.) (Assist.)	$3748.70
39712	Transcranial tumour removal or biopsy of one or more of any of the following: (a) meningioma; (b) pinealoma; (c) cranio pharyngioma; (d) pituitary tumour; (e) intraventricular lesion; (f) brain stem lesion; (g) any other intracranial tumour; by any means (with or without endoscopy), through a single craniotomy, including stereotaxy and cranioplasty (Anaes.) (Assist.)	$5492.00
39715	Pituitary tumour, removal of, by transphenoidal approach, including stereotaxy and dermis, dermofat or fascia grafting, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.)	$3958.70
39718	Arachnoidal cyst, craniotomy for, including stereotaxy and neuroendoscopy (Anaes.) (Assist.)	$1918.60
39720	Awake craniotomy for functional neurosurgery (Anaes.) (Assist.)	$5356.60
39801	Aneurysm, clipping, proximal ligation, or reinforcement of sac, including stereotaxy and cranioplasty (Anaes.) (Assist.)	$8569.30
39803	Intracranial arteriovenous malformation or fistula, treatment through a craniotomy, including stereotaxy, cranioplasty and all angiography (Anaes.) (Assist.)	$5478.80
39815	CAROTID-CAVERNOUS FISTULA, obliteration of—combined cervical and intracranial procedure (Anaes.) (Assist.)	$3318.40
39818	Intracranial vascular bypass using indirect techniques, including stereotaxy (Anaes.) (Assist.)	$3946.50
39821	Intracranial vascular bypass using direct anastomosis techniques, including stereotaxy (Anaes.) (Assist.)	$4164.90
39900	Intracranial infection, treated by burr hole, including stereotaxy, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.)	$996.30
39903	Intracranial infection, treated by craniotomy, including stereotaxy, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.)	$3039.80
39906	Osteomyelitis of skull or removal of infected bone flap, craniectomy for, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.)	$1544.30
40004	Ventricular, lumbar or cisternal shunt diversion, insertion or revision of, including stereotaxy (Anaes.) (Assist.)	$2559.20

Item no.	Description	Max fee (excl. GST)
40012	Endoscopic ventriculostomy for treatment of cerebrospinal fluid circulation disorders, including stereotaxy (Anaes.) (Assist.)	$1977.10
40018	Lumbar cerebrospinal fluid drain, insertion of (Anaes.)	$309.60
40104	Spinal myelomeningocele or spinal meningocele, excision and closure of, other than a service associated with a service to which item40600 applies (Anaes.) (Assist.)	$1570.40
40106	Chiari malformation, decompression or reconstruction of, including laminectomy, dermofat graft and stereotaxy, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.)	$2655.00
40109	Encephalocoele or cranial meningocele, excision and closure of, including stereotaxy and dermofat graft (Anaes.) (Assist.)	$2855.00
40112	Tethered cord, release of, including lipomeningocele or diastematomyelia, multiple levels, including laminectomy and rhizolysis, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.)	$2794.20
40119	Craniostenosis, operation for, other than a service associated with a service to which item40600 applies (Anaes.) (Assist.)	$1477.30
40600	Cranioplasty, reconstructive, other than a service associated with a service to which item39113, 39638, 39639, 39641, 39651, 39654, 39656, 39700, 39710, 39712, 39715, 39801, 39803 or 40703 applies (Anaes.) (Assist.)	$2063.70
40700	Corpus callosotomy, for epilepsy, including stereotaxy (Anaes.) (Assist.)	$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.)	$535.90
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.)	$250.80
40703	Corticectomy, topectomy or partial lobectomy, for epilepsy, including stereotaxy and cranioplasty (Anaes.) (Assist.)	$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.)	$1060.70
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.)	$952.40
40706	Hemispherectomy or functional hemispherectomy, for intractable epilepsy, including stereotaxy (Anaes.) (Assist.)	$3892.10
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	$298.50
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.)	$535.90
40709	Intracranial electrode placement by burr hole, including stereotaxy (Anaes.) (Assist.)	$1320.00
40712	Intracranial electrode placement by craniotomy, single or multiple, including stereotactic EEG, including stereotaxy (Anaes.) (Assist.)	$2680.00
40801	Functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation, and lesion production, by any method, in the basal ganglia, brain stem or deep white matter tracts, other than a service associated with deep brain stimulation for Parkinson s disease, essential tremor or dystonia (Anaes.) (Assist.)	$4480.00
40803	Intracranial stereotactic procedure by any method, other than: (a) a service to which item40801 applies; or (b) a service associated with a service to which item 39018, 39109, 39113, 39604, 39615, 39638, 39639, 39641, 39651, 39654, 39656, 39700, 39703, 39710, 39712, 39715, 39718, 39720, 39801, 39803, 39818, 39821, 39900, 39903, 40004, 40012, 40106, 40109, 40700, 40703, 40706, 40709 or 40712 applies (Anaes.) (Assist.)	$2334.40
40850	DEEP BRAIN STIMULATION (unilateral) functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability (Anaes.) (Assist.)	$4331.70

Item no.	Description	Max fee (excl. GST)
40851	DEEP BRAIN STIMULATION (bilateral) functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) (Assist.)	$10125.00
40852	DEEP BRAIN STIMULATION (unilateral) subcutaneous placement of neurostimulator receiver or pulse generator for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) (Assist.)	$870.00
40854	DEEP BRAIN STIMULATION (unilateral) revision or removal of brain electrode for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)	$951.10
40856	DEEP BRAIN STIMULATION (unilateral) removal or replacement of neurostimulator receiver or pulse generator for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)	$655.00
40858	DEEP BRAIN STIMULATION (unilateral) placement, removal or replacement of extension leadfor the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)	$1328.80
40860	DEEP BRAIN STIMULATION (unilateral) target localisation incorporating anatomical and physiological techniques, including intra-operative clinical evaluation, for the insertion of a single neurostimulation wire for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)	$4174.10
40862	DEEP BRAIN STIMULATION (unilateral) electronic analysis and programming of neurostimulator pulse generator for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)	$342.80
40905	Craniotomy, performed by a neurosurgeon in conjunction with the correction of craniofacial abnormalities (Anaes.) (Assist.)	$1092.70
	Ear, nose and throat	
41500	EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.)	$149.70
41501	Examination of glottal cycles and vibratory characteristics of the vocal folds by a specialist in the practice of the specialist s specialty of otolaryngology using videostroboscopy, including capturing audio, video, frequency and intensity, for confirmation of diagnosis , or for confirmation of treatment effectiveness where there is failure to progress or respond as expected, for: dysphonia where non stroboscopic techniques of the visualising the larynx have failed to identify any frank abnormality of the vocal folds; or benign or malignant vocal fold lesions; or premalignant or malignant laryngeal lesions; or vocal fold motion impairment or glottal insufficiency; or evaluation of vocal fold function after treatment or phonosurgery other than a service associated with a service to which item 41764 applies or with a services associated with the administration of a general anaesthetic	$282.80
41503	EAR, foreign body in, removal of, 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.)	$295.70
41512	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (Anaes.) (Assist.)	$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, 41557, 41560 or 41563 applies (Anaes.) (Assist.)	$779.60
41518	EXTERNAL AUDITORY MEATUS, removal of EXOSTOSES IN (Anaes.) (Assist.)	$1920.00
41521	Correction of AUDITORY CANAL STENOSIS, including meatoplasty, with or without grafting (Anaes.) (Assist.)	$2020.00
41524	RECONSTRUCTION OF EXTERNAL AUDITORY CANAL, being a service associated with a service to which items 41557, 41560 and 41563 apply (Anaes.) (Assist.)	$585.00
41527	MYRINGOPLASTY, transcanal approach (Rosen incision) (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2190.50

Item no.	Description	Max fee (excl. GST)
41536	ATTICOTOMY with reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.)	$2471.60
41539	OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.)	$2131.00
41542	OSSICULAR CHAIN RECONSTRUCTION AND MYRINGOPLASTY (Anaes.) (Assist.)	$2301.60
41545	MASTOIDECTOMY (CORTICAL) (Anaes.) (Assist.)	$1009.70
41548	OBLITERATION OF THE MASTOID CAVITY (Anaes.) (Assist.)	$1325.00
41551	MASTOIDECTOMY, intact wall technique, with myringoplasty (Anaes.) (Assist.)	$3062.50
41554	MASTOIDECTOMY, intact wall technique, with myringoplasty and ossicular chain reconstruction (Anaes.) (Assist.)	$3807.60
41557	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) (Anaes.) (Assist.)	$2140.00
41560	Mastoidectomy (radical or modified radical) and myringoplasty (Anaes.)	$2317.70
41563	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), MYRINGOPLASTY AND OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$3702.00
41566	REVISION OF MASTOIDECTOMY (radical, modified radical or intact wall), including myringoplasty (Anaes.) (Assist.)	$2091.30
41569	DECOMPRESSION OF FACIAL NERVE in its mastoid portion (Anaes.) (Assist.)	$2286.10
41572	LABYRINTHOTOMY OR DESTRUCTION OF LABYRINTH (Anaes.) (Assist.)	$1983.70
41575	CEREBELLOPONTINE ANGLE TUMOUR, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approachtransmastoid, translabyrinthine or retromastoid procedure (including aftercare) (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$7080.80
41578	CEREBELLOPONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure)—conjoint surgery, principal surgeon (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$5383.50
41584	PARTIAL TEMPORAL BONE RESECTION for removal of tumour involving mastoidectomy with or without decompression of facial nerve (Anaes.) (Assist.)	$3817.30
41587	TOTAL TEMPORAL BONE RESECTION for removal of tumour (Anaes.) (Assist.)	$5029.30
41590	ENDOLYMPHATIC SAC, TRANSMASTOID DECOMPRESSION with or without drainage of (Anaes.) (Assist.)	$2345.00
41593	TRANSLABYRINTHINE VESTIBULAR NERVE SECTION (Anaes.) (Assist.)	$2826.80
41596	RETROLABYRINTHINE VESTIBULAR NERVE SECTION or COCHLEAR NERVE SECTION, or BOTH (Anaes.) (Assist.)	$3465.00
41599	INTERNAL AUDITORY MEATUS, exploration by middle cranial fossa approach with cranial nerve decompression (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2140.00
41611	STAPES MOBILISATION (Anaes.) (Assist.)	$1353.20
41614	ROUND WINDOW SURGERY including repair of cochleotomy (Anaes.) (Assist.)	$2093.10

Item no.	Description	Max fee (excl. GST)
41615	OVAL WINDOW SURGERY, including repair of fistula, not being a service associated with a service to which any other item in this Group applies (Anaes.) (Assist.)	$2095.30
41617	COCHLEAR IMPLANT, insertion of, including mastoidectomy (Anaes.) (Assist.)	$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.)	$2953.00
41620	GLOMUS TUMOUR, transtympanic removal of (Anaes.) (Assist.)	$1584.20
41623	GLOMUS TUMOUR, transmastoid removal of, including mastoidectomy (Anaes.) (Assist.)	$2222.10
41626	ABSCESS OR INFLAMMATION OF MIDDLE EAR, operation for (excluding aftercare) (Anaes.)	$275.80
41629	MIDDLE EAR, EXPLORATION OF (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2216.40
41638	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty with ossicular chain reconstruction (Anaes.) (Assist.)	$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.)	$199.70
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.)	$150.50
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 (Anaes.) (Assist.)	$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.)	$228.30
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 OFeach attendance at which the procedure is performed, including any associated consultation (Anaes.)	$69.80
41707	MAXILLARY ARTERY, transantral ligation of (Anaes.) (Assist.)	$859.60
41710	ANTROSTOMY (RADICAL) (Anaes.) (Assist.)	$1062.60

Item no.	Description	Max fee (excl. GST)
41713	ANTROSTOMY (RADICAL) with transantral ethmoidectomy or transantral vidian neurectomy (Anaes.) (Assist.)	$1163.10
41716	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.)	$569.00
41719	Antrum, drainage of, through tooth socket (Anaes.)	$240.00
41722	OROANTRAL FISTULA, plastic closure of (Anaes.) (Assist.)	$1145.50
41725	ETHMOIDAL ARTERY OR ARTERIES, transorbital ligation of (unilateral) (Anaes.) (Assist.)	$860.90
41728	LATERAL RHINOTOMY with removal of tumour (Anaes.) (Assist.)	$1730.60
41729	DERMOID OF NOSE, excision of, with intranasal extension (Anaes.) (Assist.)	$1092.30
41731	FRONTONASAL ETHMOIDECTOMY by external approach with or without sphenoidectomy (Anaes.) (Assist.)	$1609.80
41734	RADICAL FRONTOETHMOIDECTOMY with osteoplastic flap (Anaes.) (Assist.)	$1963.70
41737	FRONTAL SINUS, OR ETHMOIDAL SINUSES ON THE ONE SIDE, intranasal operation on (Anaes.) (Assist.)	$934.70
41740	Frontal sinus, catheterisation of (Anaes.)	$122.00
41743	FRONTAL SINUS, trephine of (Anaes.) (Assist.)	$649.10
41746	FRONTAL SINUS, radical obliteration of (Anaes.) (Assist.)	$1516.30
41749	ETHMOIDAL SINUSES, external operation on (Anaes.) (Assist.)	$1162.20
41752	SPHENOIDAL SINUS, intranasal operation on (Anaes.) (Assist.)	$571.20
41755	Eustachian tube, catheterisation of (Anaes.)	$85.60
41764	Nasendoscopy or sinoscopy or fibreoptic examination of nasopharynx and larynx, one or more of these procedures, unilateral or bilateral examination (Anaes.)	$233.60
41767	NASOPHARYNGEAL ANGIOFIBROMA, removal of (Anaes.) (Assist.)	$1338.50
41770	PHARYNGEAL POUCH, removal of, with or without cricopharyngeal myotomy (Anaes.) (Assist.)	$1430.00
41773	PHARYNGEAL POUCH, ENDOSCOPIC RESECTION OF (Dohlman's operation) (Anaes.) (Assist.)	$1149.90
41776	CRICOPHARYNGEAL MYOTOMY with or without inversion of pharyngeal pouch (Anaes.) (Assist.)	$1184.80
41779	PHARYNGOTOMY (lateral), with or without total excision of tongue (Anaes.) (Assist.)	$1273.50
41782	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY (Anaes.) (Assist.)	$1912.40
41785	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY with partial or total glossectomy (Anaes.) (Assist.)	$2410.00
41786	UVULOPALATOPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.) (Assist.)	$1488.30
41787	UVULECTOMY AND PARTIAL PALATECTOMY WITH LASER INCISION OF THE PALATE, with or without tonsillectomy, 1 or more stages, including any revision procedures within 12 months (Anaes.) (Assist.)	$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.)	$534.10
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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$683.20
41828	Oesophageal stricture, dilatation of, without oesophagoscopy (Anaes.)	$101.10

Item no.	Description	Max fee (excl. GST)
41831	Oesophagus, endoscopic pneumatic dilatation of,for treatment of achalasia (Anaes.) (Assist.)	$684.20
41832	OESOPHAGUS, balloon dilatation of, using interventional imaging techniques (Anaes.)	$412.90
41834	LARYNGECTOMY (TOTAL) (Anaes.) (Assist.)	$2497.30
41837	VERTICAL HEMILARYNGECTOMY including tracheostomy (Anaes.) (Assist.)	$2416.60
41840	SUPRAGLOTTIC LARYNGECTOMY including tracheostomy (Anaes.) (Assist.)	$2933.80
41843	LARYNGOPHARYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUITY after laryngopharyngectomy USING STOMACH OR BOWEL (Anaes.) (Assist.)	$2573.10
41855	MICROLARYNGOSCOPY (Anaes.) (Assist.)	$636.20
41858	MICROLARYNGOSCOPY with removal of juvenile papillomata (Anaes.) (Assist.)	$966.40
41861	MICROLARYNGOSCOPY with removal of benign lesions of the larynx by laser surgery (Anaes.) (Assist.)	$1235.00
41864	MICROLARYNGOSCOPY WITH REMOVAL OF TUMOUR (Anaes.) (Assist.)	$812.00
41867	MICROLARYNGOSCOPY with arytenoidectomy (Anaes.) (Assist.)	$1186.10
41868	Laryngeal web, division of, using microlarygoscopic techniques (Anaes.)	$747.60
41870	INJECTION OF VOCAL CORD BY TEFLON, FAT, COLLAGEN OR GELFOAM (Anaes.) (Assist.)	$910.00
41873	LARYNX, FRACTURED, operation for (Anaes.) (Assist.)	$1125.00
41876	LARYNX, external operation on, OR LARYNGOFISSURE with or without cordectomy (Anaes.) (Assist.)	$1177.40
41879	LARYNGOPLASTY or TRACHEOPLASTY, including tracheostomy (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$785.30
41884	Cricothyrostomy by direct stab or Seldinger technique, using mini tracheostomy device (Anaes.)	$176.50
41885	TRACHE-OESOPHAGEAL FISTULA, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Anaes.) (Assist.)	$559.10
41886	Trachea, removal of foreign body in (Anaes.)	$341.70
41904	Bronchoscopy with dilatation of tracheal stricture (Anaes.)	$474.40
41907	Nasal septum button, insertion of (Anaes.)	$236.40
41910	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.)	$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
42504	Glaucoma, implantation of a micro-bypass surgery stent system into the trabecular meshwork, if: (a) conservative therapies have failed, are likely to fail, or are contraindicated; and (b) the service is performed by a specialist with training that is recognised by the Conjoint Committee for the Recognition of Training in Micro-Bypass Glaucoma Surgery (Anaes.)	$458.30
42505	Complete removal from the eye of a trans-trabecular drainage device or devices, with or without replacement, following device related medical complications necessitating complete removal. (Anaes.)	$462.70
42506	EYE, ENUCLEATION OF, with or without sphere implant (Anaes.) (Assist.)	$921.40
42509	EYE, ENUCLEATION OF, with insertion of integrated implant (Anaes.) (Assist.)	$1325.00
42510	EYE, enucleation of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes.) (Assist.)	$1480.00
42512	GLOBE, EVISCERATION OF (Anaes.) (Assist.)	$873.90
42515	GLOBE, EVISCERATION OF, AND INSERTION OF INTRASCLERAL BALL OR CARTILAGE (Anaes.) (Assist.)	$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 an existing orbital implant (Anaes.) (Assist.)	$684.70
42521	ANOPHTHALMIC SOCKET, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (Anaes.) (Assist.)	$2299.10
42524	Orbit, skin graft to, as a delayed procedure (Anaes.)	$392.90

Item no.	Description	Max fee (excl. GST)
42527	CONTRACTED SOCKET, RECONSTRUCTION INCLUDING MUCOUS MEMBRANE GRAFTING AND STENT MOULD (Anaes.) (Assist.)	$787.70
42530	ORBIT, EXPLORATION with or without biopsy, requiring REMOVAL OF BONE (Anaes.) (Assist.)	$1325.00
42533	ORBIT, EXPLORATION OF, with drainage or biopsy not requiring removal of bone (Anaes.) (Assist.)	$778.40
42536	ORBIT, EXENTERATION OF, with or without skin graft and with or without temporalis muscle transplant (Anaes.) (Assist.)	$1602.10
42539	ORBIT, EXPLORATION OF, with removal of tumour or foreign body, requiring removal of bone (Anaes.) (Assist.)	$2672.90
42542	ORBIT, exploration of anterior aspect with removal of tumour or foreign body (Anaes.) (Assist.)	$966.90
42543	ORBIT, exploration of retrobulbar aspect with removal of tumour or foreign body (Anaes.) (Assist.)	$1697.80
42545	ORBIT, decompression of, for dysthyroid eye disease, by fenestrationof 2 or more walls, or by the removal of intraorbital peribulbar and retrobulbar fat from each quadrant of the orbit, 1 eye (Anaes.) (Assist.)	$2515.00
42548	OPTIC NERVE MENINGES, incision of (Anaes.) (Assist.)	$1671.40
42551	EYE, PENETRATING WOUND OR RUPTURE OF, not involving intraocular structures repair involving suture of cornea or sclera, or both, not being a service to which item 42632 applies (Anaes.) (Assist.)	$1212.80
42554	EYE, PENETRATING WOUND OR RUPTURE OF, with incarceration or prolapse of uveal tissue repair (Anaes.) (Assist.)	$1414.50
42557	EYE, PENETRATING WOUND OR RUPTURE OF, with incarceration of lens or vitreous repair (Anaes.) (Assist.)	$1977.00
42563	INTRAOCULAR FOREIGN BODY, removal from anterior segment (Anaes.) (Assist.)	$1040.80
42569	INTRAOCULAR FOREIGN BODY, removal from posterior segment (Anaes.) (Assist.)	$1977.00
42572	Orbital abscess or cyst, drainage of (Anaes.)	$212.00
42573	Dermoid, periorbital, excision of, on a person 10 years of age or over (Anaes.)	$436.20
42574	DERMOID, orbital, excision of (Anaes.) (Assist.)	$939.80
42575	Tarsal cyst, extirpation of (Anaes.)	$158.70
42576	Dermoid, periorbital, excision of, on a person under 10 years of age (Anaes.)	$482.60
42581	Ectropion or entropion, tarsal cauterisation of (Anaes.)	$222.00
42584	TARSORRHAPHY (Anaes.) (Assist.)	$532.30
42587	Trichiasis (due to causes other than trachoma), treatment of by cryotherapy, laser or electrolysis—each eyelid (Anaes.)	$99.00
42588	Trichiasis (due to trachoma), treatment of by cryotherapy, laser or electrolysis—each eyelid (Anaes.)	$79.90
42590	CANTHOPLASTY, medial or lateral (Anaes.) (Assist.)	$755.00
42593	Lacrimal gland, excision of palpebral lobe (Anaes.)	$371.60
42596	LACRIMAL SAC, excision of, or operation on (Anaes.) (Assist.)	$967.40
42599	LACRIMAL CANALICULAR SYSTEM, establishment of patency by closed operation using silicone tubes or similar, 1 eye (Anaes.) (Assist.)	$1225.60
42602	LACRIMAL CANALICULAR SYSTEM, establishment of patency by open operation, 1 eye (Anaes.) (Assist.)	$1212.50
42605	LACRIMAL CANALICULUS, immediate repair of (Anaes.) (Assist.)	$929.70
42608	LACRIMAL DRAINAGE by insertion of glass tube, as an independent procedure (Anaes.) (Assist.)	$581.70
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.)	$239.60
42620	Punctum, occlusion of, by use of a plug (Anaes.)	$121.70

Item no.	Description	Max fee (excl. GST)
42622	Punctum, permanent occlusion of, by use of electrical cautery (Anaes.)	$161.90
42623	DACRYOCYSTORHINOSTOMY (Anaes.) (Assist.)	$1498.40
42626	DACRYOCYSTORHINOSTOMY where a previous dacryocystorhinostomy has been performed (Anaes.) (Assist.)	$2165.90
42629	CONJUNCTIVORHINOSTOMY including dacryocystorhinostomy and fashioning of conjunctival flaps (Anaes.) (Assist.)	$1651.80
42632	CONJUNCTIVAL PERITOMY OR REPAIR OF CORNEAL LACERATION by conjunctival flap (Anaes.)	$225.20
42635	CORNEAL PERFORATIONS, sealing of, with tissue adhesive (Anaes.) (Assist.)	$577.10
42638	CONJUNCTIVAL GRAFT OVER CORNEA (Anaes.) (Assist.)	$724.60
42641	AUTOCONJUNCTIVAL TRANSPLANT, or mucous membrane graft (Anaes.) (Assist.)	$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.)	$134.70
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
42652	Corneal collagen cross linking, on a person with a corneal ectatic disorder, with evidence of progression per eye. (Anaes.)	$1888.00
42653	CORNEA transplantation of (Anaes.) (Assist.)	$2715.70
42656	CORNEA, transplantation of, second and subsequent procedures (Anaes.) (Assist.)	$3237.50
42662	SCLERA, transplantation of, full thickness, including collection of donor material (Anaes.) (Assist.)	$1749.20
42665	SCLERA, transplantation of, superficial or lamellar, including collection of donor material (Anaes.) (Assist.)	$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	$259.60
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 INCISONS, to correct corneal astigmatism of more than 1½ dioptres following anterior segment surgery, including appropriate measurements and calculations, performed as an independent procedure (Anaes.) (Assist.)	$1747.60
42673	ADDITIONAL CORNEAL INCISIONS, to correct corneal astigmatism of more than 1½dioptres, including appropriate measurements and calculations, performed in conjunction with other anterior segment surgery (Anaes.) (Assist.)	$915.00
42676	Conjunctiva, biopsy of, as an independent procedure	$222.00
42677	CONJUNCTIVA, CAUTERY OF, INCLUDING TREATMENT OF PANNUSeach 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 N²0 (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 (Anaes.) (Assist.)	$530.70
42695	LIMBIC TUMOUR, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes.) (Assist.)	$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 errorexcept for anisometropia greater than 3 dioptres following the removal of cataract in the first eye (Anaes.)	$1098.50
42702	Lens extraction and insertion of intraocular lens, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye (Anaes.)	$2206.80
42703	INTRAOCULAR LENS or IRIS PROSTHESIS insertion of, into the posterior chamber with fixation to the iris or sclera (Anaes.) (Assist.)	$1110.00

Item no.	Description	Max fee (excl. GST)
42704	Intraocular lens, removal or repositioning of by open operation, not being a service associated with a service to which item 42701 applies (Anaes.)	$839.30
42705	LENS EXTRACTION AND INSERTION OF INTRAOCULAR LENS, excluding surgery performed for the correction of refractive errorexcept for anisometropia greater than 3 dioptres following the removal of cataract in the first eye, performed in association with insertion of a trans-trabecular drainage device or devices, in a patient diagnosed with open angle glaucoma who is not adequately responsive to topical anti-glaucoma medications or who is intolerant of anti-glaucoma medication. (Anaes.)	$1196.80
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.)	$1501.30
42710	INTRAOCULAR LENS, removal of, and replacement with a lens inserted into the posterior chamber and fixated to the iris or sclera (Anaes.) (Assist.)	$1538.40
42713	IRIS SUTURING, McCannell technique or similar, for fixation of intraocular lens or repair of iris defect (Anaes.) (Assist.)	$720.90
42716	CATARACT, JUVENILE, removal of, including subsequent needlings (Anaes.) (Assist.)	$2600.00
42719	REMOVAL OF VITREOUS, and/or CAPSULAR or LENS MATERIAL, via a limbal approach,not being a service associated with a service to which item 42698, 42702, 42716, 42725 or 42731 applies (Anaes.) (Assist.)	$996.30
42725	Vitrectomy via pars plana sclerotomy, including one or more of the following:(a) removal of vitreous; (b) division of vitreous bands; (c) removal of epiretinal membranes; (d) capsulotomy (Anaes.) (Assist.)	$2573.30
42731	LIMBAL OR PARS PLANA LENSECTOMY combined with vitrectomy, not being a service associated with items 42698, 42702, 42719, or 42725 (Anaes.) (Assist.)	$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.	$519.60
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 the administration of anaesthetic by a specialist anaesthetist. (Anaes.)	$519.60
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 juxtascleral depot injection of a therapeutic substance, for the treatment of subfoveal choroidal neovascularisation due to age-related macular degeneration, 1 or more of (Anaes.)	$595.70
42743	ANTERIOR CHAMBER, IRRIGATION OF BLOOD FROM, as an independent procedure (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1829.30
42749	GLAUCOMA, filtering operation for, where previous filtering operation has been performed (Anaes.) (Assist.)	$2299.00
42752	GLAUCOMA, insertion of drainage device incorporating an extraocular reservoir for, such as a Molteno device (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$996.30
42764	IRIDECTOMY (including excision of tumour of iris) OR IRIDOTOMY, as an independent procedure, other than by laser (Anaes.) (Assist.)	$994.80
42767	TUMOUR, INVOLVING CILIARY BODY OR CILIARY BODY AND IRIS, excision of (Anaes.) (Assist.)	$2216.90
42770	CYCLODESTRUCTIVE procedures for the treatment of intractable glaucoma, treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.)	$595.00
42773	DETACHED RETINA, pneumatic retinopexy for, not being a service associated with a service to which item 42776 applies (Anaes.) (Assist.)	$1728.50
42776	DETACHED RETINA, buckling or resection operation for (Anaes.) (Assist.)	$2595.70

Item no.	Description	Max fee (excl. GST)
42779	DETACHED RETINA, revision of scleral buckling operation for (Anaes.) (Assist.)	$3093.40
42782	LASER TRABECULOPLASTY, for the treatment of glaucoma. Each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes.) (Assist.)	$641.60
42785	Laser Iridotomy—each treatment episode to 1 eye, to a maximum of 3 treatments to that eye in a 2 year period (Anaes.) (Assist.)	$632.80
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.)	$632.80
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.)	$632.80
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.)	$124.20
42801	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, insertion of (Anaes.) (Assist.)	$2012.00
42802	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, removal of (Anaes.) (Assist.)	$1064.00
42805	TANTALUM MARKERS, surgical insertion to the sclera to localise the tumour base to assist in planning of radiotherapy of choroidal melanomas, 1 or more (Anaes.) (Assist.)	$1065.10
42806	IRIS TUMOUR, laser photocoagulation of (Anaes.) (Assist.)	$680.50
42807	Photomydriasis, laser	$601.00
42808	Laser peripheral iridoplasty	$601.00
42809	RETINA, photocoagulation of, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.)	$871.10
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 (Anaes.) (Assist.)	$1212.50
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	Retrobulbar injection of alcohol or other drug, as an independent procedure	$134.80
42833	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES on a patient aged 15 years or over (Anaes.) (Assist.)	$1325.00
42836	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES, on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.)	$1548.10
42839	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 OR MORE MUSCLES on a patient aged 15 years or over (Anaes.) (Assist.)	$1530.00
42842	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 or MORE MUSCLES, on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.)	$1870.00
42845	READJUSTMENT OF ADJUSTABLE SUTURES, 1 or both eyes, as an independent procedure following an operation for correction of squint (Anaes.)	$388.90
42848	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 15 years or over (Anaes.) (Assist.)	$1530.00
42851	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.)	$1689.80
42854	RUPTURED MEDIAL PALPEBRAL LIGAMENT or ruptured EXTRAOCULAR MUSCLE, repair of (Anaes.) (Assist.)	$726.50
42857	RESUTURING OF WOUND FOLLOWING INTRAOCULAR PROCEDURES with or without excision of prolapsed iris (Anaes.) (Assist.)	$783.50

Item no.	Description	Max fee (excl. GST)
42860	EYELID (upper or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid retractors (Anaes.) (Assist.)	$1717.40
42863	EYELID, recession of (Anaes.) (Assist.)	$1489.50
42866	ENTROPION or TARSAL ECTROPION, repair of, by tightening, shortening or repair of inferior retractors by open operation across the entire width of the eyelid (Anaes.) (Assist.)	$1458.10
42869	EYELID closure in facial nerve paralysis, insertion of foreign implant for (Anaes.) (Assist.)	$1065.20
42872	Eyebrow, elevation of, by skin excision, to correct for a reduced field of vision caused by paretic, involutional, or traumatic eyebrow descent/ptosis to a position below the superior orbital rim (Anaes.)	$515.00
43021	Photodynamic therapy, one eye, including the infusion of Verteporfin continuously through a peripheral vein, using a non-thermal laser at a wavelength of 689nm, for the treatment of choroidal neovascularisation.	$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.	$986.80
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.	$159.90
	Operations for osteomyelitis	
43500	OPERATION ON PHALANX (Anaes.)	$240.80
43503	OPERATION ON STERNUM, CLAVICLE, RIB, ULNA, RADIUS, CARPUS, TIBIA, FIBULA, TARSUS, SKULL, MANDIBLE OR MAXILLA (other than alveolar margins)1 BONE (Anaes.)	$392.90
43506	OPERATION ON HUMERUS OR FEMUR1 BONE (Anaes.) (Assist.)	$682.20
43509	OPERATION ON SPINE OR PELVIC BONES1 BONE (Anaes.) (Assist.)	$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)1 BONE or ANY COMBINATION OF ADJOINING BONES (Anaes.) (Assist.)	$683.50
43515	OPERATION ON HUMERUS OR FEMUR1 BONE (Anaes.) (Assist.)	$683.50
43518	OPERATION ON SPINE OR PELVIC BONES1 BONE (Anaes.) (Assist.)	$1128.90
43521	OPERATION ON SKULL (Anaes.) (Assist.)	$881.00
43524	OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 43515, 43518 or 43521 (Anaes.) (Assist.)	$1145.50
	Paediatric	
43801	INTESTINAL MALROTATION with or without volvulus, laparotomy for, not involving bowel resection (Anaes.) (Assist.)	$1729.70
43804	INTESTINAL MALROTATION with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (Anaes.) (Assist.)	$1841.80
43805	Umbilical, epigastric or linea alba hernia, repair of, on a person under 10 years of age (Anaes.)	$581.50
43807	DUODENAL ATRESIA or STENOSIS, duodenoduodenostomy or duodenojejunostomy for (Anaes.) (Assist.)	$2009.20
43810	JEJUNAL ATRESIA, bowel resection and anastomosis for, with or without tapering (Anaes.) (Assist.)	$2344.10
43813	MECONIUM ILEUS, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intesinal perforation with or without meconium peritonitis (Anaes.) (Assist.)	$2344.10
43816	ILEAL ATRESIA, COLONIC ATRESIA OR MECONIUM ILEUS not being a service associated with a service to which item 43813 applies, laparotomy for (Anaes.) (Assist.)	$2176.50
43819	Agangliosis coli, laparotomy for, with or without frozen section biopsies and formation of stoma (Anaes.) (Assist.)	$1757.90
43822	ANORECTAL MALFORMATION, laparotomy and colostomy for (Anaes.) (Assist.)	$1757.90
43825	NEONATAL ALIMENTARY OBSTRUCTION, laparotomy for, not being a service to which any other item in this Subgroup applies (Anaes.) (Assist.)	$2009.20
43828	ACUTE NEONATAL NECROTISING ENTEROCOLITIS, laparotomy for, with resection, including any anastomoses or stoma formation (Anaes.) (Assist.)	$2219.90
43831	ACUTE NEONATAL NECROTISING ENTEROCOLITIS where no definitive procedure is possible, laparotomy for (Anaes.) (Assist.)	$1729.70
43832	BRANCHIAL FISTULA, on a person under 10 years of age.Removal of, (Anaes.) (Assist.)	$1065.70
43834	BOWEL RESECTION for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (Anaes.) (Assist.)	$2009.20

Item no.	Description	Max fee (excl. GST)
43835	Strangulated, incarcerated or obstructed hernia, repair of, without bowel resection, on a person under 10 years of age (Anaes.) (Assist.)	$1105.90
43837	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (Anaes.) (Assist.)	$2511.30
43838	Diaphragmatic hernia, congential repair of, by thoracic or abdominal approach, not being a service to which any of items 31569 to 31581 apply, on a person under 10 years of age (Anaes.) (Assist.)	$2031.20
43840	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, diagnosed after the first day of life and before 20 days of age (Anaes.) (Assist.)	$2176.50
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.)	$985.50
43843	OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, not being a service to which item 43846 applies (Anaes.) (Assist.)	$3348.60
43846	OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, in infant of birth weight less than 1500 grams (Anaes.) (Assist.)	$3599.50
43849	OESOPHAGEAL ATRESIA, gastrostomy for (Anaes.) (Assist.)	$921.00
43852	Oesophageal atresia, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (Anaes.) (Assist.)	$2929.70
43855	OESOPHAGEAL ATRESIA, delayed primary anastomosis for (Anaes.) (Assist.)	$3097.60
43858	Oesophageal atresia, cervical oesophagostomy for (Anaes.) (Assist.)	$1088.10
43861	CONGENITAL CYSTADENOMATOID MALFORMATION OR CONGENITAL LOBAR EMPHYSEMA, thoracotomy and lung resection for (Anaes.) (Assist.)	$3013.70
43864	GASTROSCHISIS, operation for (Anaes.) (Assist.)	$2260.20
43867	Gastroschisis or exomphalos, secondary operation for, with removal of silo (Anaes.) (Assist.)	$1255.90
43870	EXOMPHALOS containing small bowel only, operation for (Anaes.) (Assist.)	$1757.90
43873	EXOMPHALOS containing small bowel and other viscera, operation for (Anaes.) (Assist.)	$2344.10
43876	SACROCOCCYGEAL TERATOMA, excision of, by posterior approach (Anaes.) (Assist.)	$2009.20
43879	SACROCOCCYGEAL TERATOMA, excision of, by combined posterior and abdominal approach (Anaes.) (Assist.)	$2344.10
43882	CLOACAL EXSTROPHY, operation for (Anaes.) (Assist.)	$3013.70
43900	TRACHEO-OESOPHAGEAL FISTULA without atresia, division and repair of (Anaes.) (Assist.)	$2009.20
43903	OESOPHAGEAL ATRESIA or CORROSIVE OESOPHAGEAL STRICTURE, oesophageal replacement for, utilizing gastric tube, jejunum or colon (Anaes.) (Assist.)	$3348.60
43906	OESOPHAGUS, resection of congenital, anastomic or corrosive stricture and anastomosis, not being a service to which item 43903 applies (Anaes.) (Assist.)	$2929.70
43909	TRACHEOMALACIA, aortopexy for (Anaes.) (Assist.)	$2929.70
43912	THORACOTOMY and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal teratoma (Anaes.) (Assist.)	$2768.00
43915	Eventration, plication of diaphragm for (Anaes.) (Assist.)	$2183.30
43930	HYPERTROPHIC PYLORIC STENOSIS, pyloromyotomy for (Anaes.) (Assist.)	$804.70
43933	IDIOPATHIC INTUSSUSCEPTION, laparotomy and manipulative reduction of (Anaes.) (Assist.)	$942.00
43936	INTUSSUSCEPTION, laparotomy and resection with anastomosis (Anaes.) (Assist.)	$1757.90
43939	VENTRAL HERNIA following neonatal closure of exomphalos or gastroschisis, repair of (Anaes.) (Assist.)	$1339.60
43942	Abdominal wall vitello intestinal remnant, excision of (Anaes.)	$444.90
43945	PATENT VITELLO INTESTINAL DUCT, excision of (Anaes.) (Assist.)	$1757.90
43948	Umbilical granuloma, excision of, under general anaesthesia (Anaes.)	$251.40
43951	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (Anaes.) (Assist.)	$1574.30
43954	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (Anaes.) (Assist.)	$1925.50
43957	GASTRO-OESOPHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or without hiatus hernia, in child with neurological disease, with gastrostomy (Anaes.) (Assist.)	$2092.70
43960	ANORECTAL MALFORMATION, perineal anoplasty of (Anaes.) (Assist.)	$736.20
43963	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of (Anaes.) (Assist.)	$2929.70

Item no.	Description	Max fee (excl. GST)
43966	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes.) (Assist.)	$3348.60
43969	PERSISTENT CLOACA, total correction of, with genital repair using posterior sagittal approach, with or without laparotomy (Anaes.) (Assist.)	$4604.30
43972	CHOLEDOCHAL CYST, resection of, with 1 duct anastomosis (Anaes.) (Assist.)	$3402.50
43975	CHOLEDOCHAL CYST, resection of, with 2 duct anastomoses (Anaes.) (Assist.)	$3934.70
43978	BILIARY ATRESIA, portoenterostomy for (Anaes.) (Assist.)	$3348.60
43981	NEPHROBLASTOMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.)	$921.00
43984	NEPHROBLASTOMA, radical nephrectomy for (Anaes.) (Assist.)	$2344.10
43987	NEUROBLASTOMA, radical excision of (Anaes.) (Assist.)	$2595.20
43990	Aganglionosis coli, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends to sigmoid colon (Anaes.) (Assist.)	$3181.20
43993	Aganglionosis coli, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends into descending or transverse colon with or without resiting of stoma (Anaes.) (Assist.)	$3432.20
43996	Aganglionosis coli, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or without side to side ileocolic anastomosis (Anaes.) (Assist.)	$3850.90
43999	Aganglionosis coli, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.)	$481.60
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.)	$545.20
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.)	$95.70
44105	Rectal prolapse, submucosal or perirectal injection for, on a person 2 years of age or over, under general anaesthesia (Anaes.)	$81.40
44108	Inguinal hernia repair at age less than 12 months (Anaes.) (Assist.)	$888.10
44111	Obstructed or strangulated inguinal hernia, repair, at age, less than 12 months including orchidopexy when performed (Anaes.) (Assist.)	$1040.10
44114	Inguinal hernia repair at age less than 12 months when orchidopexy also required (Anaes.) (Assist.)	$1040.10
44130	LYMPHADENECTOMY, for atypical mycobacterial infection or other granulomatous disease (Anaes.) (Assist.)	$874.00
44133	TORTICOLLIS, open division of sternomastoid muscle for (Anaes.) (Assist.)	$710.90
44136	Ingrown toe nail, operation for, under general anaesthesia (Anaes.)	$331.80
	Amputations	
44325	HAND, MIDCARPAL OR TRANSMETACARPAL, amputation of (Anaes.) (Assist.)	$568.80
44328	HAND, FOREARM OR THROUGH ARM, amputation of (Anaes.) (Assist.)	$647.20
44331	AMPUTATION AT SHOULDER (Anaes.) (Assist.)	$1067.20
44334	INTERSCAPULOTHORACIC AMPUTATION (Anaes.) (Assist.)	$2273.00
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 (Anaes.) (Assist.)	$496.70
44350	4 DIGITS of 1 foot, amputation of (Anaes.) (Assist.)	$523.40
44354	5 DIGITS of 1 foot, amputation of (Anaes.) (Assist.)	$644.90
44358	TOE, including metatarsal or part of metatarsaleach 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 microvascular disease, excluding aftercare (Anaes.) (Assist.)	$505.20
44361	FOOT AT ANKLE (Syme, Pirogoff types), amputation of (Anaes.) (Assist.)	$647.20
44364	FOOT, MIDTARSAL OR TRANSMETATARSAL, amputation of (Anaes.) (Assist.)	$567.10
44367	AMPUTATION THROUGH THIGH, AT KNEE OR BELOW KNEE (Anaes.) (Assist.)	$1006.80
44370	AMPUTATION AT HIP (Anaes.) (Assist.)	$1307.90

Item no.	Description	Max fee (excl. GST)
44373	HINDQUARTER, amputation of (Anaes.) (Assist.)	$2684.90
44376	Amputation stump, reamputation of, to provide adequate skin and mu scle 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) (Anaes.) (Assist.)	$2004.70
45009	SINGLE STAGE LOCAL muscle flap repair to 1 defect, simple and small (Anaes.) (Assist.)	$749.30
45012	SINGLE STAGE LARGE MUSCLE FLAP REPAIR to 1 defect, (pectoralis major, gastrocnemius, gracilis or similar large muscle) (Anaes.) (Assist.)	$1242.00
45015	Muscle or myocutaneous flap, delay of (Anaes.)	$735.00
45018	Dermis, dermofat or fascia graft (other than transfer of fat by injection): (a) if the service is not associated with neurosurgical services for spinal disorders mentioned in any of items51011 to 51171; and (b) other than a service associated with a service to which item39615, 39715, 40106 or 40109 applies (Anaes.) (Assist.)	$1168.00
45019	Full face chemical peel for severely sun damaged skin, if: (a) the damage affects at least 75% of the facial skin surface area; and (b) the damage involves photo-damage (dermatoheliosis); and (c) the photo-damage involves: (i) a solar keratosis load exceeding 30 individual lesions; or (ii) solar lentigines; or (iii) freckling, yellowing or leathering of the skin; or (iv) solar kertoses which have proven refractory to, or recurred following, medical therapies; and (d) at least medium depth peeling agents are used; and (e) the chemical peel is performed in the operating theatre of a hospital by a medical practitioner recognised as a specialist in the specialty of dermatology or plastic surgery. Applicable once only in any 12 month period (Anaes.)	$796.80
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.)	$246.60
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 (Anaes.) (Assist.)	$1373.40
45036	ANGIOMA (haemangioma or lymphangioma or both) of neck, deep, excision of (Anaes.) (Assist.)	$2169.40
45039	ARTERIOVENOUS MALFORMATION (3 centimetres or less) of superficial tissue, excision of (Anaes.)	$470.60
45042	ARTERIOVENOUS MALFORMATION, (greater than 3 centimetres), excision of (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1722.10
45051	Contour reconstruction by open repair of contour defects, due to deformity, if: (a) contour reconstructive surgery is indicated because the deformity is secondary to congenital absence of tissue or has arisen from trauma (other than trauma from previous cosmetic surgery); and (b) insertion of a non-biological implant is required, other than one or more of the following: (i) insertion of a non-biological implant that is a component of another service specified in Group T8; (ii) injection of liquid or semisolid material; (iii) an oral and maxillofacial implant service to which item 52321 applies; (iv) a service to insert mesh; and (c) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.)	$1125.00
45054	LIMB OR CHEST, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (Anaes.) (Assist.)	$445.40

Item no.	Description	Max fee (excl. GST)
45060	Developmental breast abnormality, single stage correction of, if: (a) the correction involves either: (i) bilateral mastopexy for symmetrical tubular breasts; or (ii) surgery on both breasts with a combination of insertion of one or more implants (which must have at least a 10% volume difference), mastopexy or reduction mammaplasty, if there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least 20% in normally shaped breasts, or 10% in tubular breasts or in breasts with abnormally high inframammary folds; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes Applicable only once per occasion on which the service is provided (Anaes.) (Assist.)	$1956.20
45061	Developmental breast abnormality, 2 stage correction of, first stage, involving surgery on both breasts with a combination of insertion of one or more tissue expanders, mastopexy or reduction mammaplasty, if: (a) there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least: (i) 20% in normally shaped breasts; or (ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes. Applicable only once per occasion on which the service is provided (Anaes.) (Assist.)	$1956.20
45062	Developmental breast abnormality, 2 stage correction of, second stage, involving surgery on both breasts with a combination of exchange of one or more tissue expanders for one or more implants (which must have at least a 10% volume difference), mastopexy or reduction mammaplasty, if: (a) there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least: (i) 20% in normally shaped breasts; or (ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes. Applicable only once per occasion on which the service is provided (Anaes.) (Assist.)	$1415.60
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.)	$661.60
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.)	$661.60
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.)	$730.20
45209	DIRECT FLAP REPAIR (cross arm, abdominal or similar), first stage (Anaes.) (Assist.)	$910.00
45212	Direct flap repair (cross arm, abdominal or similar), second stage (Anaes.)	$451.60
45215	DIRECT FLAP REPAIR, cross leg, first stage (Anaes.) (Assist.)	$1965.00
45218	DIRECT FLAP REPAIR, cross leg, second stage (Anaes.) (Assist.)	$889.60
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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$790.50
45406	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—involving not more than 3 per cent of total body surface (Anaes.) (Assist.)	$917.10

Item no.	Description	Max fee (excl. GST)
45409	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—involving 3 per cent or more but less than 6 per cent of total body surface (Anaes.) (Assist.)	$1156.90
45412	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—involving 6 per cent or more but less than 9 per cent of total body surface (Anaes.) (Assist.)	$1706.90
45415	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—involving 9 per cent or more but less than 12 per cent of total body surface (Anaes.) (Assist.)	$1731.70
45418	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—involving 12 per cent or more but less than 15 per cent of total body surface (Anaes.) (Assist.)	$1775.40
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 (Anaes.) (Assist.)	$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) (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2276.10
45461	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—involving 15 percent or more but less than 20 percent of total body surface—conjoint surgery, principal surgeon (Anaes.) (Assist.)	$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.)	$1224.20
45464	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—involving 20 percent or more but less than 30 percent of total body surface—one surgeon (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2475.30
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.)	$1866.80
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 (Anaes.) (Assist.)	$3328.20
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 (Anaes.) (Assist.)	$4183.40
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.)	$3155.60
45474	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—involving 50 percent or more but less than 60 percent of total body surface—conjoint surgery, principal surgeon (Anaes.) (Assist.)	$5036.50
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.)	$3800.00
45477	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—involving 60 percent or more but less than 70 percent of total body surface—conjoint surgery, principal surgeon (Anaes.) (Assist.)	$5889.50
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.)	$4442.20
45480	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—involving 70 percent or more but less than 80 percent of total body surface—conjoint surgery, principal surgeon (Anaes.) (Assist.)	$6742.20
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.)	$5087.00
45483	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—involving 80 percent or more of total body surface—conjoint surgery, principal surgeon (Anaes.) (Assist.)	$7681.80
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.)	$5796.10

Item no.	Description	Max fee (excl. GST)
45485	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—upper eyelid, nose, lip, ear or palm of the hand (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1031.40
45487	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—whole of toe (Anaes.) (Assist.)	$737.30
45488	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—the whole of 1 digit of the hand (Anaes.) (Assist.)	$819.30
45489	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—the whole of 2 digits of the hand (Anaes.) (Assist.)	$1229.20
45490	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—the whole of 3 digits of the hand (Anaes.) (Assist.)	$1852.50
45491	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—the whole of 4 digits of the hand (Anaes.) (Assist.)	$2048.40
45492	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—the whole of 5 digits of the hand (Anaes.) (Assist.)	$3082.80
45493	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—portion of digit of hand (Anaes.) (Assist.)	$965.00
45494	FREE GRAFTING (split skin) to burns, including excision of burnt tissue—whole of face (excluding ears) (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2090.50
45501	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.)	$3444.30
45502	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.)	$4005.00
45503	MICRO-ARTERIAL OR MICRO-VENOUS GRAFT using microsurgical techniques (Anaes.) (Assist.)	$3915.10
45504	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.)	$3421.10
45505	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.)	$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 speciality (Anaes.)	$459.40
45519	EXTENSIVE BURN SCARS OF SKIN (more than 1 percent of body surface area), excision of, for correction of scar contracture (Anaes.) (Assist.)	$1050.00
45520	Reduction mammaplasty (unilateral) with surgical repositioning of nipple,in the context of breast cancer or developmental abnormality of the breast (Anaes.) (Assist.)	$2200.00
45522	Reduction mammaplasty (unilateral) without surgical repositioning of the nipple: (a) excluding the treatment of gynaecomastia; and (b) not with insertion of any prosthesis (Anaes.) (Assist.)	$1545.00
45523	Reduction mammaplasty (bilateral) with surgical repositioning of the nipple: (a) for patients with macromastia and experiencing pain in the neck or shoulder region; and (b) not with insertion of any prosthesis (Anaes.) (Assist.)	$2078.40

Item no.	Description	Max fee (excl. GST)
45524	Mammaplasty, augmentation (unilateral) in the context of: (a) breast cancer; or (b) developmental abnormality of the breast, if there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least: (i) 20% in normally shaped breasts; or (ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds. Applicable only once per occasion on which the service is provided (Anaes.) (Assist.)	$1605.00
45527	Breast reconstruction (unilateral), following mastectomy, using a permanent prosthesis (Anaes.) (Assist.)	$1610.00
45528	Mammaplasty, augmentation, bilateral (other than a service to which item 45527 applies), if: (a) reconstructive surgery is indicated because of: (i) developmental malformation of breast tissue (excluding hypomastia); or (ii) disease of or trauma to the breast (other than trauma resulting from previous elective cosmetic surgery); or (iii) amastia secondary to a congenital endocrine disorder; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2690.00
45536	BREAST RECONSTRUCTION using breast sharing technique (second stage) including division of pedicle, insetting of breast flap, with closure of donor site or other similar procedure (Anaes.) (Assist.)	$879.40
45539	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion—insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.)	$2300.20
45542	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion—removal of tissue expansion unit and insertion of permanent prosthesis (Anaes.) (Assist.)	$1320.00
45545	NIPPLE OR AREOLA or both, reconstruction of, by any surgical technique (Anaes.) (Assist.)	$1220.60
45546	NIPPLE OR AREOLA or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple	$362.50
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 (Anaes.) (Assist.)	$3487.50

Item no.	Description	Max fee (excl. GST)
45562	FREE TRANSFER OF TISSUE involving raising of tissue on vascular or neurovascular pedicle, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.)	$2112.80
45563	NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.)	$2110.60
45564	Free transfer of tissue reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies-conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.)	$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, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies-conjoint surgery, conjoint specialist surgeon (H) (Assist.)	$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 (Anaes.) (Assist.)	$2096.40
45568	TISSUE EXPANDER, removal of, with complete excision of fibrous capsule (Anaes.) (Assist.)	$841.60
45569	CLOSURE OF ABDOMEN WITH RECONSTRUCTION OF UMBILICUS, with or without lipectomy, being a service associated with items 45562, 45564, 45565 or 45530 (Anaes.) (Assist.)	$1430.00
45570	CLOSURE OF ABDOMEN, repair of musculoaponeurotic layer, being a service associated with item 45569 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1440.40
45578	FACIAL NERVE PARALYSIS, muscle transfer for (Anaes.) (Assist.)	$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 item31525 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 (Anaes.) (Assist.)	$1015.00
45593	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.)	$1190.00
45596	MAXILLA, total resection of (Anaes.) (Assist.)	$1960.00
45597	MAXILLA, total resection of both maxillae (Anaes.) (Assist.)	$2189.00
45599	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.)	$1351.20
45602	MANDIBLE, including lower border, OR MAXILLA, sub-total resection of (Anaes.) (Assist.)	$1353.10
45605	MANDIBLE OR MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.)	$1128.00
45608	MANDIBLE, hemimandibular reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (Anaes.) (Assist.)	$1686.50
45611	MANDIBLE, condylectomy (Anaes.) (Assist.)	$1265.00

Item no.	Description	Max fee (excl. GST)
45614	EYELID, WHOLE THICKNESS RECONSTRUCTION OF other than by direct suture only (Anaes.) (Assist.)	$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
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, not caused by trachoma, correction of (unilateral) (Anaes.)	$655.00
45627	Ectropion or entropion, caused by trachoma, correction of (unilateral) (Anaes.)	$496.90
45629	SYMBLEPHARON, grafting for (Anaes.) (Assist.)	$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.)	$406.20
45646	CHOANAL ATRESIA—correction by open operation with bone removal (Anaes.) (Assist.)	$1952.30
45647	FACE, contour restoration of 1 region, using autogenous bone or cartilage graft (not being a service to which item 45644 applies) (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1132.90
45659	Correction of a congenital deformity of the ear if: (a) the patient is less than 18 years of age; and (b) the deformity is characterised by an absence of the antihelical fold and/or large scapha and/or large concha; and (c) photographic evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.)	$1145.00

Item no.	Description	Max fee (excl. GST)
45660	EXTERNAL EAR, COMPLEX TOTAL RECONSTRUCTION OF, using multiple costal cartilage grafts to form a framework, including the harvesting and sculpturing of the cartilage and its insertion, for congenital absence, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage)—performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2450.60
45662	CONGENITAL ATRESIA, reconstruction of external auditory canal (Anaes.) (Assist.)	$1311.60
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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$926.40
45676	MACROSTOMIA, operation for (Anaes.) (Assist.)	$1104.20
45677	CLEFT LIP, unilateralprimary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)	$1050.00
45680	CLEFT LIP, unilateral—primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)	$1229.20
45683	CLEFT LIP, bilateral—primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)	$1365.60
45686	CLEFT LIP, bilateral—primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)	$1733.40
45689	CLEFT LIP, lip adhesion procedure, unilateral or bilateral (Anaes.) (Assist.)	$600.00
45692	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.)	$576.90
45695	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.)	$1075.00
45698	Cleft lip, primary columella lengthening procedure, bilateral (Anaes.)	$833.10
45701	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.)	$2320.80
45704	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.)	$576.40
45707	CLEFT PALATE, primary repair (Anaes.) (Assist.)	$1444.50
45710	Cleft palate, secondary repair, closure of fistula using local flaps (Anaes.)	$941.80
45713	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.)	$1068.40
45714	ORO-NASAL FISTULA, plastic closure of, including services to which item 45200, 45203 or 45239 applies (Anaes.) (Assist.)	$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 47933or 47936 apply (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2684.90

Item no.	Description	Max fee (excl. GST)
45732	MANDIBLE OR MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$3218.60
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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$3511.40
45752	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$3956.60
45754	MIDFACIAL OSTEOTOMIES—Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.)	$5017.00
45755	TEMPOROMANDIBULAR PARTIAL OR TOTAL MENISCECTOMY (Anaes.) (Assist.)	$667.70
45758	TEMPORO-MANDIBULAR JOINT, arthroplasty (Anaes.) (Assist.)	$1261.80
45761	GENIOPLASTY, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	$1580.00
45767	HYPERTELORISM, correction of, intracranial (Anaes.) (Assist.)	$4561.20
45770	HYPERTELORISM, correction of, subcranial (Anaes.) (Assist.)	$3494.10
45773	TREACHER COLLINS SYNDROME, PERIORBITAL CORRECTION OF, with rib and iliac bone grafts (Anaes.) (Assist.)	$3184.40
45776	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, intracranial (Anaes.) (Assist.)	$3256.00
45779	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, extracranial (Anaes.) (Assist.)	$2341.30
45782	FRONTOORBITAL ADVANCEMENT, UNILATERAL (Anaes.) (Assist.)	$1889.70
45785	CRANIAL VAULT RECONSTRUCTION for oxycephaly, brachycephaly, turricephaly or similar condition(bilateral frontoorbital advancement) (Anaes.) (Assist.)	$3029.30
45788	GLENOID FOSSA, ZYGOMATIC ARCH AND TEMPORAL BONE, RECONSTRUCTION OF, (Obwegeser technique) (Anaes.) (Assist.)	$3060.60
45791	ABSENT CONDYLE AND ASCENDING RAMUS in hemifacial microsomia, CONSTRUCTION OF, not including harvesting of graft material (Anaes.) (Assist.)	$1617.80
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

Item no.	Description	Max fee (excl. GST)
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 (Anaes.) (Assist.)	$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.)	$477.40
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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1127.90
45815	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis—1 bone or in combination with adjoining bones (Anaes.) (Assist.)	$687.90
45817	OPERATION on SKULL for OSTEOMYELITIS (Anaes.) (Assist.)	$843.60
45819	OPERATION ON ANY COMBINATION OF ADJOINING BONES IN THE ORAL AND MAXILLOFACIAL REGION, being bones referred to in item 45817 (Anaes.) (Assist.)	$1964.90
45821	BONE GROWTH STIMULATOR IN THE ORAL AND MAXILLOFACIAL REGION, insertion of (Anaes.) (Assist.)	$737.60
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 (Anaes.) (Assist.)	$651.70
45827	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.)	$626.30
45829	Maxillary tuberosity, reduction of (Anaes.)	$478.00
45831	PAPILLARY HYPERPLASIA OF THE PALATE, removal of—less than 5 lesions (Anaes.) (Assist.)	$626.30
45833	PAPILLARY HYPERPLASIA OF THE PALATE, removal of—5 to 20 lesions (Anaes.) (Assist.)	$737.30
45835	PAPILLARY HYPERPLASIA OF THE PALATE, removal of—more than 20 lesions (Anaes.) (Assist.)	$914.90
45837	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed—unilateral or bilateral (Anaes.) (Assist.)	$1136.00
45839	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed—unilateral (Anaes.) (Assist.)	$1136.00
45841	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both—unilateral (Anaes.) (Assist.)	$911.00
45843	ALVEOLAR RIDGE AUGMENTATION—unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.)	$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.)	$361.50
45849	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.)	$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.)	$276.80
45853	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.)	$1617.80

Item no.	Description	Max fee (excl. GST)
45855	TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes.) (Assist.)	$742.20
45857	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions—1 or more such procedure of that joint, not being a service associated with any other arthroscopic procedure of the temporomandibular joint (Anaes.) (Assist.)	$1187.40
45859	TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.)	$598.60
45861	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.)	$1692.60
45863	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.)	$2249.10
45865	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.)	$561.20
45867	TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.)	$567.30
45869	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without meniscus or capsular surgery, including partial or total meniscectomy when performed, with or without microsurgical techniques (Anaes.) (Assist.)	$2157.90
45871	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.)	$3260.00
45873	TEMPOROMANDIBULAR JOINT, surgery of, involving procedures to which items 45863, 45867, 45869 and 45871 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1075.90
45877	TEMPOROMANDIBULAR JOINT, arthrodesis of, with synovectomy if performed, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.)	$854.70
45879	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.)	$780.00
45882	The treatment of a premalignant lesion of the oral mucosa by a treatment using cryotherapy, diathermy or carbon dioxide laser.	$78.10
45885	Facial, mandibular or lingual artery or vein or artery and vein, ligation of, not being a service to which item 41707 applies (Anaes.) (Assist.)	$829.80
45888	FOREIGN BODY, in the oral and maxillofacial region, deep, removal of using interventional imaging techniques (Anaes.) (Assist.)	$745.40
45891	SINGLE-STAGE LOCAL FLAP where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.)	$1126.70
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 (Anaes.) (Assist.)	$1931.70
45900	Mandible, fixation by intermaxillary wiring, excluding wiring for obesity	$461.90
45939	PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.)	$866.10
45945	Mandible, treatment of a dislocation of, requiring open reduction (Anaes.)	$215.60
45975	MAXILLA, unilateral or bilateral, treatment of fracture of, not requiring splinting	$234.50
45978	Mandible, treatment of fracture of, not requiring splinting	$286.40
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) (Anaes.) (Assist.)	$1119.90
45987	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.)	$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) (Anaes.) (Assist.)	$1639.70
45993	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.)	$1800.50
45996	Mandible, treatment of a closed fracture of, involving a joint surface (Anaes.)	$433.80

Item no.	Description	Max fee (excl. GST)
	Hand surgery	
46300	Note: Items 46300 to 46534 are restricted to surgery on the hand/s. INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)	$701.70
46303	CARPOMETACARPAL JOINT, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)	$738.20
46306	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, interposition arthroplasty of and including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.)	$1118.50
46307	INTERPHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT—volar plate arthroplasty for traumatic deformity including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.)	$1016.10
46309	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment—1 joint (Anaes.) (Assist.)	$1027.20
46312	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment—2 joints (Anaes.) (Assist.)	$1299.00
46315	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment—3 joints (Anaes.) (Assist.)	$1745.10
46318	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment—4 joints (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2603.40
46324	CARPAL BONE REPLACEMENT ARTHROPLASTY including associated tendon transfer or realignment when performed (Anaes.) (Assist.)	$1694.10
46325	CARPAL BONE REPLACEMENT OR RESECTION ARTHROPLASTY using adjacent tendon or other soft tissue including associated tendon transfer or realignment when performed (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$766.40
46333	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous repair of, using free tissue graft or implant (Anaes.) (Assist.)	$1126.70
46336	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, synovectomy, capsulectomy or debridement of, not being a service associated with any procedure related to that joint (Anaes.) (Assist.)	$669.40
46339	EXTENSOR TENDONS or FLEXOR TENDONS of hand or wrist, synovectomy of (Anaes.) (Assist.)	$919.30
46342	DISTAL RADIOULNAR JOINT or CARPOMETACARPAL JOINT OR JOINTS, synovectomy of (Anaes.) (Assist.)	$919.30
46345	DISTAL RADIOULNAR JOINT, reconstruction or stabilisation of, including fusion, or ligamentous arthroplasty and excision of distal ulna, when performed (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$753.20
46354	DIGIT, synovectomy of flexor tendon or tendons—3 digits (Anaes.) (Assist.)	$1001.60
46357	DIGIT, synovectomy of flexor tendon or tendons—4 digits (Anaes.) (Assist.)	$1250.00
46360	DIGIT, synovectomy of flexor tendon or tendons—5 digits (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$850.00
46375	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves—1 hand (Anaes.) (Assist.)	$1008.20
46378	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves—1 hand (Anaes.) (Assist.)	$1340.20
46381	INTER-PHALANGEAL JOINT, joint capsule release when performed in conjunction with operation for Dupuytren's Contracture—each procedure (Anaes.) (Assist.)	$593.80

Item no.	Description	Max fee (excl. GST)
46384	Z PLASTY (or similar local flap procedure) when performed in conjunction with operation for Dupuytren's Contracture—1 such procedure (Anaes.) (Assist.)	$593.80
46387	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves—operation for recurrence in that ray (Anaes.) (Assist.)	$1221.90
46390	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves—operation for recurrence in those rays (Anaes.) (Assist.)	$1644.40
46393	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves—operation for recurrence in those rays (Anaes.) (Assist.)	$1899.40
46396	PHALANX OR METACARPAL OF THE HAND, osteotomy or osteectomy of, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)	$677.50
46399	PHALANX OR METACARPAL OF THE HAND, osteotomy of, with internal fixation (Anaes.) (Assist.)	$991.40
46402	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), including obtaining of graft material (Anaes.) (Assist.)	$1046.40
46405	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), involving internal fixation and including obtaining of graft material (Anaes.) (Assist.)	$1223.20
46408	TENDON, reconstruction of, by tendon graft (Anaes.) (Assist.)	$1326.60
46411	FLEXOR TENDON PULLEY, reconstruction of, by graft (Anaes.) (Assist.)	$835.60
46414	ARTIFICIAL TENDON PROSTHESIS, INSERTION OF, in preparation for tendon grafting (Anaes.) (Assist.)	$1012.30
46417	TENDON transfer for restoration of hand function, each transfer (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$669.40
46426	FLEXOR TENDON OF HAND OR WRIST, primary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.)	$681.20
46429	FLEXOR TENDON OF HAND OR WRIST, secondary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.)	$835.60
46432	FLEXOR TENDON OF HAND, primary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.)	$912.90
46435	FLEXOR TENDON OF HAND, secondary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.)	$1026.70
46438	Mallet finger, closed pin fixation of (Anaes.)	$350.00
46441	MALLET FINGER, open repair of, including pin fixation when performed (Anaes.) (Assist.)	$680.80
46442	MALLET FINGER with intra articular fracture involving more than one third of base of terminal phalanx—open reduction (Anaes.) (Assist.)	$581.50
46444	BOUTONNIERE DEFORMITY without joint contracture, reconstruction of (Anaes.) (Assist.)	$994.40
46447	BOUTONNIERE DEFORMITY with joint contracture, reconstruction of (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1010.00
46471	AMPUTATION of 3 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.)	$1126.40
46474	AMPUTATION of 4 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.)	$1331.80
46477	AMPUTATION of 5 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.)	$1639.10
46480	AMPUTATION of SINGLE DIGIT,proximal to nail bed, involving section of bone or joint and requiring soft tissue cover, including metacarpal (Anaes.) (Assist.)	$746.50

Item no.	Description	Max fee (excl. GST)
46483	REVISION of AMPUTATION STUMP to provide adequate soft tissue cover (Anaes.) (Assist.)	$593.80
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 (Anaes.) (Assist.)	$544.60
46492	CONTRACTURE OF DIGITS OF HAND, flexor or extensor, correction of, involving tissues deeper than skin and subcutaneous tissue (Anaes.) (Assist.)	$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 thana service associated with a service to which item 30107 applies (Anaes.)	$401.10
46498	GANGLION OF FLEXOR TENDON SHEATH, excision of,other thana service associated with a service to which item 30107 applies (Anaes.)	$451.60
46500	GANGLION OF DORSAL WRIST JOINT, excision of,other thana service associated with a service to which item 30107 applies (Anaes.) (Assist.)	$538.10
46501	GANGLION OF VOLAR WRIST JOINT, excision of,other thana service associated with a service to which item 30107 applies (Anaes.) (Assist.)	$658.60
46502	RECURRENT GANGLION OF DORSAL WRIST JOINT, excision of,other thana service associated with a service to which item30107 applies (Anaes.) (Assist.)	$585.60
46503	RECURRENT GANGLION OF VOLAR WRIST JOINT, excision of,other thana service associated with a service to which item30107 applies (Anaes.) (Assist.)	$728.80
46504	NEUROVASCULAR ISLAND FLAP, for pulp innervation (Anaes.) (Assist.)	$2182.40
46507	DIGIT OR RAY, transposition or transfer of, on vascular pedicle, complete procedure (Anaes.) (Assist.)	$2464.80
46510	MACRODACTYLY, surgical reduction of enlarged elements—each digit (Anaes.) (Assist.)	$902.90
46513	Digital nail of finger or thumb, removal of, not being a service to which item 46516 applies (Anaes.)	$102.60
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 (Anaes.) (Assist.)	$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.)	$103.80
46528	INGROWING NAIL OF FINGER OR THUMB, wedge resection for, including removal of segment of nail, ungual fold and portion of the nail bed (Anaes.)	$307.70
46531	INGROWING NAIL OF FINGER OR THUMB, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.)	$154.70
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.)	$108.20
47003	Clavicle, treatment of dislocation of, by closed reduction (Anaes.)	$123.10
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.)	$297.30
47012	SHOULDER, treatment of dislocation of, requiring general anaesthesia, open reduction (Anaes.) (Assist.)	$663.70
47015	Shoulder, treatment of dislocation of, not requiring general anaesthesia	$123.10
47018	Elbow, treatment of dislocation of, by closed reduction (Anaes.)	$307.10
47021	ELBOW, treatment of dislocation of, by open reduction (Anaes.) (Assist.)	$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.)	$378.80
47027	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by open reduction, not being a service associated with fracture or dislocation in the same region (Anaes.) (Assist.)	$513.60
47030	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by closed reduction (Anaes.)	$368.70

Item no.	Description	Max fee (excl. GST)
47033	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by open reduction (Anaes.) (Assist.)	$508.00
47036	INTERPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.)	$123.10
47039	Interphalangeal joint, treatment of dislocation of, by open reduction (Anaes.)	$217.20
47042	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.)	$166.10
47045	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.)	$292.10
47048	Hip, treatment of dislocation of, by closed reduction (Anaes.)	$582.30
47051	HIP, treatment of dislocation of, by open reduction (Anaes.) (Assist.)	$848.00
47054	KNEE, treatment of dislocation of, by closed reduction (Anaes.) (Assist.)	$549.00
47057	Patella, treatment of dislocation of, by closed reduction (Anaes.)	$184.00
47060	Patella, treatment of dislocation of, by open reduction (Anaes.)	$246.60
47063	Ankle or tarsus, treatment of dislocation of, by closed reduction (Anaes.)	$368.20
47066	ANKLE or TARSUS, treatment of dislocation of, by open reduction (Anaes.) (Assist.)	$649.10
47069	Toe, treatment of dislocation of, by closed reduction (Anaes.)	$102.70
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.)	$138.80
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.)	$158.20
47307	Phalanx or metacarpal, treatment of fracture of, by closed reduction with percutaneous k wire fixation (Anaes.) (Assist.)	$319.70
47310	Phalanx or metacarpal, treatment of fracture of, by open reduction with fixation (Anaes.) (Assist.)	$527.50
47313	Phalanx or metacarpal, treatment of intra articular fracture of, by closed reduction with percutaneous k wire fixation (Anaes.) (Assist.)	$511.60
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.)	$1015.00
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.)	$1039.00
47348	CARPUS (excluding scaphoid), treatment of fracture of, not being a service to which item 47351 applies (Anaes.)	$170.80
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 47357 applies (Anaes.)	$307.70
47357	CARPAL SCAPHOID, treatment of fracture of, by open reduction (Anaes.) (Assist.)	$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	$210.80
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.)	$315.80
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.)	$447.60
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.)	$357.50
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.)	$648.90
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.)	$463.60
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.)	$307.70
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 (Anaes.) (Assist.)	$649.90

Item no.	Description	Max fee (excl. GST)
47385	RADIUS OR ULNA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction undertaken in the operating theatre of a hospital (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$495.60
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 (Anaes.) (Assist.)	$1050.40
47396	OLECRANON, treatmentof fracture of, not being a service to which item 47399 applies (Anaes.)	$341.70
47399	OLECRANON, treatment of fracture of, by open reduction (Anaes.) (Assist.)	$762.00
47402	OLECRANON, treatment of fracture of, involving excision of olecranon fragment and reimplantation of tendon (Anaes.) (Assist.)	$705.00
47405	Radius, treatment of fracture of head or neck of, closed reduction of (Anaes.)	$341.70
47408	RADIUS, treatment of fracture of head or neck of, open reduction of, including internal fixation and excision where performed (Anaes.) (Assist.)	$797.30
47411	HUMERUS, treatment of fracture of tuberosity of, not being a service to which item 47417 applies (Anaes.)	$205.00
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 (Anaes.) (Assist.)	$506.30
47420	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$856.30
47432	HUMERUS, proximal, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.)	$1041.10
47435	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.)	$802.40
47438	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.)	$1274.80
47441	HUMERUS, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.)	$1642.90
47444	Humerus, shaft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies (Anaes.)	$428.40
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 fixation (Anaes.) (Assist.)	$968.70
47451	HUMERUS, shaft of, treatment of fracture of, by intramedullary fixation (Anaes.) (Assist.)	$1159.90
47453	HUMERUS, distal, (supracondylar or condylar), treatment of fracture of, not being a service to which item 47456 or 47459 applies (Anaes.) (Assist.)	$478.70
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 (Anaes.) (Assist.)	$1017.30
47462	CLAVICLE, treatment of fracture of, not being a service to which item 47465 applies (Anaes.)	$205.00
47465	CLAVICLE, treatment of fracture of, by open reduction (Anaes.) (Assist.)	$565.00
47466	STERNUM, treatment of fracture of, not being a service to which item 47467 applies (Anaes.)	$205.00
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 (Anaes.) (Assist.)	$918.40
47471	Ribs (1 or more), treatment of fracture of—each attendance	$78.10
47474	Pelvic ring, treatment of fracture of, not involving disruption of pelvic ring or acetabulum	$364.00

Item no.	Description	Max fee (excl. GST)
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 (Anaes.) (Assist.)	$1094.10
47483	PELVIC RING, treatment of fracture of, requiring control by external fixation (Anaes.) (Assist.)	$1095.90
47486	PELVIC RING, treatment of fracture of, by open reduction and involving internal fixation of anterior segment, including diastasis of pubic symphysis (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2735.20
47492	ACETABULUM, treatment of fracture of, and associated dislocation of hip (Anaes.)	$427.90
47495	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring traction (Anaes.) (Assist.)	$920.00
47498	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring internal fixation, with or without traction (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2735.20
47507	ACETABULUM, treatment of transverse fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$683.90
47516	FEMUR, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.)	$841.20
47519	FEMUR, treatment of trochanteric or subcapital fracture of, by internal fixation (Anaes.) (Assist.)	$1661.50
47522	FEMUR, treatment of subcapital fracture of, by hemi-arthroplasty (Anaes.) (Assist.)	$1442.90
47525	FEMUR, treatment of fracture of, for slipped capital femoral epiphysis (Anaes.) (Assist.)	$1662.80
47528	FEMUR, treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.)	$1459.00
47531	FEMUR, treatment of fracture of shaft, by intramedullary fixation and cross fixation (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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.)	$410.50
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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$730.50
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 (Anaes.) (Assist.)	$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.)	$495.60
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 (Anaes.) (Assist.)	$1378.20
47566	TIBIA, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (Anaes.) (Assist.)	$1749.20
47567	TIBIA, shaft of, treatment of intra-articular fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) (Assist.)	$916.00

Item no.	Description	Max fee (excl. GST)
47570	TIBIA, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (Anaes.) (Assist.)	$1057.90
47573	TIBIA, shaft of, treatment of intra-articular fracture of, by open reduction, with or without treatment of fibula fracture (Anaes.) (Assist.)	$1334.80
47576	Fibula, treatment of fracture of (Anaes.)	$205.00
47579	PATELLA, treatment of fracture of, not being a service to which item 47582 or 47585 applies (Anaes.)	$290.70
47582	PATELLA, treatment of fracture of, by excision of patella or pole with reattachment of tendon (Anaes.) (Assist.)	$654.00
47585	PATELLA, treatment of fracture of, by internal fixation (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$3105.80
47594	Ankle joint, treatment of fracture of, not being a service to which item 47597 applies (Anaes.)	$393.10
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 (Anaes.) (Assist.)	$850.50
47603	ANKLE JOINT, treatment of fracture of, by internal fixation of more than 1 of malleolus, fibula or diastasis (Anaes.) (Assist.)	$1084.70
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.)	$427.90
47609	CALCANEUM OR TALUS, treatment of fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.)	$677.80
47612	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.)	$814.30
47615	CALCANEUM OR TALUS, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.)	$920.00
47618	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.)	$1226.50
47621	TARSO-METATARSAL, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.)	$784.50
47624	TARSO-METATARSAL, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.)	$1110.10
47627	Tarsus (excluding calcaneum or talus), treatment of fracture of (Anaes.)	$290.70
47630	TARSUS (excluding calcaneum or talus), treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.)	$650.60
47633	Metatarsal, 1 of, treatment of fracture of (Anaes.)	$205.00
47636	Metatarsal, 1 of, treatment of fracture of, by closed reduction (Anaes.)	$307.70
47639	Metatarsal, 1 of, treatment of fracture of, by open reduction (Anaes.)	$494.00
47642	Metatarsals, 2 of, treatment of fracture of (Anaes.)	$274.00
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 (Anaes.) (Assist.)	$609.10
47651	Metatarsals, 3 or more of, treatment of fracture of (Anaes.)	$427.90
47654	METATARSALS, 3 or more of, treatment of fracture of, by closed reduction (Anaes.) (Assist.)	$694.80
47657	METATARSALS, 3 or more of, treatment of fracture of, by open reduction (Anaes.) (Assist.)	$911.40
47663	Phalanx of great toe, treatment of fracture of, by closed reduction (Anaes.)	$256.70
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.)	$214.10
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

Item no.	Description	Max fee (excl. GST)
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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1066.10
47753	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.)	$1020.00
47756	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$938.90
47768	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.)	$1200.00
47771	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.)	$1380.00
47774	MAXILLA, treatment of fracture of, requiring open operation (Anaes.) (Assist.)	$845.80
47777	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.)	$791.40
47780	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.)	$1028.80
47783	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.)	$1028.80
47786	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.)	$1800.00
47789	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.)	$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.)	$102.60
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.)	$102.60
47915	Ingrowing nail of toe, wedge resection for, with removal of segment of nail, ungual fold and portion of the nail bed (Anaes.)	$324.20
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.)	$154.70
47918	Ingrowing toenail, radical excision of nailbed (Anaes.)	$454.40
47920	BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$545.00
47948	External fixation, removal of, in the operating theatre of a hospital (Anaes.)	$310.30

Item no.	Description	Max fee (excl. GST)
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 (Anaes.) (Assist.)	$792.40
47957	TENDON, large, lengthening of, as an independent procedure (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$957.90
47969	TENOSYNOVECTOMY, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$709.60
48200	FEMUR, bone graft to (Anaes.) (Assist.)	$1460.70
48203	FEMUR, bone graft to, with internal fixation (Anaes.) (Assist.)	$1768.80
48206	TIBIA, bone graft to (Anaes.) (Assist.)	$1102.20
48209	TIBIA, bone graft to, with internal fixation (Anaes.) (Assist.)	$1390.20
48212	HUMERUS, bone graft to (Anaes.) (Assist.)	$1085.70
48215	HUMERUS, bone graft to, with internal fixation (Anaes.) (Assist.)	$1393.80
48218	RADIUS AND ULNA, bone graft to (Anaes.) (Assist.)	$1086.50
48221	RADIUS AND ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.)	$1445.70
48224	RADIUS OR ULNA, bone graft to (Anaes.) (Assist.)	$722.00
48227	RADIUS OR ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.)	$1026.40
48230	SCAPHOID, bone graft to, for non-union (Anaes.) (Assist.)	$976.00
48233	SCAPHOID, bone graft to, for non-union, with internal fixation (Anaes.) (Assist.)	$1272.80
48236	SCAPHOID, bone graft to, for mal-union, including osteotomy, bone graft and internal fixation (Anaes.) (Assist.)	$1552.30
48239	BONE GRAFT, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$882.00
48242	BONE GRAFT, with internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$661.50
48403	PHALANX OR METATARSAL, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$680.80
48409	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than Acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)	$1113.70
48412	HUMERUS, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)	$1220.70
48415	HUMERUS, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)	$1538.50
48418	TIBIA, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)	$1208.50
48421	TIBIA, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)	$1807.10

Item no.	Description	Max fee (excl. GST)
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 (Anaes.) (Assist.)	$1788.90
48500	FEMUR, epiphysiodesis of (Anaes.) (Assist.)	$633.90
48503	TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.)	$631.90
48506	FEMUR, TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.)	$936.90
48509	Epiphysiodesis, staple arrest of hemiepiphysis (Anaes.)	$427.90
48512	EPIPHYSIOLYSIS, operation to prevent closure of plate (Anaes.) (Assist.)	$1749.30
48900	SHOULDER, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both (Anaes.) (Assist.)	$551.20
48903	SHOULDER, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1083.20
48909	SHOULDER, repairof rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination, not being a service associated with a service to which item 48903 applies (Anaes.) (Assist.)	$1686.20
48912	SHOULDER, arthrotomy of (Anaes.) (Assist.)	$632.30
48915	SHOULDER, hemi-arthroplasty of (Anaes.) (Assist.)	$1508.50
48918	SHOULDER, total replacement arthroplasty of, including any associated rotator cuff repair (Anaes.) (Assist.)	$3127.70
48921	SHOULDER, total replacement arthroplasty, revision of (Anaes.) (Assist.)	$3015.50
48924	SHOULDER, total replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or both (Anaes.) (Assist.)	$3601.90
48927	SHOULDER prosthesis, removal of (Anaes.) (Assist.)	$666.70
48930	SHOULDER, stabilisation procedure for recurrent anterior or posterior dislocation (Anaes.) (Assist.)	$1700.80
48933	SHOULDER, stabilisation procedure for multi-directional instability, including anterior or posterior (or both) repair when performed (Anaes.) (Assist.)	$2009.00
48936	SHOULDER, synovectomy of, as an independent procedure (Anaes.) (Assist.)	$1461.60
48939	SHOULDER, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)	$2225.00
48942	SHOULDER, arthrodesis of, with synovectomy if performed, with removal of prosthesis, requiring bone grafting or internal fixation (Anaes.) (Assist.)	$2739.20
48945	SHOULDER, diagnostic arthroscopy of (including biopsy)—not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.)	$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—not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.)	$1325.60
48951	SHOULDER, arthroscopic division of coraco-acromial ligament including acromioplasty—not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1977.70
49100	ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture (Anaes.) (Assist.)	$666.10
49103	ELBOW, ligamentous stabilisation of (Anaes.) (Assist.)	$1443.10
49106	ELBOW, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)	$1828.10
49109	ELBOW, total synovectomy of (Anaes.) (Assist.)	$1488.20

Item no.	Description	Max fee (excl. GST)
49112	ELBOW, silastic or other replacement of radial head (Anaes.) (Assist.)	$1415.70
49115	ELBOW, total joint replacement of (Anaes.) (Assist.)	$2687.70
49116	ELBOW, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.)	$2857.30
49117	ELBOW, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.)	$3646.70
49118	ELBOW, diagnostic arthroscopy of, including biopsy and lavage, not being a service associated with any other arthroscopic procedure of the elbow (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1280.40
49200	WRIST, arthrodesis of, with synovectomy if performed, with or without bone graft and internal fixation of the radiocarpal joint (Anaes.) (Assist.)	$1593.90
49203	WRIST, limited arthrodesis of the intercarpal joint, with synovectomy if performed, with or without bone graft (Anaes.) (Assist.)	$1239.70
49206	WRIST, proximal carpectomy of, including styloidectomy when performed (Anaes.) (Assist.)	$1142.20
49209	WRIST, total replacement arthroplasty of (Anaes.) (Assist.)	$1610.60
49210	WRIST, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.)	$1928.10
49211	WRIST, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1444.40
49300	SACROILIAC JOINT arthrodesis of (Anaes.) (Assist.)	$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	HIParthrodesis of, with synovectomy if performed (Anaes.) (Assist.)	$2072.40
49309	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (Austin Moore or similar (non cement)) (Anaes.) (Assist.)	$1550.10
49312	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (cemented, porous coated or similar) (Anaes.) (Assist.)	$1828.10
49315	HIP, arthroplasty of, unipolar or bipolar (Anaes.) (Assist.)	$1626.00
49318	HIP, total replacement arthroplasty of, including minor bone grafting (Anaes.) (Assist.)	$2730.40
49319	HIP, total replacement arthroplasty of, including associated minor grafting, if performed—bilateral (Anaes.) (Assist.)	$5233.80
49321	HIP, total replacement arthroplasty of, including major bone grafting, including obtaining of graft (Anaes.) (Assist.)	$3104.20
49324	HIP, total replacement arthroplasty of, revision procedure including removal of prosthesis (Anaes.) (Assist.)	$3650.70
49327	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to acetabulum, including obtaining of graft (Anaes.) (Assist.)	$4157.90
49330	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (Anaes.) (Assist.)	$4295.70
49333	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to both acetabulum and femur, including obtaining of graft (Anaes.) (Assist.)	$4729.40

Item no.	Description	Max fee (excl. GST)
49336	HIP, treatment of a fracture of the femur where revision total hip replacement is required as part of the treatment of the fracture (not including intra-operative fracture), being a service associated with a service to which items 49324 to 49333 apply (Anaes.) (Assist.)	$692.40
49339	HIP, revision total replacement of, requiring anatomic specific allograft of proximal femur greater than 5 cm in length (Anaes.) (Assist.)	$5388.90
49342	HIP, revision total replacement of, requiring anatomic specific allograft of acetabulum (Anaes.) (Assist.)	$5721.10
49345	HIP, revision total replacement of, requiring anatomic specific allograft of both femur and acetabulum (Anaes.) (Assist.)	$6393.10
49346	HIP, revision arthroplasty with replacement of acetabular liner or ceramic head, not requiring removal of femoral component or acetabular shell (Anaes.) (Assist.)	$1636.50
49360	HIP, diagnostic arthroscopy of, not being a service associated with any other arthroscopic procedure of the hip (Anaes.) (Assist.)	$669.40
49363	HIP, diagnostic arthroscopy of, with synovial biopsy, not being a service associated with any other arthroscopic procedure of the hip (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1412.50
49509	KNEE, total synovectomy or arthrodesis with synovectomy if performed (Anaes.) (Assist.)	$1460.30
49512	KNEE, arthrodesis of, with synovectomy if performed, with removal of prosthesis (Anaes.) (Assist.)	$2087.20
49515	KNEE, removal of prosthesis, cemented or uncemented, including associated cement, as the first stage of a 2 stage procedure (Anaes.) (Assist.)	$1833.50
49517	KNEE, hemiarthroplasty of (Anaes.) (Assist.)	$2625.20
49518	KNEE, total replacement arthroplasty of (Anaes.) (Assist.)	$2727.00
49519	KNEE, total replacement arthroplasty of, including associated minor grafting, if performed—bilateral (Anaes.) (Assist.)	$5145.30
49521	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur or tibia, including obtaining of graft (Anaes.) (Assist.)	$3066.70
49524	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur and tibia, including obtaining of graft (Anaes.) (Assist.)	$3611.00
49527	KNEE, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$4333.40
49534	KNEE, patello-femoral joint of, total replacement arthroplasty as a primary procedure (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1860.50
49539	KNEE, reconstructive surgery of cruciate ligament or ligaments (open or arthroscopic, or both), including notchplasty when performed and surgery to other internal derangements, not being a service to which another item in this Group applies or a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.)	$2107.90
49542	KNEE, reconstructive surgery to cruciate ligament or ligaments (open or arthroscopic, or both), including notchplasty, meniscus repair, extracapsular procedure and debridement when performed, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.)	$2822.50
49545	KNEE, revision arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)	$1367.90
49548	KNEE, revision of patello-femoral stabilisation (Anaes.) (Assist.)	$1928.60
49551	KNEE, revision of procedures to which item 49536, 49539 or 49542 applies (Anaes.) (Assist.)	$2821.20

Item no.	Description	Max fee (excl. GST)
49554	KNEE, revision of total replacement of, by anatomic specific allograft of tibia or femur (Anaes.) (Assist.)	$3611.60
49557	KNEE, diagnostic arthroscopy of (including biopsy, simple trimming of meniscal margin or plica)—not being a service associated with autologous chondrocyte implantation or matrix-induced autologous chondrocyte implantation or any other arthroscopic procedure of the knee region (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$532.40
49559	KNEE, arthroscopic surgery of, involving chondroplasty requiring multiple drilling or carbon fibre (or similar) implant; including any associated debridement or oestoplasty—not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1500.10
49563	KNEE, arthroscopic surgery of, involving 1 or more of: meniscus repair; osteochondral graft; or chondral graft (excluding autologous chondrocyte implantation or matrix-induced autologous chondrocyte implantation) -not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1906.90
49566	KNEE, arthroscopic total synovectomy of, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.)	$1754.70
49569	KNEE, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (Anaes.) (Assist.)	$1448.90
49700	ANKLE, diagnostic arthroscopy of, including biopsy (Anaes.) (Assist.)	$552.40
49703	ANKLE, arthroscopic surgery of, not being a service associated with any other arthroscopic procedure of the ankle (Anaes.) (Assist.)	$1332.20
49706	ANKLE, arthrotomy of, involving 1 or more of: lavage, removal of loose body or division of contracture (Anaes.) (Assist.)	$700.40
49709	ANKLE, ligamentous stabilisation of (Anaes.) (Assist.)	$1514.10
49712	ANKLE, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)	$1600.00
49715	ANKLE, total joint replacement of (Anaes.) (Assist.)	$2268.30
49716	ANKLE, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.)	$2837.60
49717	ANKLE, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.)	$3811.90
49718	ANKLE, Achilles' tendon or other major tendon, repair of (Anaes.) (Assist.)	$828.90
49721	Ankle, Achilles' tendon rupture managed by non-operative treatment	$453.90
49724	ANKLE, Achilles' tendon, secondary repair or reconstruction of (Anaes.) (Assist.)	$1655.00
49727	ANKLE, Achilles' tendon, operation for lengthening (Anaes.) (Assist.)	$630.80
49728	ANKLE, lengthening of the gastrocnemius aponeurosis and soleus fascia, for the correction of equinus deformity in children with cerebral palsy (Anaes.) (Assist.)	$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
49812	FOOT, tendon or ligament transplantation of, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$897.00
49815	FOOT, triple arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)	$1664.00
49818	FOOT, excision of calcaneal spur (Anaes.) (Assist.)	$654.70

Item no.	Description	Max fee (excl. GST)
49821	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure)—unilateral (Anaes.) (Assist.)	$856.90
49824	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure)—bilateral (Anaes.) (Assist.)	$1469.10
49827	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon—unilateral (Anaes.) (Assist.)	$948.50
49830	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon—bilateral (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1992.30
49837	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint—unilateral (Anaes.) (Assist.)	$1272.70
49838	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint—bilateral (Anaes.) (Assist.)	$2174.00
49839	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty—unilateral (Anaes.) (Assist.)	$1136.50
49842	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty—bilateral (Anaes.) (Assist.)	$1981.00
49845	FOOT, arthrodesis of, first metatarso-phalangeal joint, with synovectomy if performed (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$721.10
49857	FOOT, metatarso-phalangeal joint replacement (Anaes.) (Assist.)	$838.40
49860	FOOT, synovectomy of metatarso-phalangeal joint, single joint (Anaes.) (Assist.)	$581.90
49863	FOOT, synovectomy of metatarso-phalangeal joint, 2 or more joints (Anaes.) (Assist.)	$824.90
49866	FOOT, neurectomy for plantar or digital neuritis (Morton's or Bett's syndrome) (Anaes.) (Assist.)	$656.30
49878	TALIPES EQUINOVARUS, calcaneo valgus or metatarus 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 (Anaes.) (Assist.)	$528.80
50102	JOINT, arthroscopic surgery of, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$1173.10
50103	JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$649.00
50104	JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$934.10
50109	JOINT, arthrodesis of, not being a service to which another item in this Group applies, with synovectomy if performed (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$932.30
50121	GREATER TROCHANTER, transplantation of ileopsoas tendon to (Anaes.) (Assist.)	$1913.40
50127	JOINT OR JOINTS, arthroplasty of, by any technique not being a service to which another item applies (Anaes.) (Assist.)	$1353.80
50130	JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.)	$731.10

Item no.	Description	Max fee (excl. GST)
50200	Aggressive or potentially malignant bone or deep soft tissue tumour, biopsy of (not including aftercare) (Anaes.)	$364.00
50201	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, involving neurovascular structures, open biopsy of (not including aftercare) (Anaes.) (Assist.)	$659.30
50203	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes.) (Assist.)	$854.90
50206	BONE TUMOUR, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.)	$1220.30
50209	BONE TUMOUR, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$3158.90
50215	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, with intercalary reconstruction (prosthesis, allograft or autograft) (Anaes.) (Assist.)	$3967.30
50218	MALIGNANT TUMOUR of LONG BONE, enbloc resection of, with replacement or arthrodesis of adjacent joint, with synovectomy if performed (Anaes.) (Assist.)	$5271.70
50221	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$5431.80
50227	MALIGNANT BONE TUMOUR, enbloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement (Anaes.) (Assist.)	$6094.40
50230	BENIGN TUMOUR, resection of, requiring anatomic specific allograft, with or without internal fixation (Anaes.) (Assist.)	$3229.70
50233	MALIGNANT TUMOUR, amputation for, hemipelvectomy or interscapulo-thoracic (Anaes.) (Assist.)	$4150.90
50236	MALIGNANT TUMOUR, amputation for, hip disarticulation, shoulder disarticulation or proximal third femur (Anaes.) (Assist.)	$3093.30
50239	MALIGNANT TUMOUR, amputation for, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$584.20
50312	ANKLE, synovectomy of, by arthroscopic or open means—not associated with any other arthroscopic procedure of the ankle (Anaes.) (Assist.)	$1347.50
50315	TALIPES EQUINOVARUS, posterior release of (Anaes.) (Assist.)	$1332.20
50318	TALIPES EQUINOVARUS, medial release of (Anaes.) (Assist.)	$1259.00
50321	TALIPES EQUINOVARUS, combined postero-medial release of (Anaes.) (Assist.)	$1792.20
50324	TALIPES EQUINOVARUS, combined postero-medial release of, revision procedure (Anaes.) (Assist.)	$2404.60
50327	TALIPES EQUINOVARUS, bilateral procedures (Anaes.) (Assist.)	$2933.10
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 (Anaes.) (Assist.)	$1238.50
50336	TALUS, VERTICAL, CONGENITAL, combined anterior and posterior reconstruction (Anaes.) (Assist.)	$1674.40

Item no.	Description	Max fee (excl. GST)
50339	FOOT AND ANKLE, tibialis anterior tendon (split or whole) transfer to lateral column (Anaes.) (Assist.)	$1079.90
50342	FOOT AND ANKLE, tibialis or tibialis posterior tendon transfer, through the interosseous membrane to anterior or posterior aspect of foot (Anaes.) (Assist.)	$1252.50
50345	HYPEREXTENSION DEFORMITY OF TOE, release incorporating V-Y plasty of skin, lengthening of extensor tendons and release of capsule contracture (Anaes.) (Assist.)	$737.90
50348	HIP, KNEE AND LEG PROCEDURES KNEE, deformity of, post-operative manipulation and change of plaster, performed under general anaesthesiain the operating theatre of a hospital (Anaes.)	$470.50
50349	Hip, congenital dislocation of, treatment of, by closed reduction (Anaes.)	$581.40
50351	HIP, developmental dislocation of, open reduction of (Anaes.) (Assist.)	$2900.70
50352	Hip, congenital dislocation of, treatment of, involving supervision of splint, harness or cast—each attendance (Anaes.)	$109.20
50353	HIP SPICA, initial application of, for congenital dislocation of hip (excluding aftercare) (Anaes.) (Assist.)	$644.20
50354	TIBIA, pseudarthrosis of, congenital, resection and internal fixation (Anaes.) (Assist.)	$2379.10
50357	KNEE, LEG OR THIGH, rectus femoris tendon transfer, or medial or lateral hamstring tendon transfer (Anaes.) (Assist.)	$1242.20
50360	KNEE, LEG OR THIGH, combined medial and lateral hamstring tendon transfer (Anaes.) (Assist.)	$1380.50
50363	KNEE, contracture of, posterior releaseinvolving multiple tendon lengthening or tenotomies, unilateral (Anaes.) (Assist.)	$960.80
50366	KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, bilateral (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2077.30
50375	HIP, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, unilateral (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$2212.50
50387	HIP, iliopsoas tendon transfer to greater trochanter, or transfer of abdominal musculature to greater trochanter, or transfer of adductors to ischium (Anaes.) (Assist.)	$1183.40
50390	PERTHES, CEREBRAL PALSY, or other neuromuscular conditions, affecting hips or knees, application of cast under general anaesthesia, performed in the operating theatre of a hospital (Anaes.)	$443.70
50393	PELVIS, bone graft or shelf procedures for acetabular dysplasia (Anaes.) (Assist.)	$1625.40
50394	ACETABULAR DYSPLASIA, treatment of, by multiple peri-acetabular osteotomy, including internal fixation where performed (Anaes.) (Assist.)	$5378.90
50396	SHOULDER, ARM AND FOREARM PROCEDURES HAND, congenital abnormalities or duplication of digits, amputation or splitting of phalanx or phalanges, with ligament or joint reconstruction (Anaes.) (Assist.)	$915.40
50399	FOREARM, RADIAL APLASIA OR DYSPLASIA (radial club hand), centralisation or radialisation of (Anaes.) (Assist.)	$1674.40
50402	TORTICOLLIS, bipolar release of sternocleidomastoid muscle and associated soft tissue (Anaes.) (Assist.)	$816.60
50405	ELBOW, flexorplasty, or tendon transfer to restore elbow function (Anaes.) (Assist.)	$1200.70
50408	SHOULDER, congenital or developmental dislocation, open reduction of (Anaes.) (Assist.)	$1812.90
50411	AMPUTATIONS OR RECONSTRUCTIONS FOR CONGENITAL DEFORMITIES LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion (Anaes.) (Assist.)	$2379.10
50414	LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion and rotationplasty (Anaes.) (Assist.)	$3210.10
50417	LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the tibia by reconstruction of the knee, involving transfer of fibula or tibia, and repair of quadriceps mechanism (Anaes.) (Assist.)	$2379.10
50420	PATELLA, congenital dislocation of, reconstruction of the quadriceps (Anaes.) (Assist.)	$1964.00

Item no.	Description	Max fee (excl. GST)
50423	TIBIA, FIBULA OR BOTH, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (Anaes.) (Assist.)	$2285.90
50426	TUMOROUS CONDITIONS DIAPHYSEAL ACLASIA, removal of lesion or lesions from bone—1 approach (Anaes.) (Assist.)	$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: (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of femoral torsion by rotational osteotomy of the femur. (d) Correction of tibial torsion by rotational osteotomy of the tibia. (e) Correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis, with synovectomy if performed, or os calcis lengthening. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)	$2216.90
50451	UNILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with hemiplegic cerebral palsy comprising three or more of the following: (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of femoral torsion by rotational osteotomy of the femur. (d) Correction of tibial torsion by rotational osteotomy of the tibia. (e)Correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis, with synovectomy if performed, or os calcis lengthening. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.)	$2216.90
50455	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, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)	$2510.50
50456	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises: (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.)	$2510.50
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. (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, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)	$3747.90
50461	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral femoral osteotomies. (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.)	$3747.90
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. (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, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)	$5279.20
50466	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies. (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation. (d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.)	$5279.20
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. (a)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. (b)Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation. (c)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, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)	$6695.20

Item no.	Description	Max fee (excl. GST)
50471	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation. (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation. (d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. (e) Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.)	$6695.20
50475	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, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)	$7725.60
50476	SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including: (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation. (d) Correction of patella alta and quadriceps insufficiency by patella tendon shortening/reconstruction. (e) Correction of tibial torsion by rotational osteotomy of the tibia with internal fixation. (f) Correction of foot instability by os calcis lengthening or subtalar fusion. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.)	$7725.60
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 (Anaes.) (Assist.)	$670.10
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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$741.80
50528	RADIUS OR ULNA, shaft of, with open growth plate, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1482.30
50540	OLECRANON, with open growth plate, treatment of fracture of, by open reduction (Anaes.) (Assist.)	$1015.50
50544	RADIUS, with open growth plate, treatment of fracture of head or neck of, by closed reduction of (Anaes.)	$478.70
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 (Anaes.) (Assist.)	$957.70
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 (Anaes.) (Assist.)	$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.)	$861.60
50564	HUMERUS, shaft of, with open growth plate, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.)	$1148.80
50568	HUMERUS, with open growth plate, supracondylar or condylar, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.)	$1066.50

Item no.	Description	Max fee (excl. GST)
50572	HUMERUS, with open growth plate, supracondylar or condylar, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means, undertaken in the operating theatre of a hospital (Anaes.) (Assist.)	$1417.40
50576	FEMUR, with open growth plate, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.)	$1533.80
50580	TIBIA, with open growth plate, plateau or condyles, medial or lateral, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.)	$1203.90
50584	TIBIA, distal, with open growth plate, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.)	$1377.50
50588	TIBIA AND FIBULA, with open growth plates, treatment of fracture of, by internal fixation (Anaes.) (Assist.)	$1519.90
50600	SCOLIOSIS OR KYPHOSIS, in a growing child, manipulation of deformity and application of a localiser cast, under general anaesthesia, in a hospital (Anaes.) (Assist.)	$785.40
50604	SCOLIOSIS or KYPHOSIS, in a child or adolescent, spinal fusion for (without instrumentation) (Anaes.) (Assist.)	$3333.70
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 (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$6645.10
50628	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar)—more than 4 levels (Anaes.) (Assist.)	$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.)	$7144.50
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.)	$3949.30
50644	SPINE, bone graft to, for a child or adolescent, associated with surgery for correction of scoliosis or kyphosis or both (Anaes.) (Assist.)	$4242.10
50650	HIP DYSPLASIA or DISLOCATION, in a child, examination, manipulation and arthrography of the hip under anaesthesia (Anaes.)	$749.40
50654	HIP DYSPLASIA or DISLOCATION, in a child, application or reapplication of a hip spica, including examination of the hip (Anaes.) (Assist.)	$897.30
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.)	$1550.40
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 an unresectable portion of the liver that is suitable for radiofrequency ablation or microwave tissue ablation; other than a service associated with a service to which item30419 or 50950 applies. (Anaes.)	$1573.00

Item no.	Description	Max fee (excl. GST)
	Spinal Surgery	
51011	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, one motion segment, not being a service associated with a service to which item 51012, 51013, 51014 or 51015 applies (Anaes.) (Assist.)	$2208.50
51012	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, 2 motion segments, not being a service associated with a service to which item 51011, 51013, 51014 or 51015 applies (Anaes.) (Assist.)	$2944.80
51013	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, 3 motion segments, not being a service associated with a service to which item 51011, 51012, 51014 or 51015 applies (Anaes.) (Assist.)	$3681.00
51014	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, 4 motion segments, not being a service associated with a service to which item 51011, 51012, 51013 or 51015 applies (Anaes.) (Assist.)	$4417.20
51015	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, more than 4 motion segments, not being a service associated with a service to which item 51011, 51012, 51013 or 51014 applies (Anaes.) (Assist.)	$5153.30
51020	Simple fixation of part of one vertebra (not motion segment) including pars interarticularis, spinous process or pedicle, or simple interspinous wiring between 2 adjacent vertebral levels, not being a service associated with: (a) interspinous dynamic stabilisation devices; or (b) a service to which item51021, 51022, 51023, 51024, 51025 or 51026 applies (Anaes.) (Assist.)	$1177.80
51021	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, one motion segment, not being a service associated with a service to which item 51020, 51022, 51023, 51024, 51025 or 51026 applies (Anaes.) (Assist.)	$1971.40
51022	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 2 motion segments, not being a service associated with a service to which item 51020, 51021, 51023, 51024, 51025 or 51026 applies (Anaes.) (Assist.)	$2452.30
51023	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 3 or 4 motion segments, not being a service associated with a service to which item 51020, 51021, 51022, 51024, 51025 or 51026 applies (Anaes.) (Assist.)	$2918.30
51024	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 5 or 6 motion segments, not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51025 or 51026 applies (Anaes.) (Assist.)	$3369.10
51025	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 7 to 12 motion segments, not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51024 or 51026 applies (Anaes.) (Assist.)	$3937.80
51026	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, more than 12 motion segments, not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51024 or 51025 applies (Anaes.) (Assist.)	$4311.30
51031	Spine, posterior and/or posterolateral bone graft to, one motion segment, not being a service associated with a service to which item 51032, 51033, 51034, 51035 or 51036 applies (Anaes.) (Assist.)	$1448.60
51032	Spine, posterior and/or posterolateral bone graft to, 2 motion segments, not being a service associated with a service to which item 51031, 51033, 51034, 51035 or 51036 applies (Anaes.) (Assist.)	$1738.30
51033	Spine, posterior and/or posterolateral bone graft to, 3 motion segments, not being a service associated with a service to which item 51031, 51032, 51034, 51035 or 51036 applies (Anaes.) (Assist.)	$2028.10
51034	Spine, posterior and/or posterolateral bone graft to, 4 to 7 motion segments, not being a service associated with a service to which item 51031, 51032, 51033, 51035 or 51036 applies (Anaes.) (Assist.)	$2173.00
51035	Spine, posterior and/or posterolateral bone graft to, 8 to 11 motion segments, not being a service associated with a service to which item 51031, 51032, 51033, 51034 or 51036 applies (Anaes.) (Assist.)	$2317.80
51036	Spine, posterior and/or posterolateral bone graft to, 12 or more motion segments, not being a service associated with a service to which item 51031, 51032, 51033, 51034 or 51035 applies (Anaes.) (Assist.)	$2462.70
51041	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), one motion segment, not being a service associated with a service to which item 51042, 51043, 51044 or 51045 applies (Anaes.) (Assist.)	$1666.00
51042	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 2 motion segments, not being a service associated with a service to which item 51041, 51043, 51044 or 51045 applies (Anaes.) (Assist.)	$2332.40
51043	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 3 motion segments, not being a service associated with a service to which item 51041, 51042, 51044 or 51045 applies (Anaes.) (Assist.)	$2915.40

Item no.	Description	Max fee (excl. GST)
51044	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 4 motion segments, not being a service associated with a service to which item 51041, 51042, 51043 or 51045 applies (Anaes.) (Assist.)	$3165.30
51045	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 5 or more motion segments, not being a service associated with a service to which item 51041, 51042, 51043 or 51044 applies (Anaes.) (Assist.)	$3331.90
51051	Pedicle subtraction osteotomy, one vertebra, not being a service associated with a service to which item 51052, 51053, 51054, 51055, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.)	$2846.60
51052	Pedicle subtraction osteotomy, 2 vertebrae, not being a service associated with a service to which item 51051, 51053, 51054, 51055, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.)	$3462.10
51053	Vertebral column resection osteotomy performed through single posterior approach, one vertebra, not being a service associated with a service to which item 51051, 51052, 51054, 51055, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.)	$3939.10
51054	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtotal excision is defined as removal of more than 50% of the vertebral body), one vertebra, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51055, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.)	$2100.30
51055	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtotal excision is defined as removal of more than 50% of the vertebral body), 2 vertebrae, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51056, 51057, 51058 or 51059 applies (Anaes.) (Assist.)	$3150.50
51056	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtotal excision is defined as removal of more than 50% of the vertebral body), 3 or more vertebrae, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item51051, 51052, 51053, 51054, 51055, 51057, 51058 or 51059 applies (Anaes.) (Assist.)	$3675.50
51057	Vertebral body, en bloc excision of (complete spondylectomy), one vertebra, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51058 or 51059 applies (Anaes.) (Assist.)	$3692.90
51058	Vertebral body, en bloc excision of (complete spondylectomy), 2 vertebrae, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51057 or 51059 applies (Anaes.) (Assist.)	$4155.30
51059	Vertebral body, en bloc excision of (complete spondylectomy), 3 or more vertebrae, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item51051, 51052, 51053, 51054, 51055, 51056, 51057 or 51058 applies (Anaes.) (Assist.)	$5077.70
51061	Spinal fusion, anterior and posterior, including spinal instrumentation at one motion segment, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51062, 51063, 51064, 51065 or 51066 applies (Anaes.) (Assist.)	$4361.70
51062	Spinal fusion, anterior and posterior, including spinal instrumentation at 2 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51063, 51064, 51065 or 51066 applies (Anaes.) (Assist.)	$5653.70
51063	Spinal fusion, anterior and posterior, including spinal instrumentation at 3 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51062, 51064, 51065 or 51066 applies (Anaes.) (Assist.)	$6847.70
51064	Spinal fusion, anterior and posterior, including spinal instrumentation at 4 to 7 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51062, 51063, 51065 or 51066 applies (Anaes.) (Assist.)	$7621.00
51065	Spinal fusion, anterior and posterior, including spinal instrumentation at 8 to 11 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51062, 51063, 51064 or 51066 applies (Anaes.) (Assist.)	$8428.70
51066	Spinal fusion, anterior and posterior, including spinal instrumentation at 12 or more motion segments, posterior and/or posterolateral bone graft, and anterior column fusion not being a service associated with a service to which item 51061, 51062, 51063, 51064 or 51065 applies (Anaes.) (Assist.)	$8874.50
51071	Removal of intradural lesion, not being a service associated with a service to which item 51072 or 51073 applies (Anaes.) (Assist.)	$3846.80
51072	Craniocervical junction lesion, transoral approach for, not being a service associated with a service to which item 51071 or 51073 applies (Anaes.) (Assist.)	$4000.60
51073	Removal of intramedullary tumour or arteriovenous malformation, not being a service associated with a service to which item 51071 or 51072 applies (Anaes.) (Assist.)	$5077.70
51102	Thoracoplasty in combination with thoracic scoliosis correction 3 or more ribs (Anaes.) (Assist.)	$1820.90
51103	Odontoid screw fixation (Anaes.) (Assist.)	$3200.10
51110	Spine, treatment of fracture, dislocation or fracture dislocation, with immobilisation by calipers or halo, not including application of skull tongs or calipers as part of operative positioning (Anaes.)	$1159.10
51111	Skull calipers or halo, insertion of, as an independent procedure (Anaes.)	$492.60

Item no.	Description	Max fee (excl. GST)
51112	Plaster jacket, application of, as an independent procedure (Anaes.)	$333.20
51113	Halo, application of, in addition to spinal fusion for scoliosis, or other conditions (Anaes.)	$369.40
51114	Halo thoracic orthosis application of both halo and thoracic jacket (Anaes.)	$652.00
51115	Halo femoral traction, as an independent procedure (Anaes.)	$652.00
51120	Bone graft, harvesting of autogenous graft, via separate incision or via subcutaneous approach, in conjunction with spinal fusion, other than for the purposes of bone graft obtained from the cervical, thoracic, lumbar or sacral spine (Anaes.)	$362.40
51130	Lumbar artificial intervertebral total disc replacement, at one motion segment only, including removal of disc and marginal osteophytes: (a) for a patient who: (i) has not had prior spinal fusion surgery at the same lumbar level; and (ii) does not have vertebral osteoporosis; and (iii) has failed conservative therapy; and (b) not being a service associated with a service to which item 51011, 51012, 51013, 51014 or 51015 applies (Anaes.) (Assist.)	$2759.90
51131	Cervical artificial intervertebral total disc replacement, at one motion segment only, including removal of disc and marginal osteophytes, for a patient who: (a) has not had prior spinal surgery at the same cervical level; and (b) is skeletally mature; and (c) has symptomatic degenerative disc disease with radiculopathy; and (d) does not have vertebral osteoporosis; and (e) has failed conservative therapy (Anaes.) (Assist.)	$1666.00
51140	Previous spinal fusion, re-exploration for, involving adjustment or removal of instrumentation up to 3 motion segments, not being a service associated with a service to which item 51141 applies (Anaes.) (Assist.)	$680.80
51141	Previous spinal fusion, re-exploration for, involving adjustment or removal of instrumentation more than 3 motion segments, not being a service associated with a service to which item 51140 applies (Anaes.) (Assist.)	$1259.50
51145	Wound debridement or excision for post operative infection or haematoma following spinal surgery (Anaes.) (Assist.)	$680.80
51150	Coccyx, excision of (Anaes.) (Assist.)	$685.30
51160	Anterior exposure of thoracic or lumbar spine, one motion segment, not being a service to which item 51165 applies (Anaes.) (Assist.)	$1769.50
51165	Anterior exposure of thoracic or lumbar spine, more than one motion segment, not being a service to which item 51160 applies (Anaes.) (Assist.)	$2231.10
51170	Syringomyelia or hydromyelia, craniotomy for, with or without duraplasty, intradural dissection, plugging of obex or local cerebrospinal fluid shunt (Anaes.) (Assist.)	$3361.40
51171	Syringomyelia or hydromyelia, treatment by direct cerebrospinal fluid shunt (for example, syringosubarachnoid shunt, syringopleural shunt or syringoperitoneal shunt) (Anaes.) (Assist.)	$1411.60
	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 $1046.80 or at a series or combination of operations identified by the word Assist where the fee for the series or combination of operations identified by the word Assist does not exceed $1046.80.	$163.80
51303	Assistance at any operation identified by the word Assist for which the fee exceeds $1046.80 or at a series of operations identified by the word Assist for which the aggregate fee exceeds $1046.80. Derived fee: One fifth of the established fee for the operation or combination of operations.	DF
51306	Assistance at a birth involving Caesarean section	$268.20
51309	Assistance at a series or combination of operations which have been identified by the word “Assist.” and assistance at a delivery involving Caesarean section Derived Fee: one fifth of the established fee for the operation or combination of operations (the fee for item 16520 being the Schedule fee for the Caesarean section component in the calculation of the established fee)	DF
51312	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615, 16627 and 16633 Derived Fee: one fifth of the established fee for the procedure or combination of procedures.	DF
51315	Assistance at cataract and intraocular lens surgery covered by item 42698, 42701, 42702, 42704 or 42707, when performed in association with services covered by item 42551 to 42569, 42653, 42656, 42725, 42746, 42749, 42752, 42776 or 42779	$497.00
51318	Assistance at cataract and intraocular lens surgery where patient has: -total loss of vision, including no potential for central vision, in the fellow eye; or -previous significant surgical complication in the fellow eye; or -pseudo exfoliation, subluxed lens, iridodonesis, phacodonesis, retinal detachment, corneal scarring, pre-existing uveitis, bound down miosed pupil, nanophthalmos, spherophakia, Marfan’s syndrome, homocysteinuria or previous blunt trauma causing intraocular damage	$301.80

Item no.	Description	Max fee (excl. GST)
GROUP O1—CONSULTATIONS		
51700	APPROVED DENTAL PRACTITIONER, REFERRED CONSULTATION—SURGERY, HOSPITAL OR RESIDENTIAL AGED CARE FACILITY Professional attendance (other than a second or subsequent attendance in a single course of treatment) by an approved dental practitioner, at consulting rooms, hospital or residential aged care facility where the patient is referred to him or her	$158.40
51703	Professional attendance by an approved dental practitioner, each attendance subsequent to the first in a single course of treatment at consulting rooms, hospital or residential aged care facility where the patient is referred to him or her	$79.60
GROUP O2—ASSISTANCE OF OPERATIONS		
51800	Assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery at any operation identified by the word Assist. for which the fee does not exceed $1046.80 or at a series or combination of operations identified by the word Assist where the fee for the series or combination of operations identified by the word Assist does not exceed $1046.80.	$163.80
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 $1046.80 or at a series of combination of operations identified by the word Assist where the aggregate fee exceeds $1046.80. Derived fee: One fifth of the established fee for the operation or combination of operations.	DF
GROUP O3—GENERAL SURGERY		
51900	WOUND OF SOFT TISSUE, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.)	$603.30
51902	WOUNDS, DRESSING OF, under general anaesthesia, with or without removal of sutures, not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.)	$136.70
51904	LIPECTOMY—wedge excision of skin or fat—1 EXCISION (Anaes.) (Assist.)	$871.50
51906	LIPECTOMY- wedge excision of skin or fat—2 OR MORE EXCISIONS (Anaes.) (Assist.)	$1256.20
52000	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes.)	$152.60
52003	Skin and subcutaneous tissue or mucous membrane, repair of recent wound of, on face or neck, small (not more than 7 cm long), involving deeper tissue (Anaes.)	$217.60
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.)	$217.60
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 (Anaes.) (Assist.)	$569.60
52012	SUPERFICIAL FOREIGN BODY,removal of, as an independent procedure (Anaes.)	$99.90
52015	SUBCUTANEOUS FOREIGN BODY,removal of, requiring incision and suture, as an independent procedure (Anaes.)	$409.50
52018	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE,removal of, as an independent procedure (Anaes.) (Assist.)	$512.00
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.)	$333.80
52027	BIOPSY OF LYMPH NODE, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure and not being a service to which item 52025 applies (Anaes.)	$286.90
52030	Sinus, excision of, involving superficial tissue only (Anaes.)	$166.60
52033	Sinus, excision of, involving muscle and deep tissue (Anaes.)	$333.80
52034	PREMALIGNANT LESIONS of the oral mucous, treatment by cryotherapy, diathermy or carbon dioxide laser	$182.60
52035	Endoscopic laser therapy for neoplasia and benign vascular lesions of the oral cavity (Anaes.)	$1079.60
52036	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 52039 applies (Anaes.)	$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, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes.) (Assist.)	$603.30

Item no.	Description	Max fee (excl. GST)
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 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), removal of, not being a service to which another item in Groups O3 to O9 applies, involving muscle, bone, or other deep tissue (Anaes.)	$457.00
52048	TUMOUR OR DEEP CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), removal of, requiring wide excision, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.)	$719.10
52051	TUMOUR, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.)	$931.10
52054	TUMOUR, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.)	$1117.00
52055	HAEMATOMA, SMALL ABSCESS OR CELLULITIS, not requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding after care)	$50.70
52056	HAEMATOMA, aspiration of (Anaes.)	$50.70
52057	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.)	$301.50
52058	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS, usinginterventional imaging techniques—but not including imaging (Anaes.)	$439.90
52059	ABSCESS, DRAINAGE TUBE, exchange of using interventional imaging techniques—but not including imaging (Anaes.)	$1137.80
52060	MUSCLE, excision of (Anaes.)	$364.40
52061	MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.)	$406.20
52062	MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.)	$537.00
52063	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.)	$696.50
52064	BONE CYST, injection into or aspiration of (Anaes.)	$329.90
52066	SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.)	$1303.70
52069	Sublingual gland, extirpation of (Anaes.)	$460.70
52072	Salivary gland, dilatation or diathermy of duct (Anaes.)	$145.50
52073	Salivary gland, repair of cutaneous fistula of (Anaes.)	$271.70
52075	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures (Anaes.)	$326.80
52078	TONGUE, partial excision of (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$659.40
52092	OPERATION on SKULL for OSTEOMYELITIS (Anaes.) (Assist.)	$843.60
52094	OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 52092 (Anaes.) (Assist.)	$1224.40
52095	BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.)	$868.10
52096	ORTHOPAEDIC PIN OR WIRE, insertion of, into maxilla or mandible or zygoma, as an independent procedure (Anaes.)	$346.60
52097	EXTERNAL FIXATION, removal of, in the operating theatre of a hospital (Anaes.)	$308.30
52098	EXTERNAL FIXATION, 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.)	$261.30

Item no.	Description	Max fee (excl. GST)
52102	BURIED WIRE, PIN or SCREW, 1 or more, which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, where undertaken in the operating theatre of a hospital, per bone (Anaes.)	$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 (Anaes.) (Assist.)	$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 where undertaken in the operating theatre of a hospital (Anaes.)	$336.20
52108	LIP, full thickness wedge excision of, with repair by direct sutures (Anaes.) (Assist.)	$603.30
52111	VERMILIONECTOMY (Anaes.) (Assist.)	$752.70
52114	MANDIBLE or MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.)	$1133.20
52117	MANDIBLE, including lower border, or MAXILLA, sub-total resection of (Anaes.) (Assist.)	$1332.50
52120	MANDIBLE, hemimandiblectomy of, including condylectomy where performed (Anaes.) (Assist.)	$3517.20
52122	MANDIBLE, hemi-mandibular reconstruction of, OR MAXILLA, reconstruction of, with BONE GRAFT, PLATE, TRAY OR ALLOPLAST, not being a service associated with a service to which item 52123 applies (Anaes.) (Assist.)	$3517.20
52123	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.)	$1700.70
52126	MAXILLA, total resection of (Anaes.) (Assist.)	$1635.30
52129	MAXILLA, total resection of both maxillae (Anaes.) (Assist.)	$2189.00
52130	BONE GRAFT, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.)	$818.90
52131	BONE GRAFT WITH INTERNAL FIXATION, not being a service to which an item in the range (a) 51900 to 52186; or (b) 52303 to 53460 applies (Anaes.) (Assist.)	$1638.40
52132	Tracheostomy (Anaes.)	$1058.20
52133	CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.)	$165.40
52135	POST-OPERATIVE or POST-NASAL HAEMORRHAGE, or both, control of, where undertaken in the operating theatre of a hospital (Anaes.)	$267.20
52138	MAXILLARY ARTERY, ligation of (Anaes.) (Assist.)	$1420.30
52141	FACIAL, MANDIBULAR or LINGUAL ARTERY or VEIN or ARTERY and VEIN, ligation of, not being a service to which item 52138 applies (Anaes.) (Assist.)	$855.30
52144	FOREIGN BODY, deep, removal of using interventional imaging techniques (Anaes.) (Assist.)	$765.50
52147	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.)	$748.20
52148	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.)	$1252.70
52158	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.)	$2135.40
52180	MALIGNANT DISEASE AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, biopsy of (not including aftercare) (Anaes.)	$431.40
52182	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes.) (Assist.)	$805.80
52184	BONE TUMOUR, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.)	$1185.80
52186	BONE TUMOUR, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.)	$1394.10
GROUP O4—PLASTIC AND RECONSTRUCTIVE		
52300	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, with skin or mucosa (Anaes.) (Assist.)	$526.30
52303	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, with buccal pad of fat (Anaes.) (Assist.)	$751.30
52306	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.)	$1114.90
52309	Free grafting (mucosa or split skin) of a granulating area (Anaes.)	$371.70
52312	FREE GRAFTING (mucosa, split skin or connective tissue) to 1 defect, including elective dissection (Anaes.) (Assist.)	$546.70

Item no.	Description	Max fee (excl. GST)
52315	FREE GRAFTING, FULL THICKNESS, to 1 defect (mucosa or skin) (Anaes.) (Assist.)	$966.50
52318	BONE GRAFT, harvesting of, via separate incision, being a service associated with a service to which another item in Groups O3 to O9 applies—Autogenous—small quantity (Anaes.)	$402.30
52319	BONE GRAFT, harvesting of, via separate incision, being a service associated with a service to which another item in Groups O3 to O9 applies—Autogenous—large quantity (Anaes.)	$731.90
52321	FOREIGN IMPLANT (NON-BIOLOGICAL), insertion of, for CONTOUR RECONSTRUCTION of pathological deformity, not being a service associated with a service to which item 52624 applies (Anaes.) (Assist.)	$991.10
52324	DIRECT FLAP REPAIR, using tongue, first stage (Anaes.) (Assist.)	$1839.60
52327	Direct flap repair, using tongue, second stage (Anaes.)	$977.90
52330	PALATAL DEFECT (oro-nasal fistula), plastic closure of, including services to which item 52300, 52303, 52306 or 52324 applies (Anaes.) (Assist.)	$1531.20
52333	CLEFT PALATE, primary repair (Anaes.) (Assist.)	$1420.10
52336	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.) (Assist.)	$955.00
52337	ALVEOLAR CLEFT (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes.) (Assist.)	$2114.10
52339	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.)	$1010.80
52342	MANDIBLE or MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	$1852.90
52345	MANDIBLE or MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.)	$2365.40
52348	MANDIBLE or MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	$2409.20
52351	MANDIBLE or MAXILLA, bilateral osteotomy of osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.)	$4502.00
52354	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	$2692.00
52357	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.)	$4145.70
52360	MANDIBLE and MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	$3120.80
52363	MANDIBLE and MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.)	$5593.20
52366	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	$3280.40
52369	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.)	$6464.40
52372	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	$3578.60
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) (Anaes.) (Assist.)	$5932.30
52378	GENIOPLASTY including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	$2549.00
52379	FACE, contour reconstruction of 1 region, using autogenous bone or cartilage graft (Anaes.) (Assist.)	$2994.50
52380	MIDFACIAL OSTEOTOMIES—Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	$4149.60

Item no.	Description	Max fee (excl. GST)
52382	MIDFACIAL OSTEOTOMIES—Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.)	$6628.90
52420	Mandible, fixation by intermaxillary wiring, excluding wiring for obesity	$624.20
52424	DERMIS, DERMOFAT OR FASCIA GRAFT (excluding transfer of fat by injection) (Anaes.) (Assist.)	$1461.70
52430	MICROVASCULAR REPAIR OF, using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.)	$1980.00
52440	CLEFT LIP, unilateral—primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)	$983.30
52442	CLEFT LIP, unilateral—primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)	$1229.20
52444	CLEFT LIP, bilateral—primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)	$1365.60
52446	CLEFT LIP, bilateral—primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)	$1611.60
52450	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.)	$546.10
52452	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.)	$904.60
52456	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.)	$1502.40
52458	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.)	$546.10
52460	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.)	$1420.10
52480	COMPOSITE GRAFT (Chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (Anaes.) (Assist.)	$912.10
52482	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.)	$877.60
52484	MACROSTOMIA, operation for (Anaes.) (Assist.)	$1044.80
GROUP O5—PREPROSTHETIC		
52600	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.)	$655.20
52603	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.)	$598.60
52606	Maxillary tuberosity, reduction of (Anaes.)	$456.50
52609	PAPILLARY HYPERPLASIA OF THE PALATE, removal of—less than 5 lesions (Anaes.) (Assist.)	$598.60
52612	PAPILLARY HYPERPLASIA OF THE PALATE, removal of—5 to 20 lesions (Anaes.) (Assist.)	$751.30
52615	PAPILLARY HYPERPLASIA OF THE PALATE, removal of—more than 20 lesions (Anaes.) (Assist.)	$932.70
52618	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed—unilateral or bilateral (Anaes.) (Assist.)	$1085.60
52621	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed—unilateral (Anaes.) (Assist.)	$1989.20
52624	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both—unilateral (Anaes.) (Assist.)	$918.20
52626	ALVEOLAR RIDGE AUGMENTATION—unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.)	$645.30
52627	OSSEO-INTEGRATION PROCEDURE—in the practice of oral and maxillofacial surgery, extra oral implantation of titanium fixture (Anaes.) (Assist.)	$986.30
52630	OSSEO-INTEGRATION PROCEDURE—in the practice of oral and maxillofacial surgery, fixation of transcutaneous abutment (Anaes.)	$441.70
52633	OSSEO-INTEGRATION PROCEDURE—intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.)	$1624.70
52636	OSSEO-INTEGRATION PROCEDURE—fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.)	$783.50
GROUP O6—NEUROSURGICAL		
52800	NEUROLYSIS BY OPEN OPERATION, without transposition, not being a service associated with a service to which item 52803 applies (Anaes.) (Assist.)	$534.20
52803	NERVE TRUNK, internal (interfascicular), NEUROLYSIS of, using microsurgical techniques (Anaes.) (Assist.)	$737.60
52806	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from superficial peripheral nerve (Anaes.) (Assist.)	$502.60

Item no.	Description	Max fee (excl. GST)
52809	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from deep peripheral nerve (Anaes.) (Assist.)	$860.30
52812	NERVE TRUNK, PRIMARY repair of, using microsurgical techniques (Anaes.) (Assist.)	$1252.80
52815	NERVE TRUNK, SECONDARY repair of, using microsurgical techniques (Anaes.) (Assist.)	$2935.60
52818	NERVE, TRANSPOSITION OF (Anaes.) (Assist.)	$957.60
52821	NERVE GRAFT TO NERVE TRUNK, (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.)	$1871.10
52824	PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.)	$820.90
52826	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.)	$431.60
52828	CUTANEOUS NERVE, primary repair of, using microsurgical techniques (Anaes.) (Assist.)	$641.80
52830	CUTANEOUS NERVE, secondary repair of, using microsurgical techniques (Anaes.) (Assist.)	$846.50
52832	CUTANEOUS NERVE, nerve graft to, using microsurgical techniques (Anaes.) (Assist.)	$1160.90
GROUP O7—EAR, NOSE AND THROAT		
53000	Maxillary antrum, proof puncture and lavage of (Anaes.)	$71.00
53003	MAXILLARY ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission to hospital) not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.)	$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) (Anaes.) (Assist.)	$964.80
53009	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.)	$570.30
53012	Antrum, drainage of, through tooth socket (Anaes.)	$226.60
53015	ORO-ANTRAL FISTULA, plastic closure of (Anaes.) (Assist.)	$1087.70
53016	NASAL SEPTUM, septoplasty, submucous resection or closure of septal perforation (Anaes.) (Assist.)	$1225.60
53017	NASAL SEPTUM, reconstruction of (Anaes.) (Assist.)	$2336.00
53019	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.)	$1351.10
53052	Post-nasal space, direct examination of, with or without biopsy (Anaes.)	$222.90
53054	NASENDOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX one or more of these procedures (Anaes.)	$483.20
53056	EXAMINATION OF NASAL CAVITY or POST-NASAL SPACE, or NASAL CAVITY AND POST-NASAL SPACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.)	$133.00
53058	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.)	$222.90
53060	CAUTERISATION (other than by chemical means) OR CAUTERISATION by chemical means when performed under general anaesthesia OR DIATHERMY OF SEPTUM, TURBINATES FOR OBSTRUCTION OR HAEMORRHAGE SECONDARY TO SURGERY (OR TRAUMA)—1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes.)	$182.50
53062	POST SURGICAL NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.)	$163.40
53064	Cryotherapy to nose in the treatment of nasal haemorrhage (Anaes.)	$295.70
53068	Turbinectomy or turbinectomies, partial or total, unilateral (Anaes.)	$580.20
53070	Turbinates, submucous resection of, unilateral (Anaes.)	$516.70
GROUP O8—TEMPOROMANDIBULAR JOINT		
53200	Mandible, treatment of a dislocation of, not requiring open reduction (Anaes.)	$135.60
53203	Mandible, treatment of a dislocation of, requiring open reduction (Anaes.)	$215.60
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) (Anaes.) (Assist.)	$2994.80

Item no.	Description	Max fee (excl. GST)
53212	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.)	$1808.80
53215	TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes.) (Assist.)	$1737.60
53218	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions—1 or more such procedures (Anaes.) (Assist.)	$1747.60
53220	TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$598.60
53221	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.)	$1677.50
53224	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.)	$1756.20
53225	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.)	$558.20
53226	TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$567.30
53227	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without meniscus or capsular surgery, including meniscectomy when performed, with or without microsurgical techniques (Anaes.) (Assist.)	$2157.90
53230	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.)	$4520.80
53233	TEMPOROMANDIBULAR JOINT, surgery of, involving procedures to which items 53224, 53226, 53227 and 53230 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes.) (Assist.)	$4789.20
53236	TEMPOROMANDIBULAR JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$854.70
53239	TEMPOROMANDIBULAR JOINT, arthrodesis of, not being a service to which another item in this Group applies (Anaes.) (Assist.)	$854.70
53242	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.)	$601.80
GROUP O9—TREATMENT OF FRACTURES		
53400	MAXILLA, unilateral or bilateral, treatment of fracture of, not requiring splinting	$234.50
53403	Mandible, treatment of fracture of, not requiring splinting	$292.00
53406	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.)	$1139.70
53409	MANDIBLE, treatment of fracture of, requiringsplinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.)	$779.10
53410	Zygomatic bone, treatment of fracture of, not requiring surgical reduction	$155.40
53411	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.)	$598.30
53412	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.) (Assist.)	$752.40
53413	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.)	$928.30
53414	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.)	$1539.10
53415	MAXILLA, treatment of fracture of, requiring open reduction (Anaes.) (Assist.)	$838.50
53416	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.)	$806.50
53418	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.)	$1028.80
53419	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.)	$1086.30
53422	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.)	$1797.50
53423	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.)	$1374.60

Item no.	Description	Max fee (excl. GST)
53424	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.)	$2024.70
53425	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.)	$1293.60
53427	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.)	$1732.90
53429	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.)	$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 (Anaes.) (Assist.)	$1162.20
53455	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.)	$1767.20
53458	Nasal bones, treatment of fracture of, not being a service to which item 53459 or 53460 applies	$79.40
53459	Nasal bones, treatment of fracture of, by reduction (Anaes.)	$532.60
53460	NASAL BONES, treatment of fractures of, by open reduction involving osteotomies (Anaes.) (Assist.)	$1682.50
GROUP O11—REGIONAL OR FIELD NERVE BLOCKS		
53700	(Note. Where an anaesthetic combines a regional nerve block with a general anaesthetic for an operative procedure, benefits will be paid only under the anaesthetic item relevant to the operation. The items in this Group are to be used in the practice of oral and maxillofacial surgery and are not to be used for dental procedures (eg. restorative dentistry or dental extraction.)) TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent	$226.80
53702	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent	$113.60
53704	Facial nerve, injection of an anaesthetic agent	$68.20
53706	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies	$530.80
GROUP I1—ULTRASOUND		
	General	
55028	Head, ultrasound scan of (R)	$209.10
55029	Head, ultrasound scan of (NR)	$73.50
55030	Orbital contents, ultrasound scan of (R)	$211.90
55031	Orbital contents, ultrasound scan of (NR)	$82.20
55032	Neck, one or more structures of, ultrasound scan of (R)	$177.70
55033	Neck, one or more structures of, ultrasound scan of (NR)	$73.20
55036	Abdomen, ultrasound scan of (including scan of urinary tract when performed), for morphological assessment, if: (a) the service is not solely a transrectal ultrasonic examination of any of the following:(i) prostate gland;(ii) bladder base;(iii) urethra; and(b) within 24 hours of the service, a service mentioned in item 55038 is not performed on the same patient by the providing practitioner (R)	$183.30
55037	Abdomen, ultrasound scan of (including scan of urinary tract when performed), for morphological assessment, if the service is not solely a transrectal ultrasonic examination of any of the following:(i) prostate gland;(ii) bladder base;(iii) urethra (NR)	$73.50
55038	Urinary tract, ultrasound scan of, if: (a) the service is not solely a transrectal ultrasonic examination of any of the following: (i) prostate gland; (ii) bladder base; (iii) urethra; and (b) within 24 hours of the service, a service mentioned in item55036 or 55065 is not performed on the same patient by the providing practitioner (R)	$179.50
55039	Urinary tract, ultrasound scan of, if the service is not solely a transrectal ultrasonic examination of any of the following: (a) prostate gland; (b) bladder base; (c) urethra (NR)	$73.20
55048	Scrotum, ultrasound scan of (R)	$180.50
55049	Scrotum, ultrasound scan of (NR)	$75.10
55054	Ultrasonic cross-sectional echography, in conjunction with a surgical procedure (other than a procedure to which item 55848 or 55850 applies) using interventional techniques, not being a service associated with a service to which any other item in this Group applies (R)	$178.10
55065	Pelvis, ultrasound scan of, by any or all approaches, if:(a) the service is not solely: (i) a service to which an item in Subgroup 5 of this Group applies, or (ii) a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and (b) within 24 hours of the service, a service mentioned in item 55038 is not performed on the same patient by the providing practitioner (R)	$164.10

Item no.	Description	Max fee (excl. GST)
55066	Breasts, both, ultrasound scan, in conjunction with a surgical procedure using interventional techniques, if:(a) the request for the scan indicates that an ultrasound guided breast intervention be performed; and (b) the service is not performed in conjunction with any other item in this Group (R)	$327.30
55068	Pelvis, ultrasound scan of, by any or all approaches, if the service is not solely a service to which an item in Subgroup 5 of this Group applies or a transrectal ultrasonic examination of any of the following:(i) prostate gland;(ii) bladder base;(iii) urethra (NR)	$58.50
55070	Breast, one, ultrasound scan of (R)	$171.30
55071	Breast, one, ultrasound scan, in conjunction with a surgical procedure using interventional techniques, if:(a) the request for the scan indicates that an ultrasound guided breast intervention be performed; and (b) the service is not performed in conjunction with any other item in this group (R)	$311.00
55073	Breast, one, ultrasound scan of (NR)	$65.20
55076	Breasts, both, ultrasound scan of, including an ultrasound scan for post mastectomy surveillance (R)	$201.10
55079	Breasts, both, ultrasound scan of, including an ultrasound scan for post mastectomy surveillance (NR)	$89.00
55084	Urinary bladder, ultrasound scan of, by any or all approaches, if within 24 hours of the service, a service mentioned in item 11917, 55036, 55038, 55065, 55600 or 55603 is not performed on the same patient by the providing practitioner (R)	$188.40
55085	Urinary bladder, ultrasound scan of, by any or all approaches, if within 24 hours of the service, a service mentioned in item 11917, 55037, 55039, 55068, 55600 or 55603 is not performed on the same patient by the providing practitioner (NR)	$55.40
	Cardiac	
55118	Heart, two dimensional real time transoesophageal examination of, from at least 2 levels, and in more than one plane at each level, if: (a) the service includes: (i) real time colour flow mapping and, if indicated, pulsed wave Doppler examination; and (ii) recordings on video tape or digital medium; and (b) the service is not: (i) an intra operative service; or (ii) a service associated with a service to which an item in Subgroup 3 of this Group applies(R) (Anaes.)	$527.40
55130	Intra-operative two-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 being a service associated with a service to which item 55135 applies (R) (Anaes.) (Anaes.)	$325.90
55135	Intra-operative two-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 repair) 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.) (Anaes.)	$678.10
	Vascular	
55238	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb or of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with any of the following:(a) a service to which an item in Subgroup 4 applies;(b) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R)	$277.10
55244	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for acute venous thrombosis, not being a service associated with any of the following:(a) a service to which item 55246 applies;(b) a service to which an item in Subgroup 4 applies;(c) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R)	$277.70
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 any of the following:(a) a service to which item 55244 applies;(b) a service to which an item in Subgroup 4 applies;(c) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R)	$278.80
55248	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the upper limb or of arteries and bypass grafts in the upper limb, not being a service associated with a service to which an item in Subgroup 4 applies (R)	$277.50
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 associatedwith a service to which an item in Subgroup 4 applies (R).	$276.30
55274	Duplex scanning, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of extra cranial bilateral carotid and vertebral vessels, with or without subclavian and innominate vessels, with or without oculoplethysmography or peri orbital Doppler examination, not being a service associated witha service to which an item in Subgroup 4 applies (R)	$276.20

Item no.	Description	Max fee (excl. GST)
55276	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra abdominal, aorta and iliac arteries or inferior vena cava and iliac veins or of intra abdominal, aorta and iliac arteries and inferior vena cava and iliac veins, excluding pregnancy related studies, not being a service associated witha service to which an item in Subgroup 4 applies (R)	$278.00
55278	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of renal or visceral vessels or of renal and visceral vessels, including aorta, inferior vena cava and iliac vessels as required excluding pregnancy related studies, not being a service associated witha service to which an item in Subgroup 4 applies (R)	$289.70
55280	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra cranial vessels, not being a service associated witha service to which an item in Subgroup 4 applies (R)	$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) if a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is performed, immediately before or for a period during the performance of the service; and (d) if the specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroup 4 applies (R)	$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) if indicated, assess the progress and management of: (i) priapism; or (ii) fibrosis of any type; or (iii) fracture of the tunica; or (iv) arteriovenous malformations; and (c) if a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is performed, immediately before or for a period during the performance of the service; and (d) if the specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroup 4 applies (R)	$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 arteriovenous access grafts in the upper or lower limbs, not being a service associated with a service to which an item in Subgroup 4 applies (R)	$326.70
55294	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or veins, or both, including any associated skin marking, for mapping of bypass conduit before vascular surgery, not being a service associated with any of the following:(a) a service to which an item in Subgroup 3 or 4 applies; (b) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R)	$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 any of the following:(a) a service to which an item in Subgroup 3 or 4 applies;(b) a service to which item 55880, 55881, 55882, 55883, 55884, 55885, 55886, 55887, 55888, 55889, 55890, 55891, 55892, 55893, 55894 or 55895 applies (R)	$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)	$179.80
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)	$191.50
	Obstetric and gynaecological	
55700	Pelvis or abdomen, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, for determining the gestation, location, viability or number of foetuses, if the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation (R)	$121.10
55703	Pelvis or abdomen, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, for determining the gestation, location, viability or number of foetuses, if the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation (NR)	$67.20

Item no.	Description	Max fee (excl. GST)
55704	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, for determining the structure, gestation, location, viability or number of foetuses, if the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation (R)	$135.10
55705	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, for determining the structure, gestation, location, viability or number of foetuses, if the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation (NR)	$67.20
55706	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the dating for the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and(b) the service is not performed in the same pregnancy as item 55709 (R)	$202.00
55707	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) the pregnancy (as confirmed by ultrasound) is dated by a fetal crown rump length of 45 to 84 mm; and (b) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (c) the service is not performed with item 55700, 55703, 55704 or 55705 on the same patient within 24 hours (R)	$216.70
55709	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, if:(a) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and(b the service is not performed in the same pregnancy as item 55706 (NR)	$113.70
55712	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the service is requested by a medical practitioner who: (i) is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of Obstetrics; or (iv) has obstetric privileges at a non metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) further examination is clinically indicated after performance, in the same pregnancy, of a scan mentioned in item 55706 or 55709 (R)	$220.60
55715	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, if: (a) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (b) further examination is clinically indicated after performance, in the same pregnancy, of a scan mentioned in item 55706 or 55709 (NR)	$76.70
55718	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (b) the service is not performed in the same pregnancy as item 55723 (R)	$194.20
55721	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) the service is requested by a medical practitioner who: (i) is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of Obstetrics; or (iv) has obstetric privileges at a non metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (d) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (R)	$220.60
55723	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (b) the service is not performed in the same pregnancy as item 55718 (NR)	$72.80
55725	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, if: (a) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (b) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (NR)	$76.70
55729	Duplex scanning, if: (a) the service involves: (i) B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of the umbilical artery; and (ii) measured assessment of amniotic fluid volume after the 24th week of gestation; and (b) there is reason to suspect intrauterine growth retardation or a significant risk of fetal death; examination and report (R)	$52.30
55736	Pelvis, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, if a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (R)	$305.00
55739	Pelvis, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, if a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (NR)	$126.00

Item no.	Description	Max fee (excl. GST)
55759	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (c) the service mentioned in item 55706, 55709, 55712, 55715 or 55762 is not performed in conjunction with the scan during the same pregnancy (R)	$287.40
55762	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (c) the service mentioned in item55706, 55709, 55712, 55715 or 55759 is not performed in conjunction with the scan during the same pregnancy (NR)	$162.10
55764	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the service is requested by a medical practitioner who: (i) is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of Obstetrics; or (iv) has obstetric privileges at a non metropolitan hospital; and (b) 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) further examination is clinically indicated in the same pregnancy in which item 55759 or 55762 has been performed; and (e) the service mentioned in item 55706, 55709, 55712 or 55715 is not performed in conjunction with the scan during the same pregnancy (R)	$306.80
55766	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner, who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, if: (a) ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) further examination is clinically indicated in the same pregnancy in which item 55759 or 55762 has been performed; and (d) the service mentioned in item 55706, 55709, 55712 or 55715, is not performed in conjunction with the scan during the same pregnancy (NR)	$124.80
55768	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (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 service is not performed in the same pregnancy as item 55770; and (d) the service mentioned in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the scan during the same pregnancy (R)	$287.70
55770	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (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 service is not performed in the same pregnancy as item 55768; and (d) the service mentioned in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the scan during the same pregnancy (NR)	$115.00
55772	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the service is requested by a medical practitioner who: (i) is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of Obstetrics; or (iv) has obstetric privileges at a non metropolitan hospital; and (c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service mentioned in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the scan during the same pregnancy (R)	$306.80
55774	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, if: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed; and (c) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (d) the service mentioned in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the scan during the same pregnancy (NR)	$124.80
	Musculoskeletal	
55812	Chest or abdominal wall, one or more areas, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55070, 55073, 55076 or 55079 (R)	$179.20
55814	Chest or abdominal wall, one or more areas, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55070, 55073, 55076 or 55079 (NR)	$62.20
55844	Assessment of a mass associated with the skin or subcutaneous structures, not being a part of the musculoskeletal system, one or more areas, ultrasound scan of (R)	$142.90

Item no.	Description	Max fee (excl. GST)
55846	Assessment of a mass associated with the skin or subcutaneous structures, not being a part of the musculoskeletal system, one or more areas, ultrasound scan of (NR)	$72.70
55848	Musculoskeletal ultrasound, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies, and not performed in conjunction with a service mentioned in item 55054 (R)	$211.50
55850	Musculoskeletal ultrasound, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, if: (a) the medical practitioner or nurse practitioner has indicated on a request for a musculoskeletal ultrasound that an ultrasound guided intervention be performed if clinically indicated; and (b) the service is not performed in conjunction with a service mentioned in item 55054 or any other item in this Subgroup (R)	$315.20
55852	Paediatric spine, spinal cord and overlying subcutaneous tissues, ultrasound scan of (R)	$209.50
55854	Paediatric spine, spinal cord and overlying subcutaneous tissues, ultrasound scan of (NR)	$72.70
55856	Hand or wrist or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55858 (R)	$210.70
55857	Hand or wrist, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55859 (NR)	$62.20
55858	Hand or wrist, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55856 (R)	$216.10
55859	Hand or wrist, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55857 (NR)	$75.10
55860	Forearm or elbow, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55862 (R)	$208.80
55861	Forearm or elbow, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55863 (NR)	$62.00
55862	Forearm or elbow, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55860 (R)	$214.20
55863	Forearm or elbow, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55861 (NR)	$74.80
55864	Shoulder or upper arm, or both, left or right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) an injury to a muscle, tendon or muscle/tendon junction; (ii) rotator cuff tear, calcification or tendinosis (biceps, subscapular, supraspinatus or infraspinatus) ;(iii) biceps subluxation; (iv) capsulitis and bursitis; (v) a mass, including a ganglion; (vi) an occult fracture; (vii) acromioclavicular joint pathology; and (b) the service is not performed in conjunction with a service mentioned in item 55866 (R)	$210.80
55865	Shoulder or upper arm, or both, left or right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) an injury to a muscle, tendon or muscle/tendon junction; (ii) rotator cuff tear, calcification or tendinosis (biceps, subscapular, supraspinatus or infraspinatus); (iii) biceps subluxation; (iv) capsulitis and bursitis; (v) a mass, including a ganglion; (vi) an occult fracture; (vii) acromioclavicular joint pathology; and (b) the service is not performed in conjunction with a service mentioned in item 55867 (NR)	$76.20
55866	Shoulder or upper arm, or both, left and right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) an injury to a muscle, tendon or muscle/tendon junction; (ii) rotator cuff tear, calcification or tendinosis (biceps, subscapular, supraspinatus or infraspinatus); (iii) biceps subluxation; (iv) capsulitis and bursitis; (v) a mass, including a ganglion; (vi) an occult fracture; (vii) acromioclavicular joint pathology; and (b) the service is not performed in conjunction with a service mentioned in item 55864 (R)	$216.20
55867	Shoulder or upper arm, or both, left and right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) an injury to a muscle, tendon or muscle/tendon junction; (ii) rotator cuff tear, calcification or tendinosis (biceps, subscapular, supraspinatus or infraspinatus); (iii) biceps subluxation; (iv) capsulitis and bursitis; (v) a mass, including a ganglion; (vi) an occult fracture ;(vii) acromioclavicular joint pathology; and (b) the service is not performed in conjunction with a service mentioned in item 55865 (NR)	$76.20
55868	Hip or groin, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55870 (R)	$178.90
55869	Hip or groin, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55871 (NR)	$62.20
55870	Hip or groin, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55868 (R)	$215.90
55871	Hip or groin, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with a service mentioned in item 55869 (NR)	$75.10
55876	Buttock or thigh, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55878 (R)	$178.90
55877	Buttock or thigh or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55879 (NR)	$64.20

Item no.	Description	Max fee (excl. GST)
55878	Buttock or thigh, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55876 (R)	$215.90
55879	Buttock or thigh, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55877 (NR)	$65.80
55880	Knee, left or right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions :(i) abnormality of tendons or bursae about the knee; (ii) a meniscal cyst, popliteal fossa cyst, mass or pseudomass; (iii) a nerve entrapment or a nerve or nerve sheath tumour; (iv) an injury of collateral ligaments; and (b) the service is not performed in conjunction with item 55882 (R)	$178.30
55881	Knee, left or right, ultrasound scan of, if:(a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) abnormality of tendons or bursae about the knee;(ii) a meniscal cyst, popliteal fossa cyst, mass or pseudomass;(iii) a nerve entrapment or a nerve or nerve sheath tumour;(iv) an injury of collateral ligaments; and(b) the service is not performed in conjunction with item 55883 (NR)	$62.20
55882	Knee, left and right, ultrasound scan of, if :(a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) abnormality of tendons or bursae about the knee; (ii) a meniscal cyst, popliteal fossa cyst, mass or pseudomass; (iii) a nerve entrapment or a nerve or nerve sheath tumour; (iv) an injury of collateral ligaments; and (b) the service is not performed in conjunction with a service mentioned in item 55880 (R)	$215.20
55883	Knee, left and right, ultrasound scan of, if: (a) the service is used for the assessment of one or more of the following suspected or known conditions: (i) abnormality of tendons or bursae about the knee; (ii) a meniscal cyst, popliteal fossa cyst, mass or pseudomass; (iii) a nerve entrapment or a nerve or nerve sheath tumour; (iv) an injury of collateral ligaments; and (b) the service is not performed in conjunction with item 55881 (NR)	$75.10
55884	Lower leg, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55886 (R)	$177.80
55885	Lower leg, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55887 (NR)	$76.50
55886	Lower leg, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55884 (R)	$214.60
55887	Lower leg, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55885 (NR)	$76.50
55888	Ankle or hind foot, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55890 (R)	$179.90
55889	Ankle or hind foot, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55891 (NR)	$62.20
55890	Ankle or hind foot, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55888 (R)	$217.10
55891	Ankle or hind foot, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55889 (NR)	$75.10
55892	Mid foot or fore foot, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55894 (R)	$182.10
55893	Mid foot or fore foot, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55895 (NR)	$72.80
55894	Mid foot or fore foot, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55892 (R)	$186.70
55895	Mid foot or fore foot, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55893 (NR)	$72.80
	Cardiac	
55126	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.1.2 Initial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows, with recordings on digital media, if the service: (a) is for the investigation of any of the following: (i) symptoms or signs of cardiac failure; (ii) suspected or known ventricular hypertrophy or dysfunction; (iii) pulmonary hypertension; (iv) valvular, aortic, pericardial, thrombotic or embolic disease; (v) heart tumour; (vi) symptoms or signs of congenital heart disease; (vii) other rare indications; and (b) is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies Applicable not more than once in a 24 month period (R)	$351.20

Item no.	Description	Max fee (excl. GST)
55127	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.1.2 Repeat serial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows, with recordings on digital media, if the service: (a) is for the investigation of known valvular dysfunction; and (b) is requested by a specialist or consultant physician; and (c) is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies (R)	$351.20
55128	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.1.2 Repeat serial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows, with recordings on digital media, if the service: (a) is for the investigation of known valvular dysfunction; and (b) is requested by a medical practitioner (other than a specialist or consultant physician) at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies (R)	$351.20
55129	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.1.2 Repeat serial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows, with recordings on digital media, if: (a) valvular dysfunction is not the primary issue for the patient (although it may be a secondary issue); and (b) the service is for the investigation of any of the following: (i) symptoms or signs of cardiac failure; (ii) suspected or known ventricular hypertrophy or dysfunction; (iii) pulmonary hypertension; (iv) aortic, thrombotic, embolic disease or pericardial disease (excluding isolated pericardial effusion or pericarditis); (v) heart tumour; (vi) structural heart disease; (vii) other rare indications; and (c) the service is requested by a specialist or consultant physician; and (d) the service is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies (R)	$351.20
55132	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.1.2 Serial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 4 acoustic windows, with recordings on digital media, if the service: (a) is for the investigation of a patient who: (i) is under 17 years of age; or (ii) has complex congenital heart disease; and (b) is performed by a specialist or consultant physician practising in the speciality of cardiology; and (c) is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies (R)	$351.20
55133	Note: the service only applies if the patient meets one or more of the following and the requirements of Note: IR.1.2 Frequent repetition serial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows, with recordings on digital media, if the service: (a) is for the investigation of a patient who: (i) has an isolated pericardial effusion or pericarditis; or (ii) has a normal baseline study, and has commenced medication for non cardiac purposes that has cardiotoxic side effects and is a pharmaceutical benefit (within the meaning of PartVII of the National Health Act 1953) for the writing of a prescription for the supply of which under that Part an echocardiogram is required; and (b) is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies (R)	$316.10
55134	Note: the service only applies if the patient meets one or more of the following and the requirements of Note: IR.1.2 Repeat real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 3 acoustic windows, with recordings on digital media, for the investigation of rare cardiac pathologies, if the service: (a) is requested by a specialist or consultant physician; and (b) is not associated with a service to which: (i) another item in this Subgroup applies (except items 55137, 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); or (iii) an item in Subgroup 3 applies (R)	$351.20
55137	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.1.2 Serial real time transthoracic echocardiographic examination of the heart with real time colour flow mapping from at least 4 acoustic windows, with recordings on digital media, if the service: (a) is for the investigation of a fetus with suspected or confirmed: (i) complex congenital heart disease; or (ii) functional heart disease; or (iii) fetal cardiac arrhythmia; or (iv) cardiac structural abnormality requiring confirmation; and (b) is performed by a specialist or consultant physician practising in the speciality of cardiology with advanced training and expertise in fetal cardiac imaging; and (c) is not associated with a service to which: (i) another item in this Subgroup applies (except items 55141, 55143, 55145 and 55146); or (ii) an item in Subgroup 2 applies (except items 55118 and 55130); applies; or (iii) an item in Subgroup 3 applies (R)	$351.20
55141	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.0.1 and IR.1.2 Exercise stress echocardiography focused study, other than a service associated with a service to which: (a) item11704, 11705, 11707, 11714, 11729 or 11730 applies; or (b) an item in Subgroup 3 applies Applicable not more than once in a 24 month period (R)	$626.20

Item no.	Description	Max fee (excl. GST)
55143	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.0.1, IR.1.1 and IR.1.2 Repeat pharmacological or exercise stress echocardiography if: (a) a service to which item55141, 55145 or 55146 applies has been performed on the patient in the previous 24 months; and (b) the patient has symptoms of ischaemia that have evolved and are not adequately controlled with optimal medical therapy; and (c) the service is requested by a specialist or a consultant physician; and (d) the service is not associated with a service to which: (i) item 11704, 11705, 11707, 11714, 11729 or 11730 applies; or (ii) an item in Subgroup 3 applies Applicable not more than once in a 12 month period (R)	$626.20
55145	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.0.1 and IR.1.2 Pharmacological stress echocardiography, other than a service associated with a service to which: (a) item 11704, 11705, 11707, 11714, 11729 or 11730 applies; or (b) an item in Subgroup 3 applies Applicable not more than once in a 24 month period (R) Note: this item does not apply to a service provided to a patient if, in the previous 24 months, a service associated with a service to which item 55141, 55143 or 55146 applies has been provided to the patient.	$725.80
55146	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.0.1 and IR.1.2 Pharmacological stress echocardiography if: (a) a service to which item 55141 applies has been performed on the patient in the previous 4 weeks, and the test has failed due to an inadequate heart rate response; and (b) the service is not associated with a service to which: (i) item 11704, 11705, 11707, 11714, 11729 or 11730 applies; or (ii) an item in Subgroup 3 applies Applicable not more than once in a 24 month period (R) Note: this item does not apply to a service provided to a patient if, in the previous 24 months, a service associated with a service to which item 55143 or 55145 applies has been provided to the patient.	$725.80
GROUP I2—COMPUTED TOMOGRAPHY		
56001	Computed tomography scan of brain without intravenous contrast medium, not being a service to which item 57001 applies (R) (Anaes.)	$324.30
56007	Computed tomography scan of brain with intravenous contrast medium and with any scans of the brain before intravenous contrast injection, when performed, not being a service to which item 57007 applies (R) (Anaes.)	$411.00
56010	Computed tomography scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when performed (R) (Anaes.)	$487.60
56013	COMPUTED TOMOGRAPHY—scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (Anaes.)	$407.10
56016	Computed tomography scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (Anaes.)	$480.50
56022	Computed tomography scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (Anaes.)	$366.40
56028	Computed tomography scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both before intravenous contrast injection, when performed (R) (Anaes.)	$647.00
56030	Computed tomography scan of facial bones, para nasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (Anaes.)	$369.90
56036	Computed tomography scan of facial bones, para nasal sinuses or both, with scan of brain, with intravenous contrast medium, if:(a) a scan without intravenous contrast medium has been performed; and(b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (Anaes.)	$650.60
56101	Computed tomography scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56801 applies (R) (Anaes.)	$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) before intravenous contrast injection, when undertaken, not being a service associated with a service to which item 56807 applies (R) (Anaes.)	$553.20
56219	Computed tomography scan of spine, one or more regions with intrathecal contrast medium, including the preparation for intrathecal injection of contrast medium and any associated plain X rays, not being a service to which item 59724 or 59275 applies (R) (Anaes.)	$633.30
56220	Computed tomography scan of spine, cervical region, without intravenous contrast medium (R) (Anaes.)	$391.80
56221	Computed tomography scan of spine, thoracic region, without intravenous contrast medium (R) (Anaes.)	$397.90
56223	Computed tomography scan of spine, lumbosacral region, without intravenous contrast medium (R) (Anaes.)	$395.30
56224	Computed tomography scan of spine, cervical region, with intravenous contrast medium and with any scans of the cervical region of the spine before intravenous contrast injection when undertaken (R) (Anaes.)	$573.80

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 before intravenous contrast injection when undertaken (R) (Anaes.)	$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 (R) (Anaes.)	$562.60
56233	NOTE:An account issued or a patient assignment form must show the item numbers of the examinations performed under this item Computed tomography scan of spine, 2 examinations of the kind referred to in items 56220, 56221 and 56223, without intravenous contrast medium (R) (Anaes.)	$391.40
56234	NOTE:An account issued or a patient assignment form must show the item numbers of the examinations performed under this item Computed tomography scan of spine, 2 examinations of the kind referred to in items 56224, 56225 and 56226, with intravenous contrast medium and with any scans of these regions of the spine before intravenous contrast injection when undertaken (R) (Anaes.)	$675.40
56237	Computed tomography scan of spine, 3 regions cervical, thoracic and lumbosacral, without intravenous contrast medium (R) (Anaes.)	$391.80
56238	Computed tomography scan of spine, 3 regions, cervical, thoracic and lumbosacral, with intravenous contrast medium and with any scans of these regions of the spine before intravenous contrast injection when undertaken (R) (Anaes.)	$679.70
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) (Anaes.)	$483.00
56307	Computed tomography scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest, including lungs, mediastinum, chest wall or pleura and upper abdomen before intravenous contrast injection, when undertaken, not being a service to which item 56807 or 57007 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (Anaes.)	$647.40
56401	Computed tomography scan of upper abdomen only (diaphragm to iliac crest) without intravenous contrast medium, not being a service to which item 56301, 56501, 56801 or 57001 applies (R) (Anaes.)	$418.30
56407	Computed tomography scan of upper abdomen only (diaphragm to iliac crest), with intravenous contrast medium, and with any scans of upper abdomen (diaphragm to iliac crest) before intravenous contrast injection, when undertaken, not being a service to which item 56307, 56507, 56807 or 57007 applies (R) (Anaes.)	$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) (Anaes.)	$404.10
56412	Computed tomography scan of pelvis only (iliac crest to pubic symphysis), with intravenous contrast medium and with any scans of pelvis (iliac crest to pubic symphysis) before intravenous contrast injection, when undertaken, not being a service to which item 56407 applies (R) (Anaes.)	$591.80
56501	Computed tomography scan of upper abdomen and pelvis without intravenous contrast medium, not for the purposes of virtual colonoscopy and not being a service to which item 56801 or 57001 applies(R) (Anaes.)	$604.60
56507	Computed tomography scan of upper abdomen and pelvis with intravenous contrast medium and with any scans of upper abdomen and pelvis before intravenous contrast injection, when performed, not for the purposes of virtual colonoscopy and not being a service to which item 56807 or 57007 applies (R) (Anaes.)	$785.60
56553	Computed tomography scan of colon for exclusion or diagnosis of colorectal neoplasia in a symptomatic or high risk patient if:(a) one or more of the following applies:(i) the patient has had an incomplete colonoscopy in the 3 months before the scan;(ii) there is a high grade colonic obstruction;(iii) the service is requested by a specialist or consultant physician who performs colonoscopies in the practice of the specialist s or consultant physician s speciality; and(b) the service is not a service to which item 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies; and(c) the service has not been performed on the patient in the 36 months before the scan (R) (Anaes.)	$848.60
56620	Computed tomography scan of knee, without intravenous contrast medium, not being a service to which item 56622 or 56629 applies (R) (Anaes.)	$338.50
56622	Computed tomography scan of lower limb, left or right or both, one region (other than knee), or more than one region (which may include knee), without intravenous contrast medium, not being a service to which item 56620 applies (R) (Anaes.) (Anaes.)	$359.60
56623	Computed tomography scan of lower limb, left or right or both, one region (other than knee), or more than one region (which may include knee), with intravenous contrast medium and with any scans of the lower limb before intravenous contrast injection, when performed, not being a service to which item 56626 applies (R) (Anaes.) (Anaes.)	$549.00

Item no.	Description	Max fee (excl. GST)
56626	Computed tomography scan of knee, with intravenous contrast medium and with any scans of the knee before intravenous contrast injection, when performed, not being a service to which items 56623 or 56630 apply (R) (Anaes.)	$515.00
56627	Computed tomography scan of upper limb, left or right or both, any one region, or more than one region, without intravenous contrast medium (R) (Anaes.) (Anaes.)	$359.60
56628	Computed tomography scan of upper limb, left or right or both, any one region, or more than one region, with intravenous contrast medium and with any scans of the upper limb before intravenous contrast injection, when performed (R) (Anaes.) (Anaes.)	$549.00
56629	Computed tomography scan of upper limb and lower limb, left or right or both, any one region (other than knee), or more than one region (which may include knee) without intravenous contrast medium not being a service to which item 56620 applies (R) (Anaes.) (Anaes.)	$359.60
56630	Computed tomography scan of upper limb and lower limb, left or right or both, any one region (other than knee), or more than one region (which may include knee) with intravenous contrast medium with any scans of the limbs before intravenous contrast injection, when performed, not being a service to which item 56626 applies (R) (Anaes.)	$549.00
56801	Computed tomography scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (Anaes.)	$746.60
56807	Computed tomography scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck before intravenous contrast injection, when performed, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (Anaes.)	$904.00
57001	Computed tomography scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (Anaes.)	$754.00
57007	Computed tomography scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen before intravenous contrast injection, when performed, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (Anaes.)	$929.10
57201	Computed tomography pelvimetry (R) (Anaes.)	$316.10
57341	Computed tomography, in conjunction with a surgical procedure using interventional techniques (R) (Anaes.)	$719.20
57351	Computed tomography angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if: (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) a service to which item 57352, 57353 or 57354 applies has 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) (Anaes.)	$837.70
57352	Computed tomography angiography with intravenous contrast medium of any or all, or any part, of: (a) the arch of the aorta; or (b) the carotid arteries; or (c) the vertebral arteries and their branches (head and neck); including any scans performed before intravenous contrast injection one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if: (d) either: (i) the service is requested by a specialist or consultant physician; or (ii) the service is requested by a medical practitioner (other than a specialist or consultant physician) and the request indicates that the patient s case has been discussed with a specialist or consultant physician; and (e) the service is not a service to which another item in this group applies; and (f) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (g) the service is not a study performed to image the coronary arteries (R) (Anaes.)	$847.80
57353	Computed tomography angiography with intravenous contrast medium of any or all, or any part, of: (a) the ascending and descending aorta; or (b) the common iliac and abdominal branches including upper limbs (chest, abdomen and upper limbs); including any scans performed before intravenous contrast injection one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if: (c) either: (i) the service is requested by a specialist or consultant physician; or (ii) the service is requested by a medical practitioner (other than a specialist or consultant physician) and the request indicates that the patient s case has been discussed with a specialist or consultant physician; and (d) the service is not a service to which another item in this group applies; and (e) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (f) the service is not a study performed to image the coronary arteries (R) (Anaes.)	$847.80

Item no.	Description	Max fee (excl. GST)
57354	Computed tomography angiography with intravenous contrast medium of any or all, or any part, of: (a) the descending aorta; or (b) the pelvic vessels (aorto iliac segment) and lower limbs; including any scans performed before intravenous contrast injection one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if: (c) either: (i) the service is requested by a specialist or consultant physician; or (ii) the service is requested by a medical practitioner (other than a specialist or consultant physician) and the request indicates that the patient s case has been discussed with a specialist or consultant physician; and (d) the service is not a service to which another item in this group applies; and (e) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (f) the service is not a study performed to image the coronary arteries (R) (Anaes.)	$847.80
57357	Computed tomography angiography with intravenous contrast medium of any or all, or any part, of the pulmonary arteries and their branches, including any scans performed before intravenous contrast injection one or more data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy or digital recording of multiple projections, if: the service is not a service to which another item in this group applies; and the service is not a study performed to image the coronary arteries; and the service is: (i) performed for the exclusion of pulmonary arterial stenosis, occlusion, aneurysm or embolism and is requested by a specialist or consultant physician; or (ii) performed for the exclusion of pulmonary arterial stenosis, occlusion or aneurysm and is requested by a medical practitioner (other than a specialist or consultant physician) and the request indicates that the patient s case has been discussed with a specialist or consultant physician; or (iii) for the exclusion of pulmonary embolism and is requested be a medical practitioner (other than a specialist or consultant physician) (R) (Anaes.)	$776.50
57360	Computed tomography of the coronary arteries performed on a minimum of a 64 slice (or equivalent) scanner if: (a) the request is made by a specialist or consultant physician; and (b) one of the following subparagraphs applies to the patient: (i) 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; (ii) the patient requires exclusion of coronary artery anomaly or fistula; (iii) the patient will be undergoing non coronary cardiac surgery (R) (Anaes.)	$1299.30
57362	Cone beam computed tomography dental and temporo mandibular joint imaging (without contrast medium) for diagnosis and management of any of the following: (a) mandibular and dento alveolar fractures ;(b) dental implant planning; (c) orthodontics; (d) endodontic conditions; (e) periodontal conditions; (f) temporo mandibular joint conditionsApplicable once per patient per day, not being for a service to which any of items 57960 to 57969 apply, and not being a service associated with another service in Group I2 (R) (Anaes.)	$188.80
GROUP I3—DIAGNOSTIC RADIOLOGY		
	Radiographic examination of extremities	
57506	Hand, wrist, forearm, elbow or humerus (NR)	$54.30
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)	$69.50
57515	Hand and wrist, or hand, wrist and forearm, or forearm and elbow, or elbow and humerus (R)	$89.80
57518	Foot, ankle, leg or femur (NR)	$58.10
57521	Foot, ankle, leg or femur (R)	$83.30
57522	Knee (NR)	$50.10
57523	Knee (R)	$66.80
57524	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (NR)	$81.30
57527	Foot and ankle, or ankle and leg, or leg and knee, or knee and femur (R)	$107.50
	Radiographic examination of shoulder or pelvis	
57700	Shoulder or scapula (NR)	$67.60
57703	Shoulder or scapula (R)	$104.50
57706	Clavicle (NR)	$64.70
57709	Clavicle (R)	$70.60
57712	Hip joint (R)	$77.40
57715	Pelvic girdle (R)	$98.80
57721	FEMUR, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R)	$190.00
	Radiographic examination of head	
57901	Skull, not in association with item 57902 (R)	$106.10
57902	Cephalometry, not in association with item 57901 (R)	$105.40
57905	Mastoids or petrous temporal bones (R)	$96.80

Item no.	Description	Max fee (excl. GST)
57907	Sinuses or facial bones orbit, maxilla or malar, any or all (R)	$71.00
57915	Mandible, not by orthopantomography technique (R)	$77.80
57918	Salivary calculus (R)	$91.90
57921	Nose (R)	$77.80
57924	Eye (R)	$76.20
57927	Temporo mandibular joints (R)	$81.30
57930	Teeth single area (R)	$68.60
57933	Teeth—full mouth(R)	$147.60
57939	Palato pharyngeal studies with fluoroscopic screening (R)	$124.50
57942	Palato pharyngeal studies without fluoroscopic screening (R)	$95.20
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)	$70.80
57960	Orthopantomography for diagnosis or management (or both) of trauma, infection, tumour or a congenital or surgical condition of the teeth or maxillofacial region (R)	$76.70
57963	Orthopantomography for diagnosis or management (or both) of any of the following conditions, if the signs and symptoms of the condition is present:(a) impacted teeth;(b) caries;(c) periodontal pathology;(d) periapical pathology (R)	$76.60
57966	Orthopantomography for diagnosis or management (or both) of missing or crowded teeth, or developmental anomalies of the teeth or jaws (R)	$89.60
57969	Orthopantomography for diagnosis or management (or both) of temporo mandibular joint arthroses or dysfunction (R)	$91.90
	Radiographic examination of spine	
58100	Spine cervical (R)	$109.80
58103	Spine thoracic (R)	$90.40
58106	Spine lumbosacral (R)	$125.90
58108	Spine 4 regions, cervical, thoracic, lumbosacral and sacrococcygeal (R)	$179.60
58109	Spine sacrococcygeal (R)	$76.80
58112	NOTE:An account issued or a patient assignment form must show the item numbers of the examinations performed under this item Spine 2 examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R)	$160.90
58115	NOTE:An account issued or a patient assignment form must show the item numbers of the examinations performed under this item Spine 3 examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R)	$179.60
58120	Spine 4 regions, cervical, thoracic, lumbosacral and sacrococcygeal, if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year (R)	$179.60
58121	NOTE:An account issued or a patient assignment form must show the item numbers of the examinations performed under this item Spine 3 examinations of the kind mentioned in items 58100, 58103, 58106 and 58109, if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year (R)	$211.30
	Bone age study and skeletal surveys	
58300	Bone age study (R)	$81.80
58306	Skeletal survey (R)	$173.20
	Radiographic examination of thoracic region	
58500	Chest (lung fields) by direct radiography (NR)	$60.30
58503	Chest (lung fields) by direct radiography (R)	$76.80
58506	Chest (lung fields) by direct radiography with fluoroscopic screening (R)	$114.20
58509	Thoracic inlet or trachea (R)	$89.30
58521	Left ribs, right ribs or sternum (R)	$71.10
58524	Left and right ribs, left ribs and sternum, or right ribs and sternum (R)	$92.20
58527	Left ribs, right ribs and sternum (R)	$111.40
	Radiographic examination of urinary tract	
58700	Plain renal only (R)	$92.70
58706	Intravenous pyelography, with or without preliminary plain films and with or without tomography (R)	$304.30

Item no.	Description	Max fee (excl. GST)
58715	Antegrade or retrograde pyelography with or without preliminary plain films and with preparation and contrast injection, one side (R)	$264.10
58718	Retrograde cystography or retrograde urethrography with or without preliminary plain films and with preparation and contrast injection (R) (Anaes.)	$243.60
58721	Retrograde micturating cysto urethrography, with preparation and contrast injection (R) (Anaes.)	$245.40
	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)	$56.70
58903	Plain abdominal only, not being a service associated with a service to which item 58909, 58912 or 58915 applies (R)	$77.70
58909	Barium or other opaque meal of one or more of pharynx, oesophagus, stomach or duodenum, with or without preliminary plain films of pharynx, chest or duodenum, not being a service associated with a service to which item 57939, 57942 or 57945 applies (R)	$172.40
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)	$201.30
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
58921	Opaque enema, with or without air contrast study and with or without preliminary plain films (R)	$259.40
58927	Cholegraphy direct, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 30439 applies (R)	$148.40
58933	Cholegraphy, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection (R)	$402.00
58936	Cholegraphy, drip infusion, with or without preliminary plain films, with preparation and contrast injection and with or without tomography (R)	$359.00
58939	Defaecogram (R)	$226.70
	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)	$34.80
	Radiographic examination of breasts	
59300	Mammography of both breasts if there is reason to suspect the presence of malignancy because of: (a) the past occurrence of breast malignancy in the patient; or (b) significant history of breast or ovarian malignancy in the patient s family; or (c) symptoms or indications of breast disease found on examination of the patient by a medical practitioner (R) (Note: These items are intended for use in the investigation of a clinical abnormality of the breast/s and NOT for individual, group or opportunistic screening of asymptomatic patients)	$145.90
59302	Three dimensional tomosynthesis of both breasts, if there is reason to suspect the presence of malignancy because of: a) the past occurrence of breast malignancy in the patient; or b) significant history of breast or ovarian malignancy in the patient s family; or c) symptoms or indications of breast disease found on examination of the patient by a medical practitioner Not being a service to which item 59300 applies (R)	$310.80
59303	Mammography of one breast if: (a) the service is specifically requested for a unilateral mammogram; and (b) there is reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient; or (ii) significant history of breast or ovarian malignancy in the patient s family; or (iii) symptoms or indications of breast disease found on examination of the patient by a medical practitioner (R)	$103.50
59305	Three dimensional tomosynthesis of one breast, if there is reason to suspect the presence of malignancy because of: a) the past occurrence of breast malignancy in the patient; or b) significant history of breast or ovarian malignancy in the patient s family; or c) symptoms or indications of breast disease found on examination of the patient by a medical practitioner Not being a service to which item 59303 applies (R)	$175.40
59312	Radiographic examination of both breasts, in conjunction with a surgical procedure on each breast, using interventional techniques (R)	$171.10
59314	Radiographic examination of one breast, in conjunction with a surgical procedure using interventional techniques (R)	$123.90
59318	Radiographic examination of excised breast tissue to confirm satisfactory excision of one or more lesions in one breast or both following pre-operative localisation in conjunction with a service under item 31536 (R)	$92.50

Item no.	Description	Max fee (excl. GST)
	Radiographic examination with opaque or contrast media	
59700	Discography, each disc, with or without preliminary plain films and with preparation and contrast injection (R) (Anaes.) (Anaes.)	$196.20
59703	Dacryocystography, one side, with or without preliminary plain film and with preparation and contrast injection (R)	$162.90
59712	Hysterosalpingography, with or without preliminary plain films and with preparation and contrast injection (R)(Anaes.) (Anaes.)	$219.90
59715	Bronchography, one side, with or without preliminary plain films and with preparation and contrast injection, on a person under 16 years of age (R) (Anaes.) (Anaes.)	$263.30
59718	Phlebography, one side, with or without preliminary plain films and with preparation and contrast injection (R) (Anaes.) (Anaes.)	$221.70
59724	Myelography, one or more regions, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 56219 applies (R)(Anaes.) (Anaes.)	$364.00
59733	Sialography, one side, with preparation and contrast injection, not being a service associated with a service to which item 57918 applies (R)	$176.10
59739	Sinogram or fistulogram, one or more regions, with or without preliminary plain films and with preparation and contrast injection (R)	$143.60
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)	$224.60
59754	Lymphangiography, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection (R)	$421.40
59763	Air insufflation during video fluoroscopic imaging including associated consultation (R)	$255.80
	Angiography	
59903	Angiocardiography, including the service mentioned in item 59970 or 61109, not being a service to which item 59912 or 59925 applies (R) (Anaes.)	$231.10
59912	Selective coronary arteriography, including the service mentioned in item 59970 or 61109, not being a service to which item 59903 or 59925 applies (R) (Anaes.)	$611.60
59925	Selective coronary arteriography and angiocardiography, including a service mentioned in item 59903, 59912, 59970 or 61109 (R) (Anaes.)	$736.60
59970	Angiography or digital subtraction angiography, or both, with fluoroscopy and image acquisition, using a mobile image intensifier, including any preliminary plain films, preparation and contrast injection one or more regions (R) (Anaes.)	$323.20
60000	Digital subtraction angiography, examination of head and neck with or without arch aortography 1 to 3 data acquisition runs (R) (Anaes.)	$1080.50
60003	Digital subtraction angiography, examination of head and neck with or without arch aortography 4 to 6 data acquisition runs (R) (Anaes.)	$1563.60
60006	Digital subtraction angiography, examination of head and neck with or without arch aortography 7 to 9 data acquisition runs (R) (Anaes.)	$2244.40
60009	Digital subtraction angiography, examination of head and neck with or without arch aortography 10 or more data acquisition runs (R) (Anaes.)	$2670.00
60012	Digital subtraction angiography, examination of thorax 1 to 3 data acquisition runs (R) (Anaes.)	$937.90
60015	Digital subtraction angiography, examination of thorax 4 to 6 data acquisition runs (R) (Anaes.)	$1589.30
60018	Digital subtraction angiography, examination of thorax 7 to 9 data acquisition runs (R) (Anaes.)	$2300.40
60021	Digital subtraction angiography, examination of thorax 10 or more data acquisition runs (R) (Anaes.)	$2620.60
60024	Digital subtraction angiography, examination of abdomen 1 to 3 data acquisition runs (R) (Anaes.)	$919.80
60027	Digital subtraction angiography, examination of abdomen 4 to 6 data acquisition runs (R) (Anaes.)	$1603.80
60030	Digital subtraction angiography, examination of abdomen 7 to 9 data acquisition runs (R) (Anaes.)	$2279.50
60033	Digital subtraction angiography, examination of abdomen 10 or more data acquisition runs (R) (Anaes.)	$2635.20
60036	Digital subtraction angiography, examination of upper limb or limbs 1 to 3 data acquisition runs (R) (Anaes.)	$1079.30
60039	Digital subtraction angiography, examination of upper limb or limbs 4 to 6 data acquisition runs (R) (Anaes.)	$1589.30
60042	Digital subtraction angiography, examination of upper limb or limbs 7 to 9 data acquisition runs (R) (Anaes.)	$2266.30

Item no.	Description	Max fee (excl. GST)
60045	Digital subtraction angiography, examination of upper limb or limbs 10 or more data acquisition runs (R) (Anaes.)	$2658.60
60048	Digital subtraction angiography, examination of lower limb or limbs 1 to 3 data acquisition runs (R) (Anaes.)	$1080.10
60051	Digital subtraction angiography, examination of lower limb or limbs 4 to 6 data acquisition runs (R) (Anaes.)	$1609.50
60054	Digital subtraction angiography, examination of lower limb or limbs 7 to 9 data acquisition runs (R) (Anaes.)	$2279.50
60057	Digital subtraction angiography, examination of lower limb or limbs 10 or more data acquisition runs (R) (Anaes.)	$2692.10
60060	Digital subtraction angiography, examination of aorta and lower limb or limbs 1 to 3 data acquisition runs (R) (Anaes.)	$1089.60
60063	Digital subtraction angiography, examination of aorta and lower limb or limbs 4 to 6 data acquisition runs (R) (Anaes.)	$1591.40
60066	Digital subtraction angiography, examination of aorta and lower limb or limbs 7 to 9 data acquisition runs (R) (Anaes.)	$2281.90
60069	Digital subtraction angiography, examination of aorta and lower limb or limbs 10 or more data acquisition runs (R) (Anaes.)	$2641.20
60072	Selective arteriography or selective venography by digital subtraction angiography technique one vessel (NR) (Anaes.)	$92.50
60075	Selective arteriography or selective venography by digital subtraction angiography technique 2 vessels (NR) (Anaes.)	$184.10
60078	Selective arteriography or selective venography by digital subtraction angiography technique 3 or more vessels (NR) (Anaes.)	$279.90
	Fluoroscopic examination	
60500	FLUOROSCOPY, with general anaesthesia (not being a service associated with a radiographic examination) (R) (Anaes.)	$85.30
60503	FLUOROSCOPY, without general anaesthesia (not being a service associated with a radiographic examination) (R)	$73.10
60506	Fluoroscopy using a mobile image intensifier, in conjunction with a surgical procedure lasting less than 1 hour, not being a service associated with a service to which another item in this Group applies (R)	$123.30
60509	Fluoroscopy using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this Group applies (R)	$187.90
	Preparation for radiological procedure	
60918	Arteriography (peripheral) or phlebography one vessel, when used in association with a service to which item 59903, 59912, 59925 or 59970 applies, not being a service associated with a service to which any of items 60000 to 60078 apply (NR) (Anaes.)	$90.60
60927	Selective arteriogram or phlebogram, when used in association with a service to which item 59903, 59912, 59925 or 59970 applies, not being a service associated with a service to which any of items 60000 to 60078 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 Group applies (R)	$429.20
GROUP I4—NUCLEAR MEDICINE IMAGING		
61310	Myocardial infarct avid study (R)	$599.90
61311	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Single stress myocardial perfusion study, with PET if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting ECG, continuous ECG monitoring during exercise (with recording), blood pressure monitoring and the recording ofother parameters (including heart rate); and (d) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61332, 61345, 61357, 61377, 61394, 61398, 61380, 61406, 61414 or 61422 applies Applicable not more than once in 24 months (R)	$869.90
61313	Gated cardiac blood pool study, (equilibrium) (R)	$497.00

Item no.	Description	Max fee (excl. GST)
61314	Gated cardiac blood pool study, with or without intervention, and first pass blood flow or cardiac shunt study (R)	$692.90
61321	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.2 Single rest myocardial perfusion study for the assessment of the extent and severity of viable and non viable myocardium, with single photon emission tomography, with or without planar imaging, if: (a) the patient has left ventricular systolic dysfunction and probable or confirmed coronary artery disease; and (b) the service uses a single rest technetium 99m (Tc 99m) protocol; and (c) the service is requested by a specialist or a consultant physician; and (d) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61325, 61329, 61345, 61398 or 61406 applies Note: thisitem applies to a service provided to a patient who is 17 years or older not more than once each 24 months. (R)	$493.50
61324	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting ECG, continuous ECG monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a specialist or consultant physician; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61325, 61329, 61345, 61357, 61394, 61398, 61406 or 61414 applies Note: this itemapplies to a service provided to a patient who is 17 years or older not more than once each 24 months. (R)	$979.60
61325	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.2 Single rest myocardial perfusion study for the assessment of the extent and severity of viable and non viable myocardium, with single photon emission tomography, with or without planar imaging, if: (a) the patient has left ventricular systolic dysfunction and probable or confirmed coronary artery disease; and (b) the service uses: (i) an initial rest study followed by a redistribution study on the same day; and (ii) a thallous chloride 201 (Tl 201) protocol; and (c) the service is requested by a specialist or a consultant physician; and (d) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61329, 61345, 61398 or 61406 applies Note: thisitem applies to a service provided to a patient who is 17 years or older not more than twice each 24 months. (R)	$493.50
61328	Lung perfusion study (R)	$363.30
61329	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61345, 61357, 61394, 61398, 61406 or 61414 applies Note: this item applies to a service provided to a patient who is 17 years or older not more than once each 24 months. (R)	$1473.10
61332	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with PET, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61311, 61321, 61324, 61325, 61329, 61345, 61357, 61377, 61380, 61394, 61398, 61406, 61414 or 61422 applies Applicable not more than once in 24 months (R)	$1284.70
61333	Lung perfusion study and lung ventilation study using galligas or 68Ga-MAA, with PET (R) Item 61333 was only available from 14 September 2019 until 20 December 2019, during a national shortage of technetium. See the Health Insurance (Section 3C Diagnostic Imaging—Nuclear Medicine Services) Amendment (No. 2) Determination 2019 on the Federal Register of Legislation for further information.	$682.20

Item no.	Description	Max fee (excl. GST)
61336	Cerebral perfusion study, with PET (R) Item 61336 was only available from 14 September 2019 until 20 December 2019, during a national shortage of technetium. See the Health Insurance (Section 3C Diagnostic Imaging—Nuclear Medicine Services) Amendment (No. 2) Determination 2019 on the Federal Register of Legislation for further information.	$931.00
61337	Bone study whole body, with PET, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) Item 61337 was only available from 14 September 2019 until 20 December 2019, during a national shortage of technetium. See the Health Insurance (Section 3C Diagnostic Imaging—Nuclear Medicine Services) Amendment (No. 2) Determination 2019 on the Federal Register of Legislation for further information.	$738.30
61340	Lung ventilation study using aerosol, technegas or xenon gas (R)	$352.30
61341	Bone study whole body and PET, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) Item 61341 was only available from 14 September 2019 until 20 December 2019, during a national shortage of technetium. See the Health Insurance (Section 3C Diagnostic Imaging—Nuclear Medicine Services) Amendment (No. 2) Determination 2019 on the Federal Register of Legislation for further information.	$924.30
61344	Computed tomography performed at the same time and covering the same body area as positron emission tomography covered by items 61311, 61332, 61333, 61336, 61337 and 61341, for the purpose of anatomic localisation or attenuation correction if no separate diagnostic CT report is issued (R) Item 61344 was only available from 14 September 2019 until 20 December 2019, during a national shortage of technetium. See the Health Insurance (Section 3C Diagnostic Imaging—Nuclear Medicine Services) Amendment (No. 2) Determination 2019 on the Federal Register of Legislation for further information.	$153.90
61345	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a specialist or consultant physician; and (e) the service is not associated with a service to which item11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61357, 61394, 61398, 61406 or 61414 applies Note: this item applies to a service provided to a patient who is 17 years or older not more than once each 24 months. (R)	$1473.10
61348	Lung perfusion study and lung ventilation study using aerosol, technegas or xenon gas (R)	$709.50
61349	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Repeat combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) in the previous 24 months, the patient has had a service performed to which item 61324, 61329, 61345, 61357, 61394, 61398, 61406 or 61414 applies and has subsequently undergone a revascularisation procedure; and (b) the patient has one or more symptoms of cardiac ischaemia that have evolved and are not adequately controlled with optimal medical therapy; and (c) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (d) the service is requested by a specialist or a consultant physician; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730 or 61410 applies Applicable not more than once in 12 months (R)	$1473.10
61353	Liver and spleen study (colloid) (R)	$656.50
61356	Red blood cell spleen or liver study (R)	$638.90
61357	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which items 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61394, 61398, 61406 or 61414 applies Note: this item applies to a service provided to a patient who is 17 years or older not more than once each 24 months (R)	$979.60

Item no.	Description	Max fee (excl. GST)
61360	Hepatobiliary study, including morphine administration or pre-treatment with a cholagogue when performed (R)	$779.70
61361	Hepatobiliary study with formal quantification following baseline imaging, using a cholagogue (R)	$900.60
61364	Bowel haemorrhage study (R)	$792.90
61368	Meckel s diverticulum study (R)	$374.50
61369	Indium-labelled octreotide study (including single photon emission tomography when undertaken), if:(a) a gastro-entero-pancreatic endocrine tumour is suspected on the basis of biochemical evidence with negative or equivocal conventional imaging; or (b) both: (i) a surgically amenable gastro-entero-pancreatic endocrine tumour has been identified on the basis of conventional techniques; and (ii) the study is to exclude additional disease sites (R)	$3873.40
61372	Salivary study (R)	$384.90
61373	Gastro-oesophageal reflux study, including delayed imaging on a separate occasion when performed (R)	$766.60
61376	Oesophageal clearance study (R)	$247.60
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)	$1074.40
61384	Radionuclide colonic transit study (R)	$1321.30
61386	RENAL STUDY, including perfusion and renogram images and computer analysis OR cortical study with planar imaging (R)	$522.00
61387	RENAL CORTICAL STUDY, with single photon emission tomography and planar quantification (R)	$743.00
61389	SINGLE RENAL STUDY with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R)	$605.00
61390	Renal study with diuretic administration after a baseline study (R)	$644.10
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)	$1012.60
61394	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a specialist or consultant physician; and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61398, 61406 or 61414 applies Note: this item applies to a service provided to a patient who is 17 years or older not more than once each 24 months. (R)	$979.60
61397	Cystoureterogram (R)	$430.60
61398	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the services is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61406 or 61414 applies Note: this item applies to a service provided to a patient who is 17 years or older not more than once each 24 months. (R)	$1473.10
61402	Cerebral perfusion study, with single photon emission tomography and with planar imaging when performed (R)	$1023.90

Item no.	Description	Max fee (excl. GST)
61406	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a specialist or consultant physician; and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61398 or 61414 applies Note: this itemapplies to a service provided to a patient who is 17 years or older not more than once each 24 months. (R)	$1473.10
61409	Cerebro spinal fluid transport study, with imaging on 2 or more separate occasions (R)	$1327.50
61410	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Repeat combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) in the previous 24 months, the patient has had a service performed to which item 61324, 61329, 61345, 61357, 61394, 61398, 61406 or 61414 applies, and has subsequently undergone a revascularisation procedure; and (b) the patient has one or more symptoms of cardiac ischaemia that have evolved and are not adequately controlled with optimal medical therapy; and (c) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (d) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729 or 11730 applies Applicable not more than once in 12 months (R)	$1473.10
61413	Cerebro spinal fluid shunt patency study (R)	$383.20
61414	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61398 or 61406 applies Note: this itemapplies to a service provided to a patient who is 17 years or older not more than once each 24 months. (R)	$979.60
61421	Bone study whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R)	$792.50
61425	Bone study whole body and single photon emission tomography, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R)	$997.60
61426	Whole body study using iodine (R)	$872.20
61429	Whole body study using gallium (R)	$925.20
61430	Whole body study using gallium, with single photon emission tomography (R)	$1214.80
61433	Whole body study using cells labelled with technetium (R)	$782.20
61434	WHOLE BODY STUDY using cells labelled with technetium, with single photon emission tomography (R)	$1133.40
61438	Whole body study using thallium (R)	$1283.20
61441	Bone marrow study whole body using technetium labelled bone marrow agents (R)	$774.30
61442	Whole body study, using gallium with single photon emission tomography of 2 or more body regions acquired separately (R)	$1278.20
61445	Bone marrow study localised using technetium labelled agent (R)	$439.00
61446	Regional scintigraphic study, using an approved bone scanning agent,including when undertaken, blood flow imaging, blood pool imagingand repeat imaging on a separate occasion (R)	$537.60
61449	Regional scintigraphic study, using an approved bone scanning agentand single photon emission tomography, including when undertaken, blood flow imaging, blood pool imagingand repeat imaging on a separate occasion (R)	$736.50
61450	Localised study using gallium (R)	$662.90
61453	Localised study using gallium, with single photon emission tomography (R)	$837.90
61454	Localised study using cells labelled with technetium (R)	$554.00
61457	LOCALISED STUDY using cells labelled with technetium, with single photon emission tomography (R)	$904.20

Item no.	Description	Max fee (excl. GST)
61461	Localised study using thallium (R)	$1014.40
61462	Repeat planar and single photon emission tomography imaging, or repeat planar imaging or single photon emission tomography imaging on an occasion subsequent to the performance of item 61364, 61426, 61429, 61430, 61442, 61450, 61453, 61469 or 61485, if there is no additional administration of radiopharmaceutical and if the previous radionuclide scan was abnormal or equivocal (R)	$210.60
61469	Lymphoscintigraphy (R)	$668.50
61473	Thyroid study (R)	$338.90
61480	Parathyroid study (R)	$611.30
61485	Adrenal study, with single photon emission tomography (R)	$1695.00
61495	Tear duct study (R)	$374.50
61499	Particle perfusion study (infra arterial) or Le Veen shunt study (R)	$415.20
61505	CT scan performed at the same time and covering the same body area as single photon emission tomography or positron emission tomography for the purpose of anatomic localisation or attenuation correction if no separate diagnostic CT report is issued and performed in association with a service to which an item in Subgroup 1 or 2 of Group I4 applies (R)	$163.40
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)	$1831.30
61529	Whole body FDG PET study, performed for the staging of proven non-small cell lung cancer, where curative surgery or radiotherapy is planned (R)	$1831.30
61538	Fdg pet study of the brain for evaluation of suspected residual or recurrent malignant brain tumour based on anatomical imaging findings, after definitive therapy (or during ongoing chemotherapy) in patients who are considered suitable for further active therapy. (r)	$1731.40
61541	Whole body FDG PET study, following initial therapy, for the evaluation of suspected residual, metastatic or recurrent colorectal carcinoma in patients considered suitable for active therapy (R)	$1831.30
61553	Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected metastatic or recurrent malignant melanoma in patients considered suitable for active therapy (R)	$1919.80
61559	FDG PET study of the brain, performed for the evaluation of refractory epilepsy which is being evaluated for surgery (R)	$1764.10
61565	Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected residual, metastatic or recurrent ovarian carcinoma in patients considered suitable for active therapy. (R)	$1831.30
61571	Whole body FDG PET study, for the further primary staging ofpatients with histologically proven carcinoma of the uterine cervix, at FIGO stage IB2 or greater by conventional staging, prior to planned radical radiation therapy or combined modality therapy with curative intent. (R)	$1831.30
61575	Whole body FDG PET study, for the further staging of patients with confirmed local recurrence of carcinoma of the uterine cervix considered suitable for salvage pelvic chemoradiotherapy or pelvic exenteration with curative intent. (R)	$1768.90
61577	Whole body FDG PET study, performed for the staging of proven oesophageal or GEJ carcinoma, in patients considered suitable for active therapy (R).	$1831.30
61598	Whole body FDG PET study performed for the staging of biopsy-proven newly diagnosed or recurrent head and neck cancer (R).	$1831.30
61604	Whole body FDG PET study performed for the evaluation of patients with suspected residual head and neck cancer after definitive treatment, and who are suitable for active therapy (R).	$1831.30
61610	Whole body FDG PET study performed for the evaluation of metastatic squamous cell carcinoma of unknown primary site involving cervical nodes (R).	$1831.30
61620	Whole body FDG PET study for the initial staging of newly diagnosed or previously untreated Hodgkin or non-Hodgkin lymphoma (R)	$1768.90
61622	Whole body FDG PET study to assess response to first line therapy either during treatment or within three months of completing definitive first line treatment for Hodgkin or non-Hodgkin lymphoma (R)	$1831.30
61628	Whole body FDG PET study for restaging following confirmation of recurrence of Hodgkin or non-Hodgkin lymphoma (R)	$1831.30
61632	Whole body FDG PET study to assess response to second-line chemotherapy ifhaemopoietic stem cell transplantation is being considered for Hodgkin or non-Hodgkin lymphoma (R)	$1768.90
61640	Whole body FDG PET study for initial staging of patients with biopsy-proven bone or soft tissue sarcoma (excluding gastrointestinal stromal tumour) considered by conventional staging to be potentially curable. (R)	$1919.80
61646	Whole body fdg pet study for the evaluation of patients with suspected residual or recurrent sarcoma (excluding gastrointestinal stromal tumour) after the initial course of definitive therapy to determine suitability for subsequent therapy with curative intent. (r)	$1919.80

Item no.	Description	Max fee (excl. GST)
61647	Whole body 68Ga DOTA peptide PET study, if:(a) a gastro entero pancreatic neuroendocrine tumour is suspected on the basis of biochemical evidence with negative or equivocal conventional imaging; or(b) both:(i) a surgically amenable gastro entero pancreatic neuroendocrine tumour has been identified on the basis of conventional techniques; and(ii) the study is for excluding additional disease sites (R)	$1656.70
61650	LeukoScan study of the long bones and feet for suspected osteomyelitis, if:(a) the patient does not have access to ex vivo white blood cell scanning; and(b) the patient is not being investigated for other sites of infection (R)	$1664.70
	Nuclear medicine—non PET	
61310	Myocardial infarct avid study (R)	$599.90
61311	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Single stress myocardial perfusion study, with PET if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting ECG, continuous ECG monitoring during exercise (with recording), blood pressure monitoring and the recording ofother parameters (including heart rate); and (d) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61332, 61345, 61357, 61377, 61394, 61398, 61380, 61406, 61414 or 61422 applies Applicable not more than once in 24 months (R)	$869.90
61313	Gated cardiac blood pool study, (equilibrium) (R)	$497.00
61314	Gated cardiac blood pool study, with or without intervention, and first pass blood flow or cardiac shunt study (R)	$692.90
61321	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.2 Single rest myocardial perfusion study for the assessment of the extent and severity of viable and non viable myocardium, with single photon emission tomography, with or without planar imaging, if: (a) the patient has left ventricular systolic dysfunction and probable or confirmed coronary artery disease; and (b) the service uses a single rest technetium 99m (Tc 99m) protocol; and (c) the service is requested by a specialist or a consultant physician; and (d) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61325, 61329, 61345, 61398 or 61406 applies Note: thisitem applies to a service provided to a patient who is 17 years or older not more than once each 24 months. (R)	$493.50
61324	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting ECG, continuous ECG monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a specialist or consultant physician; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61325, 61329, 61345, 61357, 61394, 61398, 61406 or 61414 applies Note: this itemapplies to a service provided to a patient who is 17 years or older not more than once each 24 months. (R)	$979.60
61325	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.2 Single rest myocardial perfusion study for the assessment of the extent and severity of viable and non viable myocardium, with single photon emission tomography, with or without planar imaging, if: (a) the patient has left ventricular systolic dysfunction and probable or confirmed coronary artery disease; and (b) the service uses: (i) an initial rest study followed by a redistribution study on the same day; and (ii) a thallous chloride 201 (Tl 201) protocol; and (c) the service is requested by a specialist or a consultant physician; and (d) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61329, 61345, 61398 or 61406 applies Note: thisitem applies to a service provided to a patient who is 17 years or older not more than twice each 24 months. (R)	$493.50
61328	Lung perfusion study (R)	$363.30

Item no.	Description	Max fee (excl. GST)
61329	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61345, 61357, 61394, 61398, 61406 or 61414 applies Note: this item applies to a service provided to a patient who is 17 years or older not more than once each 24 months. (R)	$1473.10
61332	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with PET, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61311, 61321, 61324, 61325, 61329, 61345, 61357, 61377, 61380, 61394, 61398, 61406, 61414 or 61422 applies Applicable not more than once in 24 months (R)	$1284.70
61333	Lung perfusion study and lung ventilation study using galligas or 68Ga-MAA, with PET (R) Item 61333 was only available from 14 September 2019 until 20 December 2019, during a national shortage of technetium. See the Health Insurance (Section 3C Diagnostic Imaging—Nuclear Medicine Services) Amendment (No. 2) Determination 2019 on the Federal Register of Legislation for further information.	$682.20
61336	Cerebral perfusion study, with PET (R) Item 61336 was only available from 14 September 2019 until 20 December 2019, during a national shortage of technetium. See the Health Insurance (Section 3C Diagnostic Imaging—Nuclear Medicine Services) Amendment (No. 2) Determination 2019 on the Federal Register of Legislation for further information.	$931.00
61337	Bone study whole body, with PET, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) Item 61337 was only available from 14 September 2019 until 20 December 2019, during a national shortage of technetium. See the Health Insurance (Section 3C Diagnostic Imaging—Nuclear Medicine Services) Amendment (No. 2) Determination 2019 on the Federal Register of Legislation for further information.	$738.30
61340	Lung ventilation study using aerosol, technegas or xenon gas (R)	$352.30
61341	Bone study whole body and PET, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) Item 61341 was only available from 14 September 2019 until 20 December 2019, during a national shortage of technetium. See the Health Insurance (Section 3C Diagnostic Imaging—Nuclear Medicine Services) Amendment (No. 2) Determination 2019 on the Federal Register of Legislation for further information.	$924.30
61344	Computed tomography performed at the same time and covering the same body area as positron emission tomography covered by items 61311, 61332, 61333, 61336, 61337and 61341, for the purpose of anatomic localisation or attenuation correction if no separate diagnostic CT report is issued (R) Item 61344 was only available from 14 September 2019 until 20 December 2019, during a national shortage of technetium. See the Health Insurance (Section 3C Diagnostic Imaging—Nuclear Medicine Services) Amendment (No. 2) Determination 2019 on the Federal Register of Legislation for further information.	$153.90
61345	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a specialist or consultant physician; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61357, 61394, 61398, 61406 or 61414 applies Note: this item applies to a service provided to a patient who is 17 years or older not more than once each 24 months. (R)	$1473.10

Item no.	Description	Max fee (excl. GST)
61348	Lung perfusion study and lung ventilation study using aerosol, technegas or xenon gas (R)	$709.50
61349	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Repeat combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) in the previous 24 months, the patient has had a service performed to which item 61324, 61329, 61345, 61357, 61394, 61398, 61406 or 61414 applies and has subsequently undergone a revascularisation procedure; and (b) the patient has one or more symptoms of cardiac ischaemia that have evolved and are not adequately controlled with optimal medical therapy; and (c) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which item 55141, 55143, 55145 or 55146 applies; and (d) the service is requested by a specialist or a consultant physician; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730 or 61410 applies Applicable not more than once in 12 months (R)	$1473.10
61353	Liver and spleen study (colloid) (R)	$656.50
61356	Red blood cell spleen or liver study (R)	$638.90
61357	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) at least one of the following applies: (i) the patient has body habitus or other physical conditions (including heart rhythm disturbance) to the extent that a stress echocardiography would not provide adequate information; (ii) the patient is unable to exercise to the extent required for a stress echocardiography to provide adequate information; (iii) the patient has had a failed stress echocardiography provided in a service to which items 55141, 55143, 55145 or 55146 applies; and (c) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (d) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61394, 61398, 61406 or 61414 applies Note: this item applies to a service provided to a patient who is 17 years or older not more than once each 24 months. (R)	$979.60
61360	Hepatobiliary study, including morphine administration or pre-treatment with a cholagogue when performed (R)	$779.70
61361	Hepatobiliary study with formal quantification following baseline imaging, using a cholagogue (R)	$900.60
61364	Bowel haemorrhage study (R)	$792.90
61368	Meckel s diverticulum study (R)	$374.50
61369	Indium-labelled octreotide study (including single photon emission tomography when undertaken), if: (a) a gastro-entero-pancreatic endocrine tumour is suspected on the basis of biochemical evidence with negative or equivocal conventional imaging; or (b) both: (i) a surgically amenable gastro-entero-pancreatic endocrine tumour has been identified on the basis of conventional techniques; and (ii) the study is to exclude additional disease sites (R)	$3873.40
61372	Salivary study (R)	$384.90
61373	Gastro-oesophageal reflux study, including delayed imaging on a separate occasion when performed (R)	$766.60
61376	Oesophageal clearance study (R)	$247.60
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)	$1074.40
61384	Radionuclide colonic transit study (R)	$1321.30
61386	RENAL STUDY, including perfusion and renogram images and computer analysis OR cortical study with planar imaging (R)	$522.00
61387	RENAL CORTICAL STUDY, with single photon emission tomography and planar quantification (R)	$743.00
61389	SINGLE RENAL STUDY with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R)	$605.00
61390	Renal study with diuretic administration after a baseline study (R)	$644.10
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)	$1012.60

Item no.	Description	Max fee (excl. GST)
61394	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a specialist or consultant physician; and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61398, 61406 or 61414 applies Note: this item applies to a service provided to a patient who is 17 years or older not more than once each 24 months. (R)	$979.60
61397	Cystoureterogram (R)	$430.60
61398	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the services is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61406 or 61414 applies Note: thisitem applies to a service provided to a patient who is 17 years or older not more than once each 24 months. (R)	$1473.10
61402	Cerebral perfusion study, with single photon emission tomography and with planar imaging when performed (R)	$1023.90
61406	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a specialist or consultant physician; and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61398 or 61414 applies Note: this itemapplies to a service provided to a patient who is 17 years or older not more than once each 24 months. (R)	$1473.10
61409	Cerebro spinal fluid transport study, with imaging on 2 or more separate occasions (R)	$1327.50
61410	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Repeat combined stress and rest, stress and re injection or rest and redistribution myocardial perfusion study, including delayed imaging or re injection protocol on a subsequent occasion, with single photon emission tomography, with or without planar imaging, if: (a) in the previous 24 months, the patient has had a service performed to which item 61324, 61329, 61345, 61357, 61394, 61398, 61406 or 61414 applies, and has subsequently undergone a revascularisation procedure; and (b) the patient has one or more symptoms of cardiac ischaemia that have evolved and are not adequately controlled with optimal medical therapy; and (c) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (d) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (e) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729 or 11730 applies Applicable not more than once in 12 months (R)	$1473.10
61413	Cerebro spinal fluid shunt patency study (R)	$383.20
61414	Note: the service only applies if the patient meets the requirements of the descriptor and the requirements of Note: IR.4.1 Single stress myocardial perfusion study, with single photon emission tomography, with or without planar imaging, if: (a) the patient has symptoms of cardiac ischaemia; and (b) the service is provided at, or from, a practice located in a Modified Monash 3, 4, 5, 6 or 7 area; and (c) a stress echocardiography service is not available in the Modified Monash area where the service is provided; and (d) the service includes resting electrocardiograph, continuous electrocardiograph monitoring during exercise (with recording), blood pressure monitoring and the recording of other parameters (including heart rate); and (e) the service is requested by a medical practitioner (other than a specialist or consultant physician); and (f) the service is not associated with a service to which item 11704, 11705, 11707, 11714, 11729, 11730, 61321, 61324, 61325, 61329, 61345, 61357, 61394, 61398 or 61406 applies Note: this itemapplies to a service provided to a patient who is 17 years or older not more than once each 24 months. (R)	$979.60
61421	Bone study whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R)	$792.50
61425	Bone study whole body and single photon emission tomography, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R)	$997.60

Item no.	Description	Max fee (excl. GST)
61426	Whole body study using iodine (R)	$872.20
61429	Whole body study using gallium (R)	$925.20
61430	Whole body study using gallium, with single photon emission tomography (R)	$1214.80
61433	Whole body study using cells labelled with technetium (R)	$782.20
61434	WHOLE BODY STUDY using cells labelled with technetium, with single photon emission tomography (R)	$1133.40
61438	Whole body study using thallium (R)	$1283.20
61441	Bone marrow study whole body using technetium labelled bone marrow agents (R)	$774.30
61442	Whole body study, using gallium with single photon emission tomography of 2 or more body regions acquired separately (R)	$1278.20
61445	Bone marrow study localised using technetium labelled agent (R)	$439.00
61446	Regional scintigraphic study, using an approved bone scanning agent,including when undertaken, blood flow imaging, blood pool imagingand repeat imaging on a separate occasion (R)	$537.60
61449	Regional scintigraphic study, using an approved bone scanning agentand single photon emission tomography, including when undertaken, blood flow imaging, blood pool imagingand repeat imaging on a separate occasion (R)	$736.50
61450	Localised study using gallium (R)	$662.90
61453	Localised study using gallium, with single photon emission tomography (R)	$837.90
61454	Localised study using cells labelled with technetium (R)	$554.00
61457	LOCALISED STUDY using cells labelled with technetium, with single photon emission tomography (R)	$904.20
61461	Localised study using thallium (R)	$1014.40
61462	Repeat planar and single photon emission tomography imaging, or repeat planar imaging or single photon emission tomography imaging on an occasion subsequent to the performance of item 61364, 61426, 61429, 61430, 61442, 61450, 61453, 61469 or 61485, if there is no additional administration of radiopharmaceutical and if the previous radionuclide scan was abnormal or equivocal (R)	$210.60
61469	Lymphoscintigraphy (R)	$668.50
61473	Thyroid study (R)	$338.90
61480	Parathyroid study (R)	$611.30
61485	Adrenal study, with single photon emission tomography (R)	$1695.00
61495	Tear duct study (R)	$374.50
61499	Particle perfusion study (infra arterial) or Le Veen shunt study (R)	$415.20
61505	CT scan performed at the same time and covering the same body area as single photon emission tomography or positron emission tomography for the purpose of anatomic localisation or attenuation correction if no separate diagnostic CT report is issued and performed in association with a service to which an item in Subgroup 1 or 2 of Group I4 applies (R)	$163.40
61650	LeukoScan study of the long bones and feet for suspected osteomyelitis, if: (a) the patient does not have access to ex vivo white blood cell scanning; and (b) the patient is not being investigated for other sites of infection (R)	$1664.70
GROUP I5—MAGNETIC RESONANCE IMAGING		
	Scan of head—for specified conditions	
63001	MRI scan of head (including MRA, if performed) for tumour of the brain or meninges (R) (Anaes.) (Contrast) (Anaes.)	$704.70
63004	MRI scan of head (including MRA, if performed) for inflammation of brain or meninges (R) (Anaes.) (Contrast) (Anaes.)	$704.70
63007	MRI scan of head (including MRA, if performed) for skull base or orbital tumour (R) (Anaes.) (Contrast) (Anaes.)	$704.70
63010	MRI scan of head (including MRA, if performed) for stereotactic scan of brain, with fiducials in place, for the sole purpose of allowing planning for stereotactic neurosurgery (R) (Anaes.) (Contrast) (Anaes.)	$617.30
63040	MRI scan of head (including MRA, if performed) for acoustic neuroma (R) (Anaes.) (Contrast) (Anaes.)	$524.70
63043	MRI scan of head (including MRA, if performed) for pituitary tumour (R) (Anaes.) (Contrast) (Anaes.)	$549.50
63046	MRI scan of head (including MRA, if performed) for toxic or metabolic or ischaemic encephalopathy (R) (Anaes.) (Contrast) (Anaes.)	$704.70

Item no.	Description	Max fee (excl. GST)
63049	MRI scan of head (including MRA, if performed) for demyelinating disease of the brain (R) (Anaes.) (Contrast) (Anaes.)	$704.70
63052	MRI scan of head (including MRA, if performed) for congenital malformation of the brain or meninges (R) (Anaes.) (Contrast) (Anaes.)	$704.70
63055	MRI scan of head (including MRA, if performed) for venous sinus thrombosis (R) (Anaes.) (Contrast) (Anaes.)	$704.70
63058	MRI scan of head (including MRA, if performed) for head trauma (R) (Anaes.) (Contrast) (Anaes.)	$704.70
63061	MRI scan of head (including MRA, if performed) for epilepsy (R) (Anaes.) (Contrast) (Anaes.)	$704.70
63064	MRI scan of head (including MRA, if performed) for stroke (R) (Anaes.) (Contrast) (Anaes.)	$704.70
63067	MRI scan of head (including MRA, if performed) for carotid or vertebral artery dissection (R) (Anaes.) (Contrast) (Anaes.)	$704.70
63070	MRI scan of head (including MRA, if performed) for intracranial aneurysm (R) (Anaes.) (Contrast) (Anaes.)	$704.70
63073	MRI scan of head (including MRA, if performed) for intracranial arteriovenous malformation (R) (Anaes.) (Contrast) (Anaes.)	$704.70
	Scan of head and neck vessels—for specified conditions	
63101	MRI and MRA of extracranial or intracranial circulation (or both) scan of head and neck vessels for stroke (R) (Anaes.) (Contrast) (Anaes.)	$841.20
	Scan of head and cervical spine—for specified conditions	
63111	MRI scan of head and cervical spine (including MRA, if performed) for tumour of the central nervous system or meninges (R) (Anaes.) (Contrast) (Anaes.)	$841.20
63114	MRI scan of head and cervical spine (including MRA, if performed) for inflammation of the central nervous system or meninges (R) (Anaes.) (Contrast) (Anaes.)	$841.20
63125	MRI scan of head and cervical spine (including MRA, if performed) for demyelinating disease of the central nervous system (R) (Anaes.) (Contrast) (Anaes.)	$841.20
63128	MRI scan of head and cervical spine (including MRA, if performed) for congenital malformation of the central nervous system or meninges (R) (Anaes.) (Contrast) (Anaes.)	$841.20
63131	MRI scan of head and cervical spine (including MRA, if performed) for syrinx (congenital or acquired) (R) (Anaes.) (Contrast) (Anaes.)	$841.20
	Scan of spine—one region or two contiguous regions—for infection or tumour	
63151	MRI scan of one region or 2 contiguous regions of the spine for infection (R) (Anaes.) (Contrast) (Anaes.)	$549.50
63154	MRI scan of one region or 2 contiguous regions of the spine for tumour (R) (Anaes.) (Contrast) (Anaes.)	$549.50
	Scan of spine—one region or two contiguous regions—for other conditions	
63161	MRI scan of one region or 2 contiguous regions of the spine for demyelinating disease (R) (Anaes.) (Contrast) (Anaes.)	$549.50
63164	MRI scan of one region or 2 contiguous regions of the spine for congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Anaes.) (Contrast) (Anaes.)	$549.50
63167	MRI scan of one region or 2 contiguous regions of the spine for myelopathy (R) (Anaes.) (Contrast) (Anaes.)	$549.50
63170	MRI scan of one region or 2 contiguous regions of the spine for syrinx (congenital or acquired) (R) (Anaes.) (Contrast) (Anaes.)	$549.50
63173	MRI scan of one region or 2 contiguous regions of the spine for cervical radiculopathy (R) (Anaes.) (Contrast) (Anaes.)	$549.50
63176	MRI scan of one region or 2 contiguous regions of the spine for sciatica (R) (Anaes.) (Contrast) (Anaes.)	$549.50
63179	MRI scan of one region or 2 contiguous regions of the spine for spinal canal stenosis (R) (Anaes.) (Contrast) (Anaes.)	$549.50
63182	MRI scan of one region or 2 contiguous regions of the spine for previous spinal surgery (R) (Anaes.) (Contrast) (Anaes.)	$549.50
63185	MRI scan of one region or 2 contiguous regions of the spine for trauma (R) (Anaes.) (Anaes.)	$549.50
	Scan of spine—three contiguous regions or two non-contiguous regions—for infection or tumour	
63201	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for infection (R) (Anaes.) (Contrast) (Anaes.)	$773.10
63204	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for tumour (R) (Anaes.) (Contrast) (Anaes.)	$773.10

Item no.	Description	Max fee (excl. GST)
	Scan of spine—three contiguous regions or two non-contiguous regions—for other conditions	
63219	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for demyelinating disease (R) (Anaes.) (Contrast) (Anaes.)	$773.10
63222	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Anaes.) (Contrast) (Anaes.)	$773.10
63225	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for myelopathy (R) (Anaes.) (Contrast) (Anaes.)	$773.10
63228	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for syrinx (congenital or acquired) (R) (Anaes.) (Contrast) (Anaes.)	$773.10
63231	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for cervical radiculopathy (R) (Anaes.) (Contrast) (Anaes.)	$773.10
63234	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for sciatica (R) (Anaes.) (Contrast) (Anaes.)	$773.10
63237	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for spinal canal stenosis (R) (Anaes.) (Contrast) (Anaes.)	$773.10
63240	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for previous spinal surgery (R) (Anaes.) (Contrast) (Anaes.)	$773.10
63243	MRI scan of 3 contiguous or 2 non contiguous regions of the spine for trauma (R) (Anaes.) (Anaes.)	$773.10
	Scan of cervical spine and brachial plexus—for specified conditions	
63271	MRI scan of cervical spine and brachial plexus for tumour (R) (Anaes.) (Contrast) (Anaes.)	$841.20
63274	MRI scan of cervical spine and brachial plexus for trauma (R) (Anaes.) (Contrast) (Anaes.)	$841.20
63277	MRI scan of cervical spine and brachial plexus for cervical radiculopathy (R) (Anaes.) (Contrast) (Anaes.)	$841.20
63280	MRI scan of cervical spine and brachial plexus for previous surgery (R) (Anaes.) (Contrast) (Anaes.)	$841.20
	Scan of musculoskeletal system—for tumour, infection or osteonecrosis	
63301	MRI scan of musculoskeletal system for tumour arising in bone or musculoskeletal system, excluding tumours arising in breast, prostate or rectum (R) (Anaes.) (Contrast) (Anaes.)	$675.20
63304	MRI scan of musculoskeletal system for infection arising in bone or musculoskeletal system, excluding infection arising in breast, prostate or rectum (R) (Anaes.) (Contrast) (Anaes.)	$675.20
63307	MRI scan of musculoskeletal system for osteonecrosis (R) (Anaes.) (Contrast) (Anaes.)	$675.20
	Scan of musculoskeletal system—for joint derangement	
63322	MRI scan of musculoskeletal system for derangement of hip or its supporting structures (R) (Anaes.) (Contrast) (Anaes.)	$704.90
63325	MRI scan of musculoskeletal system for derangement of shoulder or its supporting structures (R) (Anaes.) (Contrast) (Anaes.)	$704.90
63328	MRI scan of musculoskeletal system for derangement of knee or its supporting structures (R) (Anaes.) (Contrast) (Anaes.)	$704.90
63331	MRI scan of musculoskeletal system for derangement of ankle or foot (or both) or its supporting structures (R) (Anaes.) (Contrast) (Anaes.)	$704.90
63334	MRI scan of musculoskeletal system for derangement of one or both temporomandibular joints or their supporting structures (R) (Anaes.) (Contrast) (Anaes.)	$617.30
63337	MRI scan of musculoskeletal system for derangement of wrist or hand (or both) or its supporting structures (R) (Anaes.) (Contrast) (Anaes.)	$773.10
63340	MRI scan of musculoskeletal system for derangement of elbow or its supporting structures (R) (Anaes.) (Contrast) (Anaes.)	$704.90
	Scan of musculoskeletal system—for Gaucher disease	
63361	MRI scan of musculoskeletal system for Gaucher disease (R) (Anaes.) (Anaes.)	$704.90
	Scan of cardiovascular system—for specified conditions	
63385	MRI scan of cardiovascular system for congenital disease of the heart or a great vessel (R) (Anaes.) (Contrast) (Anaes.)	$773.10
63388	MRI scan of cardiovascular system for tumour of the heart or a great vessel (R) (Anaes.) (Contrast) (Anaes.)	$773.10
63391	MRI scan of cardiovascular system for abnormality of thoracic aorta (R) (Anaes.) (Contrast) (Anaes.)	$704.90

Item no.	Description	Max fee (excl. GST)
63395	MRI scan of cardiovascular system for assessment of myocardial structure and function involving: (a) dedicated right ventricular views; and (b) 3D volumetric assessment of the right ventricle; and (c) reporting of end diastolic and end systolic volumes, ejection fraction and BSA indexed values;if the request for the scan indicates that: (d) the patient presented with symptoms consistent with arrhythmogenic right ventricular cardiomyopathy (ARVC); or (e) investigative findings in relation to the patient are consistent with ARVC(R) (Contrast) (Anaes.)	$1345.50
63397	MRI scan of cardiovascular system for assessment of myocardial structure and function involving: (a) dedicated right ventricular views; and (b) 3D volumetric assessment of the right ventricle; and (c) reporting of end diastolic and end systolic volumes, ejection fraction and BSA indexed values;if the request for the scan indicates that the patient: (d) is asymptomatic; and (e) has one or more first degree relatives diagnosed with confirmed arrhythmogenic right ventricular cardiomyopathy (ARVC)(R) (Contrast) (Anaes.)	$1345.50
	Magnetic resonance angiography—scan of cardiovascular system—for specified conditions	
63401	MRA if the request for the scan specifically identifies the clinical indication for the scan scan of cardiovascular system for vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (R) (Contrast) (Anaes.)	$704.90
63404	MRA if the request for the scan specifically identifies the clinical indication for the scan scan of cardiovascular system for obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (R) (Contrast) (Anaes.)	$704.90
	Magnetic resonance angiography—for specified conditions—person under the age of 16 years	
63416	MRA scan of person under the age of 16 for the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (R) (Contrast) (Anaes.)	$704.90
	Magnetic resonance imaging—person under the age of 16 years ?for physeal fusion or Gaucher disease	
63425	MRI scan of person under the age of 16 for post inflammatory or post traumatic physeal fusion (R) (Anaes.)	$704.90
63428	MRI scan of person under the age of 16 for Gaucher disease (R) (Anaes.)	$704.90
	Magnetic resonance imaging—person under the age of 16 years ?for other conditions	
63440	MRI scan of person under the age of 16 for pelvic or abdominal mass (R) (Contrast) (Anaes.)	$704.90
63443	MRI scan of person under the age of 16 for mediastinal mass (R) (Contrast) (Anaes.)	$704.90
63446	MRI scan of person under the age of 16 for congenital uterine or anorectal abnormality (R) (Contrast) (Anaes.)	$704.90
	Scan of body—for specified conditions	
63454	MRI scan of the pelvis or abdomen, if: (a) the pregnancy is at, or after, 18 weeks gestation; and (b) fetal central nervous system abnormality is suspected; and (c) an ultrasound has been performed and is provided by, or on behalf of, or at the request of, a specialist who is practising in the specialty of obstetrics; and (d) the diagnosis is indeterminate or requires further examination; and (e) the service is requested by a specialist practising in the specialty of obstetrics (R) (Contrast) (Anaes.)	$1846.40
63461	MRI scan of the body for adrenal mass in a patient with a malignancy that is otherwise resectable (R) (Anaes.)	$646.50
63464	MRI scan of both breasts for the detection of cancer, if a dedicated breast coil is used, the request for the scan identifies that the person is asymptomatic and is younger than 50 years of age, and the request for the scan identifies: (a) that the patient is at high risk of developing breast cancer, due to one of the following: (i) 3 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer; (ii) 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 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 or is a male relative who has been diagnosed with breast cancer; (iii) one first or second degree relative diagnosed with breast cancer at age 45 years or younger, and 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 (b) that genetic testing has identified the presence of a high risk breast cancer gene mutation (R) (Anaes.)	$1313.60
63467	MRI scan of both breasts for the detection of cancer, if: (a) a dedicated breast coil is used; and (b) the person has had an abnormality detected as a result of a service mentioned in item 63464 performed in the previous 12 months (R) (Anaes.)	$1308.50
63487	MRI scan of both breasts, if: (a) a dedicated breast coil is used; and(b) the request for the scan identifies that: (i) the patient has been diagnosed with metastatic cancer restricted to the regional lymph nodes; and (ii) clinical examination and conventional imaging have failed to identify the primary cancer (R) (Anaes.)	$1103.00
63489	MRI guided biopsy, if: (a) the request for the scan identifies that the patient has a suspicious lesion seen on MRI but not on conventional imaging; and (b) an ultrasound scan of the affected breast, performed immediately before the biopsy, confirms that the lesion is not amenable to biopsy guided by conventional imaging; and (c) a dedicated breast coil is used (R) (Anaes.)	$2301.90

Item no.	Description	Max fee (excl. GST)
63541	Multiparametric Magnetic Resonance Imaging scan of the prostate for the detection of cancer, if the patient is referred by an urologist, radiation oncologist, or medical oncologist and the request for the scan identifies: that the patient is suspected of developing prostate cancer, due to one of the following: (i) a digital rectal examination which is suspicious for prostate cancer; or (ii) in a person under 70 years, at least two prostate specific antigen (PSA) tests performed within an interval of 1- 3 months are greater than 3.0 ng/ml, and the free/total PSA ratio is less than 25% or the repeat PSA exceeds 5.5 ng/ml; or (iii) in a person under 70 years, whose risk of developing prostate cancer based on relevant family history is at least double the average risk, at least two PSA tests performed within an interval of 1- 3 months are greater than 2.0 ng/ml, and the free/total PSA ratio is less than 25%; or (iv) in a person 70 years or older, at least two PSA tests performed within an interval of 1- 3 months are greater than 5.5ng/ml and the free/total PSA ratio is less than 25%.using a standardised image acquisition protocol involving T2 Weighted Imaging, Diffusion Weighted Imaging, and Dynamic Contrast Enhancement (unless contraindicated) (R) Note: Benefits are payable on one occasion only in any 12 month period. Relevant family history is a first degree relative with prostate cancer, or suspected of carrying a BRCA 1 or BRCA 2 mutation. (Anaes.)	$708.00
63543	Multiparametric Magnetic Resonance Imaging scan of the prostate for the assessment of cancer, if the patient is referred by an urologist, radiation oncologist, or medical oncologist and: the request for the scan identifies: (i) the patient is under active surveillance following a confirmed diagnosis of prostate cancer by biopsy histopathology; and (ii) the patient is not planning or undergoing treatment for prostate cancer. using a standardised image acquisition protocol involving T2 Weighted Imaging, Diffusion Weighted Imaging, and Dynamic Contrast Enhancement (unless contraindicated)(R) Note: Benefits are payable at the time of diagnosis of prostate cancer, 12 months following diagnosis and then every 3rd year thereafter or at any time, if there is a clinical concern, including PSA progression. This item is not to be used for the purposes of treatment planning or for monitoring after treatment. (Anaes.)	$708.00
63547	MRI scan of both breasts for the detection of cancer, if: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that: (i) the patient has a breast implant in situ; and (ii) anaplastic large cell lymphoma has been diagnosed (R) (Contrast) (Anaes.)	$1085.60
	Scan of pelvis and upper abdomen—for specified conditions	
63470	MRI scan of the pelvis for the staging of histologically diagnosed cervical cancer at FIGO stage 1B or greater, if the request for scan identifies that: (a) a histological diagnosis of carcinoma of the cervix has been made; and(b) the patient has been diagnosed with cervical cancer at FIGO stage 1B or greater (R) (Contrast) (Anaes.)	$704.90
63473	MRI scan of the pelvis and upper abdomen, in a single examination, for the staging of histologically diagnosed cervical cancer at FIGO stage 1B or greater, if the request for the scan identifies that: (a) a histological diagnosis of carcinoma of the cervix has been made; and(b) the patient has been diagnosed with cervical cancer at FIGO stage 1B or greater (R) (Contrast) (Anaes.)	$1045.80
63476	MRI scan of the pelvis for the initial staging of rectal cancer, if: (a) a phased array body coil is used; and (b) the request for the scan identifies that the indication is for the initial staging of rectal cancer (including cancer of the rectosigmoid and anorectum) (R) (Contrast) (Anaes.)	$774.50
63740	MRI scan to evaluate small bowel Crohn s disease if the service is provided to a patient for: (a) evaluation of disease extent at time of initial diagnosis of Crohn s disease; or (b) evaluation of exacerbation, or suspected complications, of known Crohn s disease; or (c) evaluation of known or suspected Crohn s disease in pregnancy; or (d) assessment of change to therapy in a patient with small bowel Crohn s disease (R) (Contrast)	$763.40
63741	MRI scan with enteroclysis for Crohn s disease if the service is related to item 63740 (R)	$442.80
63743	MRI scan for fistulising perianal Crohn s disease if the service is provided to a patient for:(a) evaluation of pelvic sepsis and fistulas associated with established or suspected Crohn s disease; or(b) assessment of change to therapy of pelvis sepsis and fistulas from Crohn s disease (R) (Contrast)	$673.10
	Scan of body—for suspected hepato-biliary or pancreatic pathology	
63482	MRI scan of pancreas and biliary tree for suspected biliary or pancreatic pathology (R) (Anaes.)	$658.30
63545	MRI multiphase scans of liver (including delayed imaging, if performed) with a contrast agent, for characterisation or intervention planning, if: (a) the patient has: (i) known colorectal carcinoma; and (ii) known, suspected, or possible liver metastasis; and (b) computed tomography, or ultrasound imaging, has identified a mass lesion in patient s liver.For any particular patient applicable not more than once in a 12 month period (R) (Contrast) (Anaes.)	$846.30
63546	MRI multiphase scans of the liver (including delayed imaging, if performed) with a contrast agent, for diagnosis or staging, if: (a) the patient has: (i) known or suspected hepatocellular carcinoma; and (ii) chronic liver disease that has been confirmed by a specialist or consultant physician; and (b) the patient s liver function has been identified as Child Pugh or B; and (c) the patient has an identified hepatic lesion over 10 mm in diameter.For any particular patient applicable not more than once in a 12 month period (R) (Contrast) (Anaes.)	$846.30
	Modifying items	
63491	NOTE: Benefits in Subgroup 22 are only payable for modifying items where claimed simultaneously with MRI services. Modifiers for sedation and anaesthesia may not be claimed for the same service. MRI or MRA service to which an item in this Group (other than an item in this Subgroup) applies if: (a) the service is performed on a person in accordance with clause 2.5.1; and (b) the item for the service includes in its description (Contrast) ; and (c) the service is performed using a contrast agent	$73.30

Item no.	Description	Max fee (excl. GST)
63494	MRI or MRA service to which an item in this Group (other than an item in this Subgroup) applies if: (a) the service is performed on a person in accordance with clause 2.5.1; and (b) the service is performed using intravenous or intra muscular sedation	$86.20
63496	NOTE: Benefits in Subgroup 22 are only payable for modifying items where claimed simultaneously with MRI services. Modifiers for sedation and anaesthesia may not be claimed for the same service. MRI service to which item 63545 or 63546 applies if: (a) the service is performed on a person under the supervision of an eligible provider; and (b) the service is performed using an hepatobiliary specific contrast agent	$384.70
63497	MRI or MRA service to which an item in this Group (other than an item in this Subgroup) applies if: (a) the service is performed on a person in accordance with clause 2.5.1; and (b) the service is performed under anaesthetic in the presence of a medical practitioner who is qualified to perform an anaesthetic	$256.00
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	$83.00
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.	$291.00
	Magnetic resonance imaging—PIP breast implant	
63501	MRI scan of one or both breasts for the evaluation of implant integrity where: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient: (i) has or is suspected of having a silicone breast implant manufactured by Poly Implant Prosthese (PIP); and (ii) the result of the scan confirms a loss of integrity of the implant. (R) Note: Benefits are payable on one occasion only in any 24 Month Period	$928.00
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 Prosthese (PIP); and (ii) the result of the scan does not demonstrate a loss of integrity of the implant (R) Note: Benefits are payable on one occasion only in any 24Month Period	$928.00
63504	MRI—scan of one or both breasts for the evaluation of implant integrity where: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient: (i) has or is suspected of having a silicone breast implant manufactured by Poly Implant Prosthese (PIP); and (ii) presents with symptoms where implant rupture is suspected; and (iii) the result of the scan confirms a loss of integrity of the implant (R)	$928.00
63505	MRI—scan of one or both breasts for the evaluation of implant integrity where: (a) a dedicated breast coil is used; and (b) the request for the scan identifies that the patient: (i) has or is suspected of having a silicone breast implant manufactured by Poly Implant Prosthese (PIP); and (ii) presents with symptoms where implant rupture is suspected; and (iii) the result of the scan does not demonstrate a loss of integrity of the implant (R)	$928.00
	Scan of body—person under the age of 16 years ?general practice requests	
63507	MRI scan of head for a patient under 16 years if the service is for:(a) an unexplained seizure; or (b) an unexplained headache if significant pathology is suspected; or (c) paranasal sinus pathology that has not responded to conservative therapy (R) (Contrast) (Anaes.)	$704.70
63510	MRI scan of spine following radiographic examination for a patient under 16 years if the service is for: (a) significant trauma; or (b) unexplained neck or back pain with associated neurological signs; or (c) unexplained back pain if significant pathology is suspected (R) (Contrast) (Anaes.)	$773.10
63513	MRI scan of knee for internal joint derangement for a patient under 16 years (R) (Contrast) (Anaes.)	$704.90
63516	MRI scan of hip following radiographic examination for a patient under 16 years if any of the following is suspected: (a) septic arthritis; (b) slipped capital femoral epiphysis; (c) Perthes disease (R) (Contrast) (Anaes.)	$704.90
63519	MRI scan of elbow following radiographic examination for a patient under 16 years if a significant fracture or avulsion injury, which would change the way in which the patient is managed, is suspected (R) (Contrast) (Anaes.)	$704.90
63522	MRI scan of wrist following radiographic examination for a patient under 16 years if a scaphoid fracture is suspected (R) (Contrast) (Anaes.)	$773.10
	Scan of body—person over the age of 16 years ?general practice requests	
63551	MRI—scan of head for a patient 16 years or older, after a request by a medical practitioner (other than a specialist or consultant physician), for any of the following: (a) unexplained seizure(s); (b) unexplained chronic headache with suspected intracranial pathology (R) (Contrast) (Anaes.)	$694.00
63554	MRI—scan of spine for a patient 16 years or older, after referral by a medical practitioner (other than a specialist or consultant physician), for suspected cervical radiculopathy (R) (Contrast) (Anaes.)	$616.90
63557	MRI—scan of spine for a patient 16 years or older, after referral by a medical practitioner (other than a specialist or consultant physician), for suspected cervical spinal trauma (R) (Contrast) (Anaes.)	$848.20

Item no.	Description	Max fee (excl. GST)
63560	MRI—scan of knee following acute knee trauma, after referral by a medical practitioner (other than a specialist or consultant physician), for a patient 16 to 49 years with: (a) inability to extend the knee suggesting the possibility of acute meniscal tear; or(b) clinical findings suggesting acute anterior cruciate ligament tear (R) (Contrast) (Anaes.)	$694.00
GROUP P1—HAEMATOLOGY		
65060	Haemoglobin, erythrocyte sedimentation rate, blood viscosity—1 or more tests	$15.30
65066	Examination of: (a) a blood film by special stains to demonstrate Heinz bodies, parasites or iron; or (b) a blood film by enzyme cytochemistry for neutrophil alkaline phosphatase, alpha-naphthyl acetate esterase or chloroacetate esterase; or (c) a blood film using any other special staining methods including periodic acid Schiff and Sudan Black; or (d) a urinary sediment for haemosiderin including a service described in item 65072	$14.60
65070	Erythrocyte count, haematocrit, haemoglobin, calculation or measurement of red cell index or indices, platelet count, leucocyte count and manual or instrument generated differential count—not being a service where haemoglobin only is requested—one or more instrument generated sets of results from a single sample; and (if performed) (a) a morphological assessment of a blood film; (b) any service in item 65060 or 65072	$32.70
65072	Examination for reticulocytes including a reticulocyte count by any method—1 or more tests	$19.60
65075	Haemolysis or metabolic enzymes—assessment by: (a) erythrocyte autohaemolysis test; or (b) erythrocyte osmotic fragility test; or (c) sugar water test; or (d) G-6-P D (qualitative or quantitative) test; or (e) pyruvate kinase (qualitative or quantitative) test; or (f) acid haemolysis test; or (g) quantitation of muramidase in serum or urine; or (h) Donath Landsteiner antibody test; or (i) other erythrocyte metabolic enzyme tests 1 or more tests	$90.10
65078	Tests for the diagnosis of thalassaemia consisting of haemoglobin electrophoresis or chromatography and at least 2 of: (a) examination for HbH; or (b) quantitation of HbA2; or (c) quantitation of HbF; including (if performed) any service described in item 65060 or 65070	$169.90
65079	Tests described in item 65078 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18)	$169.90
65081	Tests for the investigation of haemoglobinopathy consisting of haemoglobin electrophoresis or chromatography and at least 1 of: (a) heat denaturation test; or (b) isopropanol precipitation test; or (c) tests for the presence of haemoglobin S; or (d) quantitation of any haemoglobin fraction (including S, C, D, E); including (if performed) any service described in item 65060, 65070 or 65078	$182.40
65082	Tests described in item 65081 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18)	$182.40
65084	Bone marrow trephine biopsy—histopathological examination of sections of bone marrow and examination of aspirated material (including clot sections where necessary), including (if performed): any test described in item 65060, 65066 or 65070	$314.60
65087	Bone marrow—examination of aspirated material (including clot sections where necessary), including (if performed): any test described in item 65060, 65066 or 65070	$156.50
65090	Blood grouping (including back-grouping if performed)—ABO and Rh (D antigen)	$21.40
65093	Blood grouping—Rh phenotypes, Kell system, Duffy system, M and N factors or any other blood group system—1 or more systems, including item 65090 (if performed)	$41.50
65096	Blood grouping (including back-grouping if performed), and examination of serum for Rh and other blood group antibodies, including: (a) identification and quantitation of any antibodies detected; and (b) (if performed) any test described in item 65060 or 65070	$77.30
65099	Compatibility tests by crossmatch—all tests performed on any1 day for up to 6 units, including: (a) direct testing of donor red cells from each unit against the serum of the patient by one or more accepted crossmatching techniques; and (b) all grouping checks of the patient and donor; and (c) examination for antibodies, and if necessary identification of any antibodies detected; and (d) (if performed) any tests described in item 65060, 65070, 65090 or 65096 (Item is subject to rule 5)	$208.50
65102	Compatibility tests by crossmatch—all tests performed on any1 day in excess of 6 units, including: (a) direct testing of donor red cells from each unit against serum of the patient by one or more accepted crossmatching techniques; and (b) all grouping checks of the patient and donor; and (c) examination for antibodies, and if necessary identification of any antibodies detected; and (d) (if performed) any tests described in item 65060, 65070, 65090, 65096, 65099 or 65105 (Item is subject to rule 5)	$310.90
65105	Compatibility testing using at least a 3 cell panel and issue of red cells for transfusion—all tests performed on any one day for up to 6 units, including: (a) all grouping checks of the patient and donor; and (b) examination for antibodies and, if necessary, identification of any antibodies detected; and (c) (if performed) any tests described in item 65060, 65070, 65090 or 65096 (Item is subject to rule 5)	$210.60
65108	Compatibility testing using at least a 3 cell panel and issue of red cells for transfusion—all tests performed on any one day in excess of 6 units, including: (a)all grouping checks of the patient and donor; and (b)examination for antibodies and, if necessary, identification of any antibodies detected; and (c) (if performed) any tests described in item 65060, 65070, 65090, 65096, 65099 or 65105 (Item is subject to rule 5)	$277.50
65109	Release of fresh frozen plasma or cryoprecipitate for the use in a patient for the correction of a coagulopathy—1 release.	$24.90

Item no.	Description	Max fee (excl. GST)
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	$12.80
65117	1 or more of the following tests: (a) Spectroscopic examination of blood for chemically altered haemoglobins; (b) detection of methaemalbumin (Schumm's test)	$38.20
65120	Prothrombin time (including INR where appropriate), activated partial thromboplastin time, thrombin time (including test for the presence of heparin), test for factor XIII deficiency (qualitative), Echis test, Stypven test, reptilase time, fibrinogen, or 1 of fibrinogen degradation products, fibrin monomer or D-dimer—1 test	$25.90
65123	2 tests described in item 65120	$39.30
65126	3 tests described in item 65120	$53.50
65129	4 or more tests described in item 65120	$67.90
65137	Test for the presence of lupus anticoagulant not being a service associated with any service to which items 65175, 65176, 65177, 65178 and 65179 apply	$48.80
65142	Confirmation or clarification of an abnormal or indeterminate result from a test described in item 65175, by testing a specimen collected on a different day—1 or more tests	$48.80
65144	Platelet aggregation in response to ADP, collagen, 5HT, ristocetin or other substances; or heparin, low molecular weight heparins, heparinoid or other drugs—1 or more tests	$106.70
65147	Quantitation of anti-Xa activity when monitoring is required for a patient receiving a low molecular weight heparin or heparinoid—1 test	$72.90
65150	Quantitation of von Willebrand factor antigen, von Willebrand factor activity (ristocetin cofactor assay), von Willebrand factor collagen binding activity, factor II, factor V, factor VII, factor VIII, factor IX, factor X, factor XI, factor XII, factor XIII, Fletcher factor, Fitzgerald factor, circulating coagulation factor inhibitors other than by Bethesda assay—1 test (Item is subject to rule 6)	$133.70
65153	2 tests described in item 65150 (Item is subject to rule 6)	$267.50
65156	3 or more tests described in item 65150 (Item is subject to rule 6)	$401.20
65157	A test described in item 65150, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP—1 test (Item is subject to rule 6 and 18)	$133.70
65158	Tests described in item 65150, other than that described in 65157, if rendered by a receiving APP—each test to a maximum of 2 tests (Item is subject to rule 6 and 18)	$133.70
65159	Quantitation of circulating coagulation factor inhibitors by Bethesda assay—1 test	$133.70
65162	Examination of a maternal blood film for the presence of fetal red blood cells (Kleihauer test)	$20.10
65165	Detection and quantitation of fetal red blood cells in the maternal circulation by detection of red cell antigens using flow cytometric methods including (if performed) any test described in item 65070 or 65162	$66.10
65166	A test described in item 65165 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18)	$65.00
65171	Test for the presence of antithrombin III deficiency, protein C deficiency, protein S deficiency or activated protein C resistance in a first degree relative of a person who has a proven defect of any of the above—1 or more tests	$48.80
65175	Test for the presence of antithrombin III deficiency, protein C deficiency, protein S deficiency, lupus anticoagulant, activated protein C resistance—where the request for the test(s) specifically identifies that the patient has a history of venous thromboembolism—quantitation by 1 or more techniques—1 test (Item is subject to Rule 6)	$48.80
65176	2 tests described in item 65175 (Item is subject to rule 6)	$91.60
65177	3 tests described in item 65175 (Item is subject to rule 6)	$135.80
65178	4 tests described in item 65175 (Item is subject to rule 6)	$179.70
65179	5 tests described in item 65175 (Item is subject to rule 6)	$223.40
65180	A test described in item 65175, if rendered by a receiving APA, where no tests in the item have been rendered by the referring APA—1 test (Item is subject to rule 6 and 18)	$48.80
65181	A test described in item65175, if rendered by a receiving APP, if one or more tests described in the item have been rendered by the referring APP—one test (Item is subject to rule 6 and 18)	$44.00

Item no.	Description	Max fee (excl. GST)
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	$13.60
66503	2 tests described in item 66500	$16.10
66506	3 tests described in item 66500	$19.10
66509	4 tests described in item 66500	$22.00
66512	5 or more tests described in item 66500	$24.90
66517	Quantitation of bile acids in blood in pregnancy. Applicable not more than 3 times in a pregnancy.	$38.00
66518	Investigation of cardiac or skeletal muscle damage by quantitative measurement of creatine kinase isoenzymes, troponin or myoglobin in blood—testing on 1 specimen in a 24 hour period	$38.20
66519	Investigation of cardiac or skeletal muscle damage by quantitative measurement of creatine kinase isoenzymes, troponin or myoglobin in blood—testing on 2 or more specimens in a 24 hour period	$76.90
66536	Quantitation of hdl cholesterol	$15.40
66539	Electrophoresis of serum for demonstration of lipoprotein subclasses, if the cholesterol is > 6.5 mmol/L and triglyceride & gt;4.0 mmol/L or in the diagnosis of types III and IV hyperlipidaemia—(Item is subject to rule 25)	$44.70
66542	Oral glucose tolerance test for the diagnosis of diabetes mellitus that includes: (a) administration of glucose; and (b) at least 2 measurements of blood glucose; and (c) (if performed) any test described in item 66695	$32.20
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)	$32.40
66554	Quantitation of glycated haemoglobin performed in the management of pre-existing diabetes where the patient is pregnant—including a service in item 66551 (if performed)—(Item is subject to rule 25)	$32.40
66557	Quantitation of fructosamine performed in the management of established diabetes—each test to a maximum of 4 tests in a 12 month period	$18.80
66560	Microalbumin—quantitation in urine	$38.10
66563	Osmolality, estimation by osmometer, in serum or in urine—1 or more tests	$34.60
66566	Quantitation of: (a) blood gases (including pO2, oxygen saturation and pCO2) ; and (b) bicarbonate and pH; including any other measurement (eg. haemoglobin, lactate, potassium or ionised calcium) or calculation performed on the same specimen—1 or more tests on 1 specimen	$54.80
66569	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 2 specimens performed within any 1 day	$80.30
66572	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 3 specimens performed within any 1 day	$98.80
66575	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 4 specimens performed within any 1 day	$113.90
66578	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 5 specimens performed within any 1 day	$133.30
66581	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 6 or more specimens performed within any 1 day	$149.60
66584	Quantitation of ionised calcium (except if performed as part of item 66566)—1 test	$18.80
66587	Urine acidification test for the diagnosis of renal tubular acidosis including the administration of an acid load, and pH measurements on 4 or more urine specimens and at least 1 blood specimen	$89.60
66590	Calculus, analysis of 1 or more	$58.60
66593	Ferritin—quantitation, except if requested as part of iron studies	$34.70
66596	Iron studies, consisting of quantitation of: (a) serum iron; and (b) transferrin or iron binding capacity; and (c) ferritin	$62.80

Item no.	Description	Max fee (excl. GST)
66605	Vitamins—quantitation of vitamins B1, B2, B3, B6 or Cin blood, urine or other body fluid—1 or more tests	$57.80
66606	A test described in item 66605 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18 and 25)	$57.80
66607	Vitamins—quantitation of vitamins a or e in blood, urine or other body fluid—1 or more tests within a 6 month period	$142.80
66610	A test described in item 66607 if rendered by a receiving app—1 or more tests	$141.50
66623	All qualitative and quantitative tests on blood, urine or other body fluid for: (a) a drug or drugs of abuse (including illegal drugs and legally available drugs taken other than in appropriate dosage); or (b) ingested or absorbed toxic chemicals; including a service described in item 66800, 66803, 66806, 66812 or 66815 (if performed), but excluding: (c) the surveillance of sports people and athletes for performance improving substances; and (d) the monitoring of patients participating in a drug abuse treatment program	$58.10
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	$68.60
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	$28.20
66647	C-1 esterase inhibitor—functional assay	$63.10
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 that lies at or above the age related median but below the age related, method specific 97.5% reference limit—1 of this item in a 12 month period (Item is subject to rule 25)	$71.80
66660	Prostate specific antigen—quantitation of 2 or more fractions of PSA and any derived index including (if performed) a test described in item 66656, in the follow up of a PSA result that lies at or above the age related, method specific 97.5% reference limit, but below a value of 10 ug/L—4 of this item in a 12 month period. (Item is subject to rule 25)	$70.90
66662	Quantitation of hormone receptors on proven primary breast or ovarian carcinoma or a metastasis from a breast or ovarian carcinoma or a subsequent lesion in the breast—1 or more tests	$150.80
66663	A test described in item 66662 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18)	$150.80
66665	Lead quantitation in blood or urine (other than for occupational health screening purposes) to a maximum of 3 tests in a 6 month period—each test	$42.90

Item no.	Description	Max fee (excl. GST)
66666	A test described in item 66665 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18)	$57.80
66667	Quantitation of serum zinc in a patient receiving intravenous alimentation—each test	$57.80
66671	Quantitation of serum aluminium in a patient in a renal dialysis program—each test	$69.60
66674	Quantitation of: (a)faecal fat; or (b)breath hydrogen in response to loading with disaccharides; 1 or more tests within a 28 day period	$75.90
66677	Test for tryptic activity in faeces in the investigation of diarrhoea of longer than 4 weeks duration in children under 6 years old	$21.40
66680	Quantitation of disaccharidases and other enzymes in intestinal tissue—1 or more tests	$142.90
66683	Enzymes—quantitation in solid tissue or tissues other than blood elements or intestinal tissue—1 or more tests	$140.50
66686	Performance of 1 or more of the following procedures: (a) growth hormone suppression by glucose loading; (b) growth hormone stimulation by exercise; (c) dexamethasone suppression test; (d)sweat collection by iontophoresis for chloride analysis; (e) pharmacological stimulation of growth hormone	$95.50
66695	Quantitation in blood or urine of hormones and hormone binding proteins—ACTH, aldosterone, androstenedione, C-peptide, calcitonin, cortisol, DHEAS, 11-deoxycortisol, dihydrotestosterone, FSH, gastrin, glucagon, growth hormone, hydroxyprogesterone, insulin, LH, oestradiol, oestrone, progesterone, prolactin, PTH, renin, sex hormone binding globulin, somatomedin C(IGF-1), free or total testosterone, urine steroid fraction or fractions, vasoactive intestinal peptide,- 1 test (Item is subject to rule 6)	$42.70
66696	A test described in item 66695, if rendered by a receiving APP—where no tests in the item have been rendered by the referring APP (Item is subject to rule 6 and 18)	$57.60
66697	Tests described in item 66695, other than that described in 66696, if rendered by a receiving APP—each test to a maximum of 4 tests (Item is subject to rule 6 and 18)	$25.40
66698	2 tests described in item 66695 (Item is subject to rule 6)	$82.40
66701	3 tests described in item 66695 (Item is subject to rule 6)	$107.50
66704	4 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 tests specified on the request form or performs 4 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)	$132.20
66707	5 or more tests described in item 66695 (Item is subject to rule 6)	$157.30
66711	Quantitation in saliva of cortisol in: (a) the investigation of Cushing's syndrome; or (b) the management of children with congenital adrenal hyperplasia (Item is subject to rule 6)	$58.20
66712	Two tests described in item 66711 (Item is subject to rule 6)	$83.50
66714	A test described in item 66711, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP (Item is subject to rule 6 and 18)	$57.80
66715	Tests described in item 66711, other than that described in 66714, if rendered by a receiving APP, each test to a maximum of 1 test (Item is subject to rule 6 and 18)	$30.00
66716	TSH quantitation	$35.10
66719	Thyroid function tests (comprising the service described in item 66716 and either or bothof a test for free thyroxine and a test for free T3) for a patient, if: (a) the patient has a level of TSH that is outside the normal reference range for the particular method of assay used to determine the level; or (b) the request from the requesting medical practitioner indicates that the tests are performed: (i) for the purpose of monitoring thyroid disease in the patient; or (ii) to investigate the sick euthyroid syndrome if the patient is an admitted patient; or (iii) to investigate dementia or psychiatric illness of the patient; or (iv) to investigate amenorrhoea or infertility of the patient; or (c) the request from the requesting medical practitioner indicates that themedical practitionersuspects the patient has a pituitary dysfunction; or (d) the request from the requesting medical practitioner indicates that thepatient is on drugs that interfere with thyroid hormone metabolism or function	$48.60
66722	TSH quantitation described in item 66716 and 1 test described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)	$71.50
66723	Tests described in item 66722, that is, TSH quantitation and 1 test described in 66695, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP—1 test (Item is subject to rule 6 and 18)	$71.50
66724	Tests described in item 66722, if rendered by a receiving APP, other than that described in 66723. It is to include a quantitation of TSH—each test to a maximum of 4 tests described in item 66695 (Item is subject to rule 6 and 18)	$24.80
66725	TSH quantitation described in item 66716 and 2 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 tests specified on the request form or performs 3 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)	$96.20

Item no.	Description	Max fee (excl. GST)
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 2 of the following to detect foetal abnormality- total human chorionic gonadotrophin (total HCG), free alpha human chorionic gonadotrophin (free alpha HCG), free beta human chorionic gonadotrophin (free beta HCG), pregnancy associated plasma protein A (PAPP-A), unconjugated oestriol (uE3), alpha-fetoprotein (AFP)—including (if performed) a service described initem 73527or 73529—Applicable not more than once in a pregnancy	$76.40
66751	Quantitation, in pregnancy, of any three or more tests described in 66750 (Item is subject to rule 25)	$106.00
66752	Quantitation of acetoacetate, beta-hydroxybutyrate, citrate, oxalate, total free fatty acids, cysteine, homocysteine, cystine, lactate, pyruvate or other amino acids and hydroxyproline (except if performed as part of item 66773 or 66776)—1 test	$47.70
66755	2 or more tests described in item 66752	$73.40
66756	Quantitation of 10 or more amino acids for the diagnosis of inborn errors of metabolism—up to 4 tests in a 12 month period on specimens of plasma, CSF and urine.	$185.40
66757	Quantitation of 10 or more amino acids for monitoring of previously diagnosed inborn errors of metabolism in 1 tissue type.	$185.40
66758	Quantitation of angiotensin converting enzyme, or cholinesterase—1 or more tests	$47.70
66761	Test for reducing substances in faeces by any method (except reagent strip or dipstick)	$24.80
66764	Examination for faecal occult blood (including tests for haemoglobin and its derivatives in the faeces except by reagent strip or dip stick methods) with a maximum of 3 examinations on specimens collected on separate days in a 28 day period	$16.90
66767	2 examinations described in item 66764 performed on separately collected and identified specimens	$34.40
66770	3 examinations described in item 66764 performed on separately collected and identified specimens	$50.50
66773	Quantitation of products of collagen breakdown or formation for the monitoring of patients with proven low bone mineral density, and if performed, a service described in item 66752—1 or more tests (Low bone densitometry is defined in the explanatory notes to Category 2—Diagnostic Procedures and Investigations of the Medicare Benefits Schedule)	$34.50
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	$34.50
66779	Adrenaline, noradrenaline, dopamine, histamine, hydroxyindoleacetic acid (5HIAA), hydroxymethoxymandelic acid (HMMA), homovanillic acid (HVA), metanephrines, methoxyhydroxyphenylethylene glycol (MHPG), phenylacetic acid (PAA) or serotoninquantitation—1 or more tests	$75.50
66780	A test described in item 66779 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18)	$75.50
66782	Porphyrins or porphyrins precursors—detection in plasma, red cells, urine or faeces—1 or more tests	$25.30
66783	A test described in item 66782 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18)	$24.80
66785	Porphyrins or porphyrins precursors—quantitation in plasma, red cells, urine or faeces—1 test (Item is subject to rule 6)	$75.50
66788	Porphyrins or porphyrins precursors—quantitation in plasma, red cells, urine or faeces—2 or more tests (Item is subject to rule 6)	$124.20
66789	A test described in item 66785 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP—1 test (Item is subject to rule 6 and 18)	$75.50
66790	A test described in item 66785 other than that described in 66789, if rendered by a receiving APP—to a maximum of 1 test (Item is subject to rule 6 and 18)	$49.00

Item no.	Description	Max fee (excl. GST)
66791	Porphyrin biosynthetic enzymes—measurement of activity in blood cells or other tissues—1 or more tests	$140.50
66792	A test described in item 66791 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18)	$140.50
66800	Quantitation in blood, urine or other body fluid by any method (except reagent tablet or reagent strip) of any of the following being used therapeutically by the patient from whom the specimen was taken: amikacin, carbamazepine, digoxin, disopyramide, ethanol, ethosuximide, gentamicin, lithium, lignocaine, netilmicin, paracetamol, phenobarbitone, primidone, phenytoin, procainamide, quinidine, salicylate, theophylline, tobramycin, valproate or vancomycin—1 test (Item to be subject to rule 6)	$35.50
66803	2 tests described in item 66800 (Item is subject to rule 6)	$59.70
66804	A test described in item 66800 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP—1 test (Item is subject to rule 6 and 18)	$34.90
66805	A test described in item 66800 other than that described in 66804, if rendered by a receiving APP—each test to a maximum of 2 tests (Item is subject to rule 6 and 18)	$23.30
66806	3 tests described in item 66800 (Item is subject to rule 6)	$81.30
66812	Quantitation, not elsewhere described in this Table by any method or methods, in blood, urine or other body fluid, of a drug being used therapeutically by the patient from whom the specimen was taken—1 test (This fee applies where 1 laboratory performs the only test specified on the request form or performs 1 test and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)	$67.20
66815	2 tests described in item 66812 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)	$112.30
66816	A test described in item 66812 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP—1 test (Item is subject to rule 6 and 18)	$67.20
66817	A test described in item 66812, other than that described in 66816, if rendered by a receiving APP—to a maximum of 1 test (Item is subject to rule 6 and 18)	$47.80
66819	Quantitation of copper, manganese, selenium, or zinc (except if item 66667 applies), in blood, urine or other body fluid—1 test. (Item is subject to rule 6, 22 and 25)	$57.80
66820	A test described in item 66819 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP—1 test (Item is subject to rule 6, 18, 22 and 25)	$57.80
66821	A test described in item 66819 other than that described in 66820 if rendered by a receiving APP to a maximum of 1 test (Item is subject to rule 6, 18,22 and 25)	$42.10
66822	Quantitation of copper, manganese, selenium, or zinc (except if item 66667 applies), in blood, urine or other body fluid—2 or more tests. (Item is subject to rule 6, 22 and 25)	$98.80
66825	Quantitation of aluminium (except if item 66671 applies), arsenic, beryllium, cadmium, chromium, gold, mercury, nickel, or strontium, in blood, urine or other body fluid or tissue—1 test. To a maximum of 3 of this item in a 6 month period (Item is subject to rule 6, 22 and 25)	$57.80
66826	A test described in item 66825 if rendered by a receiving APP where no tests have been rendered by the referring APP—1 test (Item is subject to rules 6, 18, 22 and 25)	$57.80
66827	A test described in item 66825, other than that described in 66826, if rendered by a receiving APP to a maximum of 1 test (Item is subject to rules 6, 18, 22 and 25)	$42.10
66828	Quantitation of aluminium (except if item 66671 applies), arsenic, beryllium, cadmium, chromium, gold, mercury, nickel, or strontium, in blood, urine or other body fluid or tissue—2 or more tests. To a maximum of 3 of this item in a 6 month period (Item is subject to rule 6, 22 and 25)	$98.80
66830	Quantitation of BNP or NT-proBNP for the diagnosis of heart failure in patients presenting with dyspnoea to a hospital Emergency Department (Item is subject to rule 25)	$113.60
66831	Quantitation of copper or iron in liver tissue biopsy	$59.30
66832	A test described in item 66831 if rendered by a receiving app (item is subject to rule 18a and 22)	$58.40
66833	25-hydroxyvitamin D, quantification in serum, for the investigation of a patient who: (a) has signs or symptoms of osteoporosis or osteomalacia; or (b)has increased alkaline phosphatase and otherwise normal liver function tests; or (c) has hyperparathyroidism, hypo- or hypercalcaemia, or hypophosphataemia; or (d) is suffering from malabsorption (for example, because the patient has cystic fibrosis, short bowel syndrome, inflammatory bowel disease or untreated coeliac disease, or has had bariatric surgery); or (e) has deeply pigmented skin, or chronic and severe lack of sun exposure for cultural, medical, occupational or residential reasons; or (f) is taking medication known to decrease 25OH-D levels (for example, anticonvulsants); or (g) has chronic renal failure or is a renal transplant recipient; or (h) is less than 16 years of age and has signs or symptoms of rickets; or (i) is an infant whose mother has established vitamin D deficiency; or (j) is a exclusively breastfed baby and has at least one other risk factor mentioned in a paragraph in this item; or (k) has a sibling who is less than 16 years of age and has vitamin D deficiency	$50.30
66834	A test described in item 66833 if rendered by a receiving APP (Item is subject to Rule 18)	$50.30

Item no.	Description	Max fee (excl. GST)
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	$65.20
66836	1, 25-dihydroxyvitamin D-quantification in serum, if: (a) the patient has hypercalcaemia; and (b) the request for the test is made by a general practitioner managing the treatment of the patient	$65.20
66837	A test described in item 66835 or 66836 if rendered by a receiving APP (Item is subject to Rule 18)	$65.20
66838	Serum vitamin B12 test (Item is subject to Rule 25)	$39.40
66839	Quantification of vitamin B12 markers such as holoTranscobalamin or methylmalonic acid, where initial serum vitamin B12 result is low or equivocal	$71.70
66840	Serum folate test and, if required, red cell folate test for a patient at risk of folate deficiency, including patients with malabsorption conditions, macrocytic anaemia or coeliac disease	$39.40
66841	Quantitation of HbA1c (glycated haemoglobin) performed for the diagnosis of diabetes in asymptomatic patients at high risk.(Item is subject to rule 25)	$28.00
66900	CARBON-LABELLED UREA BREATH TEST using oral C-13 or C-14 urea, including the measurement of exhaled 13CO2 or 14CO2 (except if item 12533 applies) for either:- (a) the confirmation of Helicobacter pylori colonisation OR (b) the monitoring of the success of eradication of Helicobacter pylori.	$146.40
GROUP P3—MICROBIOLOGY		
69300	Microscopy of wet film material other than blood, from 1 or more sites, obtained directly from a patient (not cultures) including: (a) differential cell count (if performed); or (b) examination for dermatophytes; or (c) dark ground illumination; or (d) stained preparation or preparations using any relevant stain or stains; 1 or more tests	$21.20
69303	Culture and (if performed) microscopy to detect pathogenic micro-organisms from nasal swabs, throat swabs, eye swabs and ear swabs (excluding swabs taken for epidemiological surveillance), including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in item 69300; specimens from 1 or more sites	$41.50
69306	Microscopy and culture to detect pathogenic micro-organisms from skin or other superficial sites, including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in items 69300, 69303, 69312, 69318; 1 or more tests on 1 or more specimens	$63.50
69309	Microscopy and culture to detect dermatophytes and other fungi causing cutaneous disease from skin scrapings, skin biopsies, hair and nails (excluding swab specimens) and including (if performed): (a) the detection of antigens not elsewhere specified in this Schedule; or (b) a service described in items 69300, 69303, 69306, 69312, 69318; 1 or more tests on 1 or more specimens	$92.20
69312	Microscopy and culture to detect pathogenic micro-organisms from urethra, vagina, cervix or rectum (except for faecal pathogens), including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in items 69300, 69303, 69306 and 69318; 1 or more tests on 1 or more specimens	$63.50
69316	Detection of Chlamydia trachomatis by any method—1 test (Item is subject to rule 26)	$54.00
69317	1 test described in item 69494 and a test described in 69316.(Item is subject to rule 26)	$67.60
69318	Microscopy and culture to detect pathogenic micro-organisms from specimens of sputum (except when part of items 69324, 69327 and 69330), including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in items 69300, 69303, 69306 and 69312; 1 or more tests on 1 or more specimens	$63.50
69319	2 tests described in item 69494 and a test described in 69316. (Item is subject to rule 26)	$82.90
69321	Microscopy and culture of post-operative wounds, aspirates of body cavities, synovial fluid, CSF or operative or biopsy specimens, for the presence of pathogenic micro-organisms involving aerobic and anaerobic cultures and the use of different culture media, and including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in item 69300, 69303, 69306, 69312 or 69318; specimens from 1 or more sites	$92.60
69324	Microscopy (with appropriate stains) and culture for mycobacteria—1 specimen of sputum, urine, or other body fluid or 1 operative or biopsy specimen, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b) pathogen identification and antibiotic susceptibility testing; including a service described in item 69300	$82.40
69325	A test described in item 69324 if rendered by a receiving APP (Item is subject to rule 18)	$81.00
69327	Microscopy (with appropriate stains) and culture for mycobacteria—2 specimens of sputum, urine, or other body fluid or 2 operative or biopsy specimens, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b) pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300	$161.40
69328	A test described in item 69327 if rendered by a receiving APP (Item is subject to rule 18)	$160.20
69330	Microscopy (with appropriate stains) and culture for mycobacteria—3 specimens of sputum, urine, or other body fluid or 3 operative or biopsy specimens, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b)pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300	$244.70

Item no.	Description	Max fee (excl. GST)
69331	A test described in item 69330 if rendered by a receiving APP (Item is subject to rule 18)	$241.40
69333	Urine examination (including serial examinations) by any means other than simple culture by dip slide, including: (a) cell count; and (b) culture; and (c) colony count; and (d) (if performed) stained preparations; and (e) (if performed) identification of cultured pathogens; and (f) (if performed) antibiotic susceptibility testing; and (g) (if performed) examination for pH, specific gravity, blood, protein, urobilinogen, sugar, acetone or bile salts	$38.90
69336	Microscopy of faeces for ova, cysts and parasites that must include a concentration technique, and the use of fixed stains or antigen detection for cryptosporidia and giardia—including (if performed) a service described in item 69300—1 of this item in any 7 day period	$64.50
69339	Microscopy of faeces for ova, cysts and parasites using concentration techniques examined subsequent to item 69336 on a separately collected and identified specimen collected within 7 days of the examination described in 69336—1 examination in any 7 day period	$26.80
69345	Culture and (if performed) microscopy without concentration techniques of faeces for faecal pathogens, using at least 2 selective or enrichment media and culture in at least 2 different atmospheres including (if performed): (a) pathogen identification and antibiotic susceptibility testing; and (b) the detection of clostridial toxins; and (c) a service described in item 69300;—1 examination in any 7 day period	$99.80
69354	Blood culture for pathogenic micro-organisms (other than viruses), including sub-cultures and (if performed): (a) identification of any cultured pathogen;and (b) necessary antibiotic susceptibility testing; to a maximum of 3 sets of cultures—1 set of cultures	$50.20
69357	2 sets of cultures described in item 69354	$99.90
69360	3 sets of cultures described in item 69354	$149.60
69363	Detection of clostridium difficile or clostridium difficile toxin (except if a service described in item 69345 has been performed)—one or more tests	$48.30
69378	Quantitation of HIV viral RNA load in plasma or serum in the monitoring of a HIV sero-positive patient not on antiretroviral therapy—1 or more tests	$339.70
69379	A test described in item 69378 if rendered by a receiving APP—1 or more tests (Item is subject to rule 18)	$339.70
69380	Genotypic testing for HIV antiretroviral resistance in a patient with confirmed HIV infection if the patient's viral load is greater than 1,000 copies per ml at any of the following times: (a) at presentation; or (b) before antiretroviral therapy: or (c) when treatment with combination antiretroviral agents fails; maximum of 2 tests in a 12 month period	$1439.40
69381	Quantitation of HIV viral RNA load in plasma or serum in the monitoring of antiretroviral therapy in a HIV sero-positive patient—1 or more tests on 1 or more specimens	$339.70
69382	Quantitation of HIV viral RNA load in cerebrospinal fluid in a HIV sero-positive patient—1 or more tests on 1 or more specimens	$339.70
69383	A test described in item 69381 if rendered by a receiving APP—1 or more tests on 1 or more specimens (Item is subject to rule 18)	$339.70
69384	Quantitation of 1 antibody to microbial antigens not elsewhere described in the Schedule—1 test (This fee applies where a laboratory performs the only antibody test specified on the request form or performs 1 test and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)	$29.60
69387	2 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 estimations specified on the request form or performs 2 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6)	$54.80
69390	3 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 estimations specified on the request form or performs 3 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6)	$81.40
69393	4 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 estimations specified on the request form or performs 4 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6)	$102.70
69396	5 or more tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 5 estimations specified on the request form or performs 5 of the antibody tests specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6)	$124.00
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

Item no.	Description	Max fee (excl. GST)
69405	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of 1 of the following—rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481	$29.60
69408	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of 2 of the following—rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481	$54.80
69411	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a)the determination of 3 of the following—rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b)(if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481	$80.00
69413	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a)the determination of 4 of the following—rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b)(if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481	$105.00
69415	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of all 5 of the following—rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481	$124.00
69445	Detection of Hepatitis C viral RNA in a patient undertaking antiviral therapy for chronic HCV hepatitis (including a service described in item 69499)—1 test. To a maximum of 4 of this item in a 12 month period (Item is subject to rule 25)	$173.80
69451	A test described in item 69445 if rendered by a receiving APP—1 test. (Item is subject to rule 18 and 25)	$173.80
69471	Test of cell mediated immune response in blood for the detection of latent tuberculosis by interferon gamma release assay (IGRA) in the following people: (a) a person who has been exposed to a confirmed case of active tuberculosis; (b) a person who is infected with human immunodeficiency virus; (c) a person who is to commence, or has commenced, tumour necrosis factor (TNF) inhibitor therapy; (d) a person who is to commence, or has commenced, renal dialysis; (e) a person with silicosis; (f) a person who is, or is about to become, immunosuppressed because of a disease, or a medical treatment, not mentioned in paragraphs(a) to (e)	$67.30
69472	Detection of antibodies to Epstein Barr Virus using specific serology—1 test	$29.60
69474	Detection of antibodies to Epstein Barr Virus using specific serology—2 or more tests	$54.00
69475	One test for hepatitis antigen or antibodies to determine immune status or viral carriage following exposure or vaccination to Hepatitis A, Hepatitis B, Hepatitis C or Hepatitis D (Item subject to rule 11)	$29.60
69478	2 tests described in 69475 (item subject to rule 11)	$55.10
69481	Investigation of infectious causes of acute or chronic hepatitis—3 tests for hepatitis antibodies or antigens, (item subject to rule 11)	$76.40
69482	Quantitation of Hepatitis B viral DNA in patients who are Hepatitis B surface antigen positive and have chronic hepatitis B, but are not receiving antiviral therapy—1 test (Item is subject to rule 25)	$286.80
69483	Quantitation of Hepatitis B viral DNA in patients who are Hepatitis B surface antigen positive and who have chronic hepatitis B and are receiving antiviral therapy—1 test (Item is subject to rule 25)	$286.80
69484	Supplementary testing for Hepatitis B surface antigen or Hepatitis C antibody using a different assay on the specimen which yielded a reactive result on initial testing (Item is subject to rule 18)	$32.90
69488	Quantitation of HCV RNA load in plasma or serum in: (a) the pre-treatment evaluation,of a patient with chronic HCV hepatitis, for antiviral therapy;or (b) the assessment of efficacy of antiviral therapy for such a patient (including a service in item 69499 or 69445) (Item is subject to rule 18 and 25)	$339.70
69489	A test described in item 69488 if rendered by a receiving APP (Item is subject to rule 18 and 25)	$339.70
69491	Nucleic acid amplification and determination of Hepatitis C virus (HCV) genotype if the patient is HCV RNA positive and is being evaluated for antiviral therapy of chronic HCV hepatitis. To a maximum of 1 of this item in a 12 month period	$386.20
69492	A test described in item 69491 if rendered by a receiving APP—1 test (Item is subject to rule 18 and 25)	$386.20
69494	Detection of a virus or microbial antigen or microbial nucleic acid (not elsewhere specified) 1 test (Item is subject to rule 6 and 26)	$54.00
69495	2 tests described in 69494 (Item is subject to rule 6 and 26)	$67.60
69496	3 or more tests described in 69494 (Item is subject to rule 6 and 26)	$83.10

Item no.	Description	Max fee (excl. GST)
69497	A test described in item 69494, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP—1 test (Item is subject to rule 6, 18 and 26)	$54.00
69498	A test described in item 69494, other than that described in 69497, if rendered by a receiving APP—each test to a maximum of 2 tests (Item is subject to rule 6, 18 and 26)	$13.70
69499	Detection of Hepatitis C viral RNA if at least 1 of the following criteria is satisfied: (a) the patient is Hepatitis C seropositive; (b) the patient's serological status is uncertain after testing; (c)the test is performed for the purpose of: (i) determining the Hepatitis C status of an immunosuppressed or immunocompromised patient; or (ii) the detection of acute Hepatitis C prior to seroconversion where considered necessary for the clinical management of the patient; To a maximum of 1 of this item in a 12 month period (Item is subject to rule 19 and 25)	$173.80
69500	A test described in item 69499 if rendered by a receiving APP—1 test (Item is subject to rule 18, 19 and 25)	$173.80
GROUP P4—IMMUNOLOGY		
71057	Electrophoresis, quantitative and qualitative, of serum, urine or other body fluid all collected within a 28 day period, to demonstrate: (a) protein classes; or (b) presence and amount of paraprotein; including the preliminary quantitation of total protein, albumin and globulin—1 specimen type	$63.10
71058	Examination as described in item 71057 of 2 or more specimen types	$97.20
71059	Immunofixation or immunoelectrophoresis or isoelectric focusing of: (a) urine for detection of Bence Jones proteins; or (b) serum, plasma or other body fluid; and characterisation of a paraprotein or cryoglobulin- examination of 1 specimen type (eg. serum, urine or CSF)	$56.40
71060	Examination as described in item 71059 of 2 or more specimen types	$84.50
71062	Electrophoresis and immunofixation or immunoelectrophoresis or isoelectric focussing of CSF for the detection of oligoclonal bands and including if required electrophoresis of the patient's serum for comparison purposes—1 or more tests	$84.50
71064	Detection and quantitation of cryoglobulins or cryofibrinogen—1 or more tests	$39.30
71066	Quantitation of total immunoglobulin A by any method in serum, urine or other body fluid—1 test	$27.50
71068	Quantitation of total immunoglobulin G by any method in serum, urine or other body fluid—1 test	$27.50
71069	2 tests described in items 71066, 71068, 71072 or 71074	$31.90
71071	3 or more tests described in items 71066, 71068, 71072 or 71074	$43.50
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	$148.60
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)	$32.20
71076	A test described in item 71073 if rendered by a receiving APP—1 test (Item is subject to rule 18)	$200.10
71077	Quantitation of immunoglobulin E (total) in the follow up of a patient with proven immunoglobulin-E-secreting myeloma, proven congenital immunodeficiency or proven allergic bronchopulmonary aspergillosis, 1 test. (Item is subject to rule 25)	$51.00
71079	Detection of specific immunoglobulin E antibodies to single or multiple potential allergens, 1 test (Item is subject to rule 25)	$50.60
71081	Quantitation of total haemolytic complement	$78.30
71083	Quantitation of complement components C3 and C4 or properdin factor B—1 test	$28.20
71085	2 tests described in item 71083	$40.60
71087	3 or more tests described in item 71083	$54.50
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)	$40.80
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)	$74.10
71092	Tests described in item 71089, other than that described in 71090, if rendered by a receiving APP—each test to a maximum of 2 tests (Item is subject to rule 6 and 18)	$45.80
71093	3 or more tests described in item 71089 (Item is subject to rule 6)	$107.10
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	$34.20

Item no.	Description	Max fee (excl. GST)
71099	Double-stranded DNA antibodies—quantitation by 1 or more methods other than the Crithidia method	$37.10
71101	Antibodies to 1 or more extractable nuclear antigens—detection in serum or other body fluids	$24.40
71103	Characterisation of an antibody detected in a service described in item 71101 (including that service)	$72.90
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	$24.40
71121	Detection of 2 antibodies specified in item 71119	$29.10
71123	Detection of 3 antibodies specified in item 71119	$34.00
71125	Detection of 4 or more antibodies specified in item 71119	$38.70
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	$247.10
71129	2 tests described in item 71127	$305.10
71131	3 or more tests described in item 71127	$363.30
71133	Investigation of recurrent infection by qualitative assessment for the presence of defects in oxidative pathways in neutrophils by the nitroblue tetrazolium (NBT) reduction test	$20.00
71134	Investigation of recurrent infection by quantitative assessment of oxidative pathways by flow cytometric techniques, including a test described in 71133 (if performed)	$196.20
71135	Quantitation of neutrophil function, comprising at least 2 of the following: (a) chemotaxis; (b) phagocytosis; (c) oxidative metabolism; (d) bactericidal activity; including any test described in items 65066, 65070, 71133 or 71134 (if performed), 1 of this item to a maximum of 2 in a 12 month period	$291.20
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	$145.80
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	$276.50
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 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	$364.10
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	$624.00
71146	Enumeration of CD34+ cells, only for the purposes of autologous or directed allogeneic haemopoietic stem cell transplantation, including a total white cell count on the pherisis collection	$196.20
71147	HLA-B27 typing (Item is subject to rule 27)	$76.40
71148	A test described in item 71147 if rendered by a receiving APP. (Item is subject to rule 18 and 27)	$76.40
71149	Complete tissue typing for 4 HLA-A and HLA-B Class I antigens (including any separation of leucocytes), including (if performed) a service described in item 71147	$151.60
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	$166.50
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)	$48.30
71154	A test described in item 71153, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP—1 test. (Item is subject to rule 6, 18 and 23)	$65.20
71155	Detection of 2 antibodies described in item 71153 (Item is subject to rule 6 and 23)	$66.50
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)	$84.50

Item no.	Description	Max fee (excl. GST)
71159	Detection of 4 or more antibodies described in item 71153 (Item is subject to rule 6 and 23)	$102.50
71163	Detection of one of the following antibodies (of 1 or more class or isotype) in the assessment or diagnosis of coeliac disease or other gluten hypersensitivity syndromes and including a service described in item 71066 (if performed): a)Antibodies to gliadin; or b)Antibodies to endomysium; or c)Antibodies to tissue transglutaminase;—1 test	$47.80
71164	Two or more tests described in 71163 and including a service described in 71066 (if performed)	$75.40
71165	Antibodies to tissue antigens (acetylcholine receptor, adrenal cortex, heart, histone, insulin, insulin receptor, intrinsic factor, islet cell, lymphocyte, neuron, ovary, parathyroid, platelet, salivary gland, skeletal muscle, skin basement membrane and intercellular substance, thyroglobulin, thyroid microsome or thyroid stimulating hormone receptor)—detection, including quantitation if required, of 1 antibody (Item is subject to rule 6)	$65.20
71166	Detection of 2 antibodies described in item 71165 (Item is subject to rule 6)	$89.50
71167	Detection of 3 antibodies described in item 71165 (Item is subject to rule 6)	$113.90
71168	Detection of 4 or more antibodies described in item 71165 (Item is subject to rule 6)	$137.90
71169	A test described in item 71165, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP—1 test (Item is subject to rule 6 and 18)	$65.20
71170	Tests described in item 71165, other than that described in 71169, if rendered by a receiving APP—each test to a maximum of 3 tests (Item is subject to rule 6 and 18)	$24.40
71180	Antibody to cardiolipin or beta-2 glycoprotein I—detection, including quantitation if required; one antibody specificity (IgG or IgM)	$65.20
71183	Detection of two antibodies described in item 71180	$89.50
71186	Detection of three or more antibodies described in item 71180	$113.90
71189	Detection of specific IgG antibodies to 1 or more respiratory disease allergens not elsewhere specified.	$29.90
71192	2 items described in item 71189.	$53.60
71195	3 or more items described in item 71189.	$75.60
71198	Estimation of serum tryptase for the evaluation of unexplained acute hypotension or suspected anaphylactic event, assessment of risk in stinging insect anaphylaxis, exclusion of mastocytosis, monitoring of known mastocytosis.	$76.40
71200	Detection and quantitation, if present, of free kappa and lambda light chains in serum for the diagnosis or monitoring of amyloidosis, myeloma or plasma cell dyscrasias.	$70.60
71203	Determination of HLAB5701 status by flow cytometry or cytotoxity assay prior to the initiation of Abacavir therapy including item 73323 if performed.	$76.40
GROUP P5—TISSUE PATHOLOGY		
72813	Examination of complexity level 2 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions—1 or more separately identified specimens (Item is subject to rule 13)	$138.30
72814	Immunohistochemical examination by immunoperoxidase or other labelled antibody techniques using the programmed cell death ligand 1 (PD-L1) antibody of tumour material from a patient diagnosed with non-small cell lung cancer, to determine if the requirements relating to PD-L1 status for access to pembrolizumab under the Pharmaceutical Benefits Scheme are fulfilled.	$114.70
72816	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions—1 separately identified specimen (Item is subject to rule 13)	$162.90
72817	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions—2 to 4 separately identified specimens (Item is subject to rule 13)	$182.70
72818	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions—5 or more separately identified specimens (Item is subject to rule 13)	$207.50
72823	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions—1 separately identified specimen (Item is subject to rule 13)	$187.40
72824	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions—2 to 4 separately identified specimens (Item is subject to rule 13)	$231.20
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

Item no.	Description	Max fee (excl. GST)
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)	$435.30
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)	$710.00
72838	Examination of complexicity level 7 biopsy material with multiple tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions—1 or more separately identified specimens. (Item is subject to rule 13)	$886.90
72844	Enzyme histochemistry of skeletal muscle for investigation of primary degenerative or metabolic muscle diseases or of muscle abnormalities secondary to disease of the central or peripheral nervous system—1 or more tests	$59.20
72846	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen—1 to 3 antibodies except those listed in 72848 (Item is subject to rule 13)	$92.00
72847	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen—4-6 antibodies (Item is subject to rule 13)	$140.20
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)	$126.10
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)	$160.00
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)	$182.30
72851	Electron microscopic examination of biopsy material—1 separately identified specimen (Item is subject to rule 13)	$313.60
72852	Electron microscopic examination of biopsy material—2 or more separately identified specimens (Item is subject to rule 13)	$430.90
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)	$338.50
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)	$449.10
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.	$293.80
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.	$604.00
72860	Retrieval and review of one or more archived formalin fixed paraffin embedded blocks to determine the appropriate samples for the purpose of conducting genetic testing, other than: (a) a service associated with a service to which item72858 or 72859 applies; or (b) a service associated with, and rendered in the same patient episode as, a service to which an item in Group P5, P6, P10 or P11 applies Applicable not more than once in a patient episode	$130.80
GROUP P6—CYTOLOGY		
73043	Cytology (including serial examinations) of nipple discharge or smears from skin, lip, mouth, nose or anus for detection of precancerous or cancerous changes1 or more tests	$41.50
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	$84.50

Item no.	Description	Max fee (excl. GST)
73047	Cytology of a series of 3 sputum or urine specimens for malignant cells	$176.30
73049	Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues—1 identified site	$119.00
73051	Cytology of material obtained directly from a patient at one identified site by fine needle aspiration of solid tissue or tissues if a recognized pathologist: (a) performs the aspiration; or (b) attends the aspiration and performs cytological examination during the attendance	$328.00
73059	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen—1 to 3 antibodies except those listed in 73061 (Item is subject to rule 13)	$83.00
73060	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen—4 to 6antibodies (Item is subject to rule 13)	$97.20
73061	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen—1 to 3 of the following antibodies—oestrogen, progesterone and c-erb-B2 (HER2) (Item is subject to rule 13)	$98.40
73062	Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues—2 or more separately identified sites.	$167.90
73063	Cytology of material obtained directly from a patient at one identified site by fine needle aspiration of solid tissue or tissues if an employee of an approved pathology authority attends the aspiration for confirmation of sample adequacy	$187.40
73064	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen—7 to 10 antibodies (Item is subject to rule 13)	$135.30
73065	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen—11 or more antibodies (Item is subject to rule 13)	$162.20
73066	Cytology of material obtained directly from a patient at 2 or more separately identified sites by fine needle aspiration of solid tissue or tissues if a recognized pathologist: (a)performs the aspiration; or (b) attends the aspiration and performs cytological examination during the attendance	$413.90
73067	Cytology of material obtained directly from a patient at 2 or more separately identified sites by fine needle aspiration of solid tissue or tissues if an employee of an approved pathology authority attends the aspiration for confirmation of sample adequacy	$241.30
73070	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	$55.10
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	$55.10
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	$55.10
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	$55.10
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	$55.10
73075	A test, including partial genotyping, for oncogenic human papillomavirus, if: (a) the test is a repeat of a test to which item 73070, 73071, 73072, 73073, 73074 or this item applies; and (b) the specimen collected for the previous test is unsatisfactory	$55.10

Item no.	Description	Max fee (excl. GST)
73076	Cytology of a liquid based cervical or vaginal vault specimen, where the stained cells are examined microscopically or by automated image analysis by or on behalf of a pathologist, if: (a) the cytology is associated with the detection of oncogenic human papillomavirus infection by: (i) a test to which item 73070, 73071, 73073, 73074 or 73075 applies; or (ii) a test to which item73072 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	$72.40
GROUP P7—GENETICS		
73287	The study of the whole of every chromosome by cytogenetic or other techniques, performed on 1 or more of any tissue or fluid except blood (including a service mentioned in item 73293, if performed)—1 or more tests	$761.30
73289	The study of the whole of every chromosome by cytogenetic or other techniques, performed on blood (including a service mentioned in item 73293, if performed)—1 or more tests	$676.90
73290	The study of the whole of each chromosome by cytogenetic or other techniques, performed on blood or bone marrow, in the diagnosis and monitoringof haematological malignancy (including a service in items 73287 or 73289, if performed).—1 or more tests.	$744.00
73291	Analysis of one or more chromosome regions for specific constitutional genetic abnormalities of blood or fresh tissue in a)diagnostic studies of a person with developmental delay, intellectual disability, autism, or at least two congenital abnormalities, in whom cytogenetic studies (item 73287 or 73289) are either normal or have not been performed; or b)studies of a relative for an abnormality previously identified in such an affected person.—1 or more tests.	$435.50
73292	Analysis of chromosomes by genome-wide micro-array including targeted assessment of specific regions for constitutional genetic abnormalities in diagnostic studies of a person with developmental delay, intellectual disability, autism, or at least two congenital abnormalities (including a service in items 73287, 73289 or 73291, if performed)—1 or more tests.	$1112.20
73293	Analysis of one or more regions on all chromosomes for specific constitutional genetic abnormalities of fresh tissue in diagnostic studies of the products of conception, including exclusion of maternal cell contamination.—1 or more tests.	$435.50
73294	Analysis of the PMP22 gene for constitutional genetic abnormalities causing peripheral neuropathy, either as: a)diagnostic studies of an affected person; or b)studies of a relative for an abnormality previously identified in an affected person—1 or more tests.	$435.50
73295	Detection of germline BRCA1 or BRCA2 pathogenic or likely pathogenic gene variants, in a patient with advanced (FIGO III-IV) high-grade serous or high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer for whom testing of tumour tissue is not feasible, requested by a specialist or consultant physician, to determine eligibility for olaparib under the Pharmaceutical Benefits Scheme (PBS) Maximum of one test per patient s lifetime	$1918.10
73296	Characterisation of germline gene variants: (a) including copy number variation in: (i) BRCA1 genes; and (ii) BRCA2 genes; and (iii) one or more of the genes STK11, PTEN, CDH1, PALB2 and TP53; and (b) in a patient: (i) with breast, ovarian, fallopian tube or primary peritoneal cancer; and (ii) 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 greater than 10% risk of having a pathogenic or likely pathogenic gene variation identified in one or more of the genes specified in subparagraphs(a)(i), (ii) and (iii); requested by a specialist or consultant physician	$1888.00
73297	Characterisation of germline gene variations: (a) including copy number variation in: (i) BRCA1 genes; and (ii) BRCA2 genes; and (iii) one or more of the genes STK11, PTEN, CDH1, PALB2 and TP53; and (b) in a patient who: (i) is a biological relative of a patient who has had a pathogenic or likely pathogenic gene variation identified in one or more of the genes mentioned in subparagraphs(a)(i), (ii) and (iii); and (ii) has not previously received a service to which item73295, 73296 or 73297 applies; requested by a specialist or consultant physician	$629.30
73298	Characterisation of germline gene variants in the following genes: (a) COL4A3; and (b) COL4A4; and (c) COL4A5; in a patient for whom clinical and relevant family history criteria have been assessed by a specialist or consultant physician, who requests the service to be strongly suggestive of Alport syndrome.	$1846.40
73299	Characterisation of germline gene variants: (a) in the following genes: (i) COL4A3; and (ii) COL4A4; and (iii) COL4A5; (b) in a patient who: (i) is a first degree biological relative of a patient who has had a pathogenic mutation identified in one or more of the genes mentioned insubparagraphs(a)(i), (ii) and (iii); and (ii) has not previously received a service which item 73298 applies; requested by a specialist or consultant physician.	$615.50
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 FMR1 mutation 1 or more tests	$190.80
73305	Detection of mutation of the FMR1 gene by Southern Blot analysis where the results in item 73300 are inconclusive	$382.20
73308	Characterisation of the genotype of a patient for Factor V Leiden gene mutation, or detection of the other relevant mutations in the investigation of proven venous thrombosis or pulmonary embolism—1 or more tests	$68.90

Item no.	Description	Max fee (excl. GST)
73309	A test described in item 73308, if rendered by a receiving APP—1 or more tests (Item is subject to rule 18)	$68.90
73311	Characterisation of the genotype of a person who is a first degree relative of a person who has proven to have 1 or more abnormal genotypes under item 73308—1 or more tests	$68.90
73312	A test described in item 73311, if rendered by a receiving APP—1 or more tests (Item is subject to rule 18)	$68.90
73314	Characterisation of gene rearrangement or the identification of mutations within a known gene rearrangement, in the diagnosis and monitoring of patients with laboratory evidence of: (a) acute myeloid leukaemia; or (b) acute promyelocytic leukaemia; or (c) acute lymphoid leukaemia; or (d) chronic myeloid leukaemia;	$435.60
73315	A test described in item 73314, if rendered by a receiving APP—1 or more tests (Item is subject to rule 18)	$435.60
73317	Detection of the C282Y genetic mutation of the HFE gene and, if performed, detection of other mutations for haemochromatosis where: (a) the patient has an elevated transferrin saturation or elevated serum ferritin on testing of repeated specimens; or (b) the patient has a first degree relative with haemochromatosis; or (c) the patient has a first degree relative with homozygosity for the C282Y genetic mutation, or with compound heterozygosity for recognised genetic mutations for haemochromatosis (Item is subject to rule 20)	$68.90
73318	A test described in item 73317, if rendered by a receiving APP—1 or more tests (Item is subject to rule 18 and 20)	$68.90
73320	Detection of HLA-B27 by nucleic acid amplification includes a service described in 71147 unless the service in item 73320 is rendered as a pathologist determinable service. (Item is subject to rule 27)	$76.40
73321	A test described in item 73320, if rendered by a receiving APP—1 or more tests. (Item is subject to rule 18 and 27)	$76.40
73323	Determination of HLAB5701 status by molecular techniques prior to the initiation of Abacavir therapy including item 71203 if performed.	$76.40
73324	A test described in item 73323 if rendered by a receiving APP 1 or more tests (Item is subject to Rule 18)	$77.30
73325	Characterisation of mutations in: (a) the JAK2 gene; or (b) the MPL gene; or (c) both genes; in the diagnostic work-up, by, or on behalf of, the specialist or consultant physician, of a patient with clinical and laboratory evidence of: a) polycythaemia vera; or b) essential thrombocythaemia; 1 or more tests	$139.30
73326	Characterisation of the gene rearrangement FIP1L1-PDGFRA in the diagnostic work-up and management of a patient with laboratory evidence of: a) mast cell disease; or b) idiopathic hypereosinophilic syndrome; or c) chronic eosinophilic leukaemia;. 1 or more tests	$431.70
73327	Detection of genetic polymorphisms in the Thiopurine S-methyltransferase gene for the prevention of dose-related toxicity during treatment with thiopurine drugs; including (if performed) any service described in item 65075. 1 or more tests	$97.10
73332	An in situ hybridization (ISH) test of tumour tissue from a patient with breast cancer requested by, or on the advice of, a specialist or consultant physician who manages the treatment of the patient to determine if the requirements relating to human epidermal growth factor receptor 2 (HER2) gene amplification for access to trastuzumab under the Pharmaceutical Benefits Scheme (PBS) or the Herceptin Program are fulfilled.	$589.20
73333	Detection of germline mutations of the von Hippel-Lindau (VHL) gene: (a)in a patient who has a clinical diagnosis of VHL syndrome and: (i) a family history of VHL syndrome and one of the following: (A) haemangioblastoma (retinal or central nervous system); (B) phaeochromocytoma; (C) renal cell carcinoma; or (i) two or more haemangioblastomas; or (ii) one haemangioblastoma and a tumour or a cyst of: (A) the adrenal gland; or (B) the kidney; or (C) the pancreas; or (D) the epididymis; or (E) a broad ligament (other than epididymal and single renal cysts, which are common in the general population); or (a) in a patient presenting with one or more of the following clinical features suggestive of VHL syndrome: (i) haemangioblastomas of the brain, spinal cord, or retina; (ii) phaeochromocytoma; (iii) functional extra-adrenal paraganglioma	$1056.60
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	$598.80
73335	Detection of somatic mutations of the von Hippel-Lindau (VHL) gene in a patient with: (a)2 or more tumours comprising: (i)2 or more haemangioblastomas, or (ii)one haemangioblastoma and a tumour of: (A)the adrenal gland; or (B)the kidney; or (C)the pancreas; or (D)the epididymis; and (b)no germline mutations of the VHL gene identified by genetic testing	$827.70
73336	A test of tumour tissue from a patient withstage III or stage IV metastatic cutaneous melanoma, requested by, or on behalf of, a specialist or consultant physician, to determine if the requirements relating to BRAF V600 mutation status for access to dabrafenib,vemurafenib or encorafenibunder the Pharmaceutical Benefits Scheme are fulfilled.	$397.50
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 toan EGFR tyrosine kinase inhibitor listedunder the Pharmaceutical Benefits Scheme (PBS) are fulfilled.	$684.00

Item no.	Description	Max fee (excl. GST)
73338	A test of tumour tissue from a patient with metastatic colorectal cancer (stage IV), requested by a specialist or consultant physician, to determine if the requirements relating to rat sarcoma oncogene (RAS) gene mutation status for access to cetuximab or panitumumab under the Pharmaceutical Benefits Scheme (PBS) are fulfilled, if: (a) the test is conducted for all clinically relevant mutations on KRAS exons 2, 3 and 4 and NRAS exons 2, 3, and 4; or (b) a RAS mutation is found.	$397.50
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)	$667.80
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)	$333.90
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 an anaplastic lymphoma kinase inhibitor under the Pharmaceutical Benefits Scheme (PBS) are fulfilled	$652.80
73342	An in situ hybridisation (ISH) test of tumour tissue from a patient with metastatic adenocarcinoma of the stomach or gastro-oesophageal junction, with documented evidence of human epidermal growth factor receptor 2 (HER2) overexpression by immunohistochemical (IHC) examination giving a staining intensity score of 2+ or 3+ on the same tumour tissue sample, requested by, or on the advice of, a specialist or consultant physician who manages the treatment of the patient to determine if the requirements relating to HER2 gene amplification for access to trastuzumab under the pharmaceutical benefits scheme are fulfilled.	$514.60
73343	Detection of 17p chromosomal deletions by fluorescence in situ hybridisation, in a patient with relapsed or refractory chronic lymphocytic leukaemia or small lymphocytic lymphoma, on a peripheral blood or bone marrow sample, requested by a specialist or consultant physician, to determine if the requirements for access to idelalisib, ibrutinib, venetoclaxor acalabrutinib on the Pharmaceutical Benefits Scheme are fulfilled.	$363.30
73344	Fluorescence in situ hybridization (FISH) test of tumour tissue from a patient with locally advanced or metastatic non-small-cell lung cancer (NSCLC), which is of non-squamous histology or histology not otherwise specified, with documented evidence of ROS proto-oncogene 1 (ROS1) immunoreactivity by immunohistochemical (IHC) examination giving a staining intensity score of 2+ or 3+; and with documented absence of both activating mutations of the epidermal growth factor receptor (EGFR) gene and anaplastic lymphoma kinase (ALK) immunoreactivity by IHC, requested by a specialist or consultant physician to determine if requirements relating to ROS1 gene rearrangement status for access to crizotinib or entrectinib under the Pharmaceutical Benefits Scheme are fulfilled.	$615.50
73345	Testing of a patient for pathogenic cystic fibrosis transmembrane conductance regulator variants for the purpose of investigating, making or excluding a diagnosis of cystic fibrosis or a cystic fibrosis transmembrane conductance regulator related disorder when requested by a specialist or consultant physician who manages the treatment of the patient, not being a service associated with a service to which item 73347, 73348, or 73349 applies. The patient must have clinical or laboratory findings suggesting there is a high probability suggestive of cystic fibrosis or a cystic fibrosis transmembrane conductance regulator related disorder.	$786.70
73346	Testing of a pregnant patient whose carrier status for pathogenic cystic fibrosis transmembrane conductance regulator variants, as well as their reproductive partner carrier status is unknown, for the purpose of determining whether pathogenic cystic fibrosis transmembrane conductance regulator variants are present in the fetus, in order to make or exclude a diagnosis of cystic fibrosis or a cystic fibrosis transmembrane conductance regulator related disorder in the fetus when requested by a specialist or consultant physician who manages the treatment of the patient, not being a service associated with a service to which item 73350 applies. The fetus must have ultrasonic findings of echogenic gut, with unknown familial cystic fibrosis transmembrane conductance regulator variants.	$786.70
73347	Testing of a prospective parent for pathogenic cystic fibrosis transmembrane conductance regulator variants for the purpose of determining the risk of their fetus having pathogenic cystic fibrosis transmembrane conductance regulator variants. This is indicated when the fetus has ultrasonic evidence of echogenic gut when requested by a specialist or consultant physician who manages the treatment of the patient, not being a service associated with a service to which item 73345, 73348, or 73349 applies.	$786.70
73348	Testing of a patient with a laboratory-established family history of pathogenic cystic fibrosis transmembrane conductance regulator variants, for the purpose of determining whether the patient is an asymptomatic genetic carrier of the pathogenic cystic fibrosis transmembrane conductance regulator variants that have been laboratory established in the family history, not being a service associated with a service to which item 73345, 73347, or 73349 applies. The patient must have a positive family history, confirmed by laboratory findings of pathogenic cystic fibrosis transmembrane conductance regulator variants, with a personal risk of being a heterozygous genetic carrier of at least 6%. (This includes family relatedness of: parents, children, full-siblings, half-siblings, grand-parents, grandchildren, aunts, uncles, first cousins, and first cousins once-removed, but excludes relatedness of second cousins or more distant relationships).	$393.30

Item no.	Description	Max fee (excl. GST)
73349	Testing of a patient for pathogenic cystic fibrosis transmembrane conductance regulator variants for the purpose of determining the reproductive risk of the patient with their reproductive partner because their reproductive partner is already known to have pathogenic cystic fibrosis transmembrane conductance regulator variants requested by a specialist or consultant physician who manages the treatment of the patient, not being a service associated with a service to which item 73345, 73347, or 73348 applies.	$786.70
73350	Testing of a pregnant patient, where one or both prospective parents are known to be a genetic carrier of pathogenic cystic fibrosis transmembrane conductance regulator variants for the purpose of determining whether pathogenic cystic fibrosis transmembrane conductance regulator variants are present in the fetus in order to make or exclude a diagnosis of cystic fibrosis or a cystic fibrosis transmembrane conductance regulator related disorder in the fetus, when requested by a specialist or consultant physician who manages the treatment of the patient, not being a service associated with a service to which item 73346 applies. The fetus must be at 25% or more risk of cystic fibrosis or a cystic fibrosis transmembrane conductance regulator related disorder because of known familial cystic fibrosis transmembrane conductance regulator variants.	$393.30
73351	A test of tumour tissue that is derived from a new sample from a patient with locally advanced (Stage IIIb) or metastatic (Stage IV) non-small cell lung cancer (NSCLC), who has progressed on or after treatment with an epidermal growth factor receptor tyrosine kinase inhibitor (EGFR TKI). The test is to be requested by a specialist or consultant physician, to determine if the requirements relating to EGFR T790M gene status for access to osimertinib under the Pharmaceutical Benefits Scheme are fulfilled.	$611.40
GROUP P8—INFERTILITY AND PREGNANCY TESTS		
73521	Semen examination for presence of spermatozoa or examination of cervical mucus for spermatozoa (Huhner's test)	$18.70
73523	Semen examination (other than post-vasectomy semen examination), including: (a)measurement of volume, sperm count and motility; and (b)examination of stained preparations; and (c)morphology; and (if performed) (d)differential count and 1 or more chemical tests; (Item is subject to rule 25)	$87.00
73525	Sperm antibodies—sperm-penetrating ability—1 or more tests	$54.70
73527	Human chorionic gonadotrophin (hcg)—detection in serum or urine by 1 or more methods for diagnosis of pregnancy—1 or more tests	$18.90
73529	Human chorionic gonadotrophin (HCG), quantitation in serum by 1 or more methods (except by latex, membrane, strip or other pregnancy test kit) for diagnosis of threatened abortion, or follow up of abortion or diagnosis of ectopic pregnancy, including any services performed in item 73527—1 test	$54.00
GROUP P9—SIMPLE BASIC PATHOLOGY TESTS		
73801	Semen examination for presence of spermatozoa	$13.30
73802	Leucocyte count, erythrocyte sedimentation rate, examination of blood film (including differential leucocyte count), haemoglobin, haematocrit or erythrocyte count—1 test	$8.80
73803	2 tests described in item 73802	$12.00
73804	3 or more tests described in item 73802	$15.70
73805	Microscopy of urine, excluding dipstick testing.	$8.80
73806	Pregnancy test by 1 or more immunochemical methods	$19.60
73807	Microscopy for wet film other than urine, including any relevant stain	$13.30
73808	Microscopy of Gram-stained film, including (if performed) a service described in item 73805 or 73807	$19.00
73809	Chemical tests for occult blood in faeces by reagent stick, strip, tablet or similar method	$4.50
73810	Microscopy for fungi in skin, hair or nails—1 or more sites	$15.20
73811	Mantoux test	$21.70
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	$9.60
73900	Initiation of a patient episode that consists of a service described in item 72858 or 72859 if the service is rendered in a prescribed laboratory.	$4.00
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

Item no.	Description	Max fee (excl. GST)
73924	Initiation of a patient episode that consists of 1 or more services described in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 (in circumstances other than those described in item 73925) from a person who is an in-patient of a hospital.	$28.10
73925	Initiation of a patient episode that consists of 1 or more services described in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 if the person is: (a)a private patient of a recognised hospital;or (b) a private patient of a hospital who receives the service or services from a prescribed laboratory.	$4.70
73926	Initiation of a patient episode that consists of 1 or more services described in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 (in circumstances other than those described in item 73927) from a person who is not a patient of a hospital.	$15.70
73927	Initiation of a patient episode by a prescribed laboratory that consists of 1 or more services described in items, 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 from a person who is not a patient of a hospital.	$4.60
73928	Initiation of a patient episode by collection of a specimen for 1 or moreservices (other than those services described in items 73922, 73924 or 73926) if the specimen is collected in an approved collection centre. Unless item 73920 or 73929 applies	$11.40
73929	Initiation of a patient episode by collection of a specimen for 1 or more services(other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner for a prescribed laboratory or by an employee of an approved pathology authority, who conducts a prescribed laboratory, if the specimen is collected in an approved pathology collection centre	$4.60
73930	Initiation of a patient episode by collection of a specimen for a service for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person who is an in-patient of a hospital other than a recognised hospital. Unless item 73931 applies	$15.20
73931	Initiation of a patient episode by collection of a specimen for 1 or more services(other than those services described in items 73922, 73924 or 73926) if: ()the specimen is collected by an approved pathology practitioner for a prescribed laboratory or by an employee of an approved pathology authority, who conducts a prescribed laboratory, from a person who is a private patient in a hospital or () the person is a private patient in a recognised hospital and the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority	$4.70
73932	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person in the place where the person was residing. Unless item 73933 applies	$19.80
73933	Initiation of a patient episode by collection of a specimen for 1 or more services(other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner for a prescribed laboratory or by an employee of an approved pathology authority, who conducts a prescribed laboratory, from a person in the place where the person is residing	$4.60
73934	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 and 73926) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person in a residential aged care home or institution. Unless 73935 applies	$33.30
73935	Initiation of a patient episode by collection of a specimen for 1 or more services(other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner or by an employee of an approved pathology authority, who conducts a prescribed laboratory, from a person in a residential aged care home or institution	$4.60
73936	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected from the person by the person.	$11.50
73937	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926), if the specimen is collected from the person by the person and if: (a)the service is performed in a prescribed laboratory or (b)the person is a private patient in a recognised hospital	$4.60
73938	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by or on behalf of the treating practitioner. Unless item 73939 applies	$15.40
73939	Initiation of a patient episode by collection of a specimen for 1 or more services(other than those services described in items 73922, 73924 or 73926), if the specimen is collected by or on behalf of the treating practitioner and if: (a)the service is performed in a prescribed laboratory or (b)the person is a private patient in a recognised hospital	$4.60
GROUP P11—SPECIMEN REFERRED		
73940	Receipt of a specimen by an approved pathology practitioner of an approved pathology authority from another approved pathology practitioner of a different approved pathology authority or another approved pathology authority (Item is subject to rules 14, 15 and 16)	$19.80

Item no.	Description	Max fee (excl. GST)
GROUP A35—SERVICES FOR PATIENTS IN RESIDENTIAL AGED CARE FACILITIES		
90001	A flag fall service to which item 2733, 2735, 90020, 90035, 90043, 90051, 93287, 93288, 93400, 93401, 93402, 93403, 93421, 93469 or 93470 applies. For the initial attendance at one residential aged care facility on one occasion, applicable to a maximum of one patient attended on.	$84.60
90002	A flag fall service to which item 941, 942, 90092, 90093, 90095, 90096, 90183, 90188, 90202, 90212, 93291, 93292, 93431, 93432, 93433, 93434, 93451, 93475 and 93479 applies. For the initial attendance at one residential aged care facility on one occasion, applicable to a maximum of one patient attended on.	$61.50
90020	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in a residential aged care facility (other than accommodation in a self contained unit) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management an attendance on one or more patients at one residential aged care facility on one occasion—each patient.	$26.50
90035	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation an attendance on one or more patients at one residential aged care facility on one occasion each patient	$57.90
90043	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation an attendance on one or more patients at one residential aged care facility on one occasion each patient	$112.00
90051	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation an attendance on one or more patients at one residential aged care facility on one occasion each patient	$164.80
90092	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self contained unit) of not more than 5 minutes in duration an attendance on one or more patients at one residential aged care facility on one occasion each patient, by a medical practitioner who is not a general practitioner.	$13.10
90093	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self contained unit) of more than 5 minutes in duration but not more than 25 minutes an attendance on one or more patients at one residential aged care facility on one occasion each patient, by a medical practitioner who is not a general practitioner.	$24.60
90095	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self contained unit) of more than 25 minutes in duration but not more than 45 minutes an attendance on one or more patients at one residential aged care facility on one occasion each patient, by a medical practitioner who is not a general practitioner.	$54.70
90096	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self contained unit) of more than 45 minutes in duration an attendance on one or more patients at one residential aged care facility on one occasion each patient, by a medical practitioner who is not a general practitioner.	$88.50
90183	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self contained unit) of not more than 5 minutes in duration an attendance on one or more patients at one residential aged care facility on one occasion each patient, by medical practitioner in an eligible area.	$21.10

Item no.	Description	Max fee (excl. GST)
90188	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self contained unit) of more than 5 minutes in duration but not more than 25 minutes an attendance on one or more patients at one residential aged care facility on one occasion each patient, by a medical practitioner in an eligible area.	$46.40
90202	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self contained unit) of more than 25 minutes in duration but not more than 45 minutes an attendance on one or more patients at one residential aged care facility on one occasion each patient, by a medical practitioner in an eligible area.	$89.70
90212	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self contained unit) of more than 45 minutes in duration an attendance on one or more patients at one residential aged care facility on one occasion each patient, by a medical practitioner in an eligible area.	$131.90

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 12pt
- signed by the provider of the report.

Item no.	Description	Max fee (excl. GST)
RECOVERY AND RETURN TO WORK PLANS		
RRTWG	General practitioners: reviewing and signing of a Recovery and return to work plan, expected to be provided within 10 business days of receipt of the initial request.	$66.80 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.	$131.30 flat fee
	|Note 1: A Recovery and return to work plan must be requested by:—a claims manager or self-insured employer—a worker's employer (including the employer's return to work coordinator)—an approved return to work service provider. Note 2: The date of request is taken to be two business days after the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia. Note 3: Payment will only be made following submission of the signed plan.	
SHORT MEDICAL REPORT—TREATING DOCTOR		
WMG37	General practitioners: Short medical report, expected to be provided within 72 hours of receipt of the initial request or examination (where applicable), whichever is the later.	$102.80 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.	$131.30 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.	$131.30 flat fee

Item no.	Description	Max fee (excl. GST)
	Note 1: A short medical report must be requested in writing and may be requested by a:—claims manager or self-insured employer—worker, worker's representative or advocate.	
	Note 2: The date of request is taken to be two business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.	
	Note 3: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified.	
	Note 4: A short report should be based on the medical practitioner's notes and would not usually require a consultation with the patient. Where a consultation is appropriate (for example, if the practitioner has not seen the patient for some time), a consultation fee is to be billed in accordance with item numbers WMG70; WMP70; WMS70; WMY73. Consultation items in Schedule 1A must not be used for this purpose.	
	Note 5: A short report should be concise and focused. The expected length of a short report is approximately half an A4 page.	
	Note 6: A short report may be faxed to the requestor with the relevant account for services.	
	Note 7: Payment will only be made following submission of the report.	
STANDARD MEDICAL REPORT—TREATING DOCTOR (EXCLUDING PSYCHIATRISTS)		
WMG16	General practitioners: Treating doctor standard medical report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the later.	$267.60 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.	$501.50 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.	$501.50 flat fee
	Note 1: A standard medical report must be requested in writing and may be requested by a:—claims manager or self-insured employer—worker, worker's representative or advocate.	
	Note 2: The date of request is taken to be two business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.	
	Note 3: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified.	
	Note 4: A standard medical report should be based on the medical practitioner's notes and would not usually require a consultation with the patient. Where a consultation is appropriate (for example, if the practitioner has not seen the patient for some time), a consultation fee is to be billed in accordance with item numbers WMG70; WMP70 or WMS70. Consultation items in Schedule 1A must not be used for this purpose.	
	Note 5: Payment will only be made following submission of the report.	
COMPLEX MEDICAL REPORT—TREATING DOCTOR (EXCLUDING PSYCHIATRISTS)		
WMG40	General practitioners: Treating doctor complex medical report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the later.	$334.50 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.	$628.90 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.	$628.90 flat fee
	Note 1: A complex medical report must be requested in writing and may be requested by a:—claims manager or self-insured employer—worker, worker's representative or advocate.	
	Note 2: The date of request is taken to be two business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.	
	Note 3: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified.	
	Note 4: A complex medical report should be based on the medical practitioner's notes and would not usually require a consultation with the patient. Where a consultation is appropriate (for example, if the practitioner has not seen the patient for some time), a consultation fee is to be billed in accordance with item numbers WMG70; WMP70 or WMS70. Consultation items in Schedule 1A must not be used for this purpose.	
	Note 5: A complex medical report requires additional information above that required in a standard report, and may be deemed complex compared to a standard report when the worker has:—three or more ongoing compensable injuries arising from the same claim—pre-existing conditions that have a significant impact on the compensable disability—co-morbidities that have a significant impact on the compensable disability.	
	Note 6: Payment will only be made following submission of the report.	

Item no.	Description	Max fee (excl. GST)
STANDARD MEDICAL REPORT—TREATING PSYCHIATRIST		
WMY43	Psychiatrists: Treating doctor standard medical report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the later.	$628.90 flat fee
	Note 1: A standard medical report must be requested in writing and may be requested by a:—claims manager or self-insured employer,—worker, worker's representative or advocate.	
	Note 2: The date of request is taken to be two business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.	
	Note 3: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified.	
	Note 4: A standard medical report should be based on the medical practitioner's notes and would not usually require a consultation with the patient. Where a consultation is appropriate (for example, if the practitioner has not seen the patient for some time), a consultation fee is to be billed in accordance with item number WMY73. Consultation items in Schedule 1A must not be used for this purpose.	
	Note 5: Payment will only be made following submission of the report.	
COMPLEX MEDICAL REPORT—TREATING PSYCHIATRIST		
WMY46	Psychiatrists: Treating doctor complex medical report, expected to be provided within 10 business days of receipt of the initial request or examination (where applicable), whichever is the later.	$782.60 flat fee
	Note 1: A complex medical report must be requested in writing and may be requested by a:—claims manager or self-insured employer,—worker, worker's representative or advocate.	
	Note 2: The date of request is taken to be two business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.	
	Note 3: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified.	
	Note 4: A complex medical report should be based on the medical practitioner's notes and would not usually require a consultation with the patient. Where a consultation is appropriate (for example, if the practitioner has not seen the patient for some time), a consultation fee is to be billed in accordance with item number WMY73. Consultation items in Schedule 1A must not be used for this purpose.	
	Note 5: Payment will only be made following submission of the report.	
CONSULTATION, MEDICAL REVIEW FOR PREPARATION OF A REPORT—TREATING DOCTOR		
WMG70	General Practitioner: Consultation: medical review for the preparation of a treating doctor report.	$61.20 flat fee
WMP70	Consultant Physicians: Consultation: medical review for the preparation of a treating doctor report.	$122.70 flat fee
WMS70	Specialist in a surgical discipline: Consultation: medical review for the preparation of a treating doctor report.	$122.70 flat fee
WMY73	Psychiatrists: Consultation: medical review for the preparation of a treating doctor report.	$340.50 flat fee
READING TIME TO PREPARE A REPORT—TREATING DOCTOR		
WMG55	DERIVED FEE, General practitioners: Reading time payable to a treating doctor for reading prior reports or other information forwarded or approved by the requestor in order to prepare a report. Derived fee: The fee for item WMG55 is $61.20 for reading time up to and including 12 pages, plus $5.30 per page thereafter.	DF
WMP55	DERIVED FEE, Consultant physicians: Reading time payable to a treating doctor for reading prior reports or other information forwarded or approved by the requestor in order to prepare a report. Derived fee: The fee for item WMP55 is $122.70 for reading time up to and including 12 pages, plus $9.70 per page thereafter.	DF
WMS55	DERIVED FEE, Specialists in a surgical discipline: Reading time payable to a treating doctor for reading prior reports or other information forwarded or approved by the requestor in order to prepare a report. Derived fee: The fee for item WMS55 is $122.70 for reading time up to and including 12 pages, plus $9.70 per page thereafter.	DF
WMY55	DERIVED FEE, Psychiatrists: Reading time payable to a treating doctor for reading prior reports or other information forwarded or approved by the requestor in order to prepare a report. Derived fee: The fee for item WMY55 is $159.40 for reading time up to and including 12 pages, plus $9.70 per page thereafter.	DF

Item no.	Description	Max fee (excl. GST)
	Note 1: Payment for reading of written material will only be made where the reading is required in order for the doctor to prepare a report, and where the reading is at the request or approval of a:—claims manager or self-insured employer—worker, worker's representative or advocate.	
	Note 2: A fee is not payable for the reading of case notes, clinical material or any other material that is not directly supplied or approved by the parties listed in note 1.	
	Note 3: A full page for reading time consists of a whole A4 size page of standard print (12 point font or smaller) of information, full page letters and detailed reports. Examples include: hospital treatment notes, medical reports, investigation reports. A half page of reading time consists of half an A4 page or a full A5 size page of standard print (12 point font or smaller) of information, brief file notes, scattered file notes on a page, letters consisting of one or two paragraphs, results and certificates. Examples include: pathology results, notice of disability, full page of handwritten notes.	
	Note 4: The reading of material supplied by the requestor can only be charged once. No additional charge can be submitted for re-reading of material.	
MEDICAL REPORT CLARIFICATION—TREATING DOCTOR		
WMG25	General practitioners: Clarification of a medical report, re-examination not required.	$60.20 flat fee
WMP25	Consultant physicians: Clarification of a medical report, re-examination not required.	$109.50 flat fee
WMS25	Specialists in a surgical discipline: Clarification of a medical report, re-examination not required.	$109.50 flat fee
	Note 1: Clarification of a medical report must be requested in writing and may be requested by a:—claims manager or self-insured employer—worker, worker's representative or advocate.	
	Note 2: The requestor must specify that he or she is seeking a clarification of a previous medical report.	
	Note 3: A medical report clarification fee is not payable if the clarification is sought as a result of failure by the doctor to address the original questions in the letter of request.	
	Note 4: Payment will only be made following submission of the report.	
TELEPHONE CALL (EXCLUDING CALLS MADE TO OR RECEIVED FROM INJURED WORKERS)		
WMG24	General practitioners: Telephone call up to and including 60 minutes duration.	$267.60 per hour
WMP24	Consultant physicians: Telephone call up to and including 60 minutes duration.	$524.50 per hour
WMS24	Specialists in a surgical discipline: Telephone call up to and including 60 minutes duration.	$524.50 per hour
	Note 1: Telephone calls are chargeable if related to the management of the worker's claim, or to progress their recovery and return to work, made to or received from:—a claims manager or self-insured employer—a worker's employer (including the employer's return to work co-ordinator)—a worker's representative or advocate—a ReturnToWorkSA medical advisor—an approved return to work service provider—a worker's referring/treating practitioner.	
	Note 2: There is no charge for a telephone call to or from a worker.	
	Note 3: A fee is payable if the telephone contact occurs during a consultation with the worker provided that the consultation duration excludes the duration of the telephone call. For example, if the consultation and telephone call duration is 20 minutes and the call duration alone is 10 minutes, the consultation should be charged as a 10 minute consultation.	
	Note 4: Invoices for telephone calls in accordance with this item must record the name of the other party and the duration of the phone call in minutes.	
	Note 5: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.	
CASE CONFERENCE		
WMG09	General practitioners: Case conference to determine details of limitations to work, recommendations facilitating a return to work and options for management of the injured worker's recovery, including medical treatment strategies.	$267.60 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.	$524.50 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.	$524.50 per hour

Item no.	Description	Max fee (excl. GST)
	Note 1: A case conference may be requested by:—a claims manager or self-insured employer—a worker's employer (including the employer's rehabilitation and return to work co-ordinator)—a worker or worker's representative—an approved return to work service provider—a treating medical expert.	
	Note 2: The claims manager or self-insured employer should attend the case conference if at all possible. If the claims manager or self-insured employer is unable to attend, they should delegate a representative. No fee is payable for records made by any medical practitioner during the case conference unless delegated as the representative by the claims manager or self-insured employer. It is the responsibility of the claims manager, self-insured employer or delegated representative to make a written and signed record of the case conference that is to be distributed to all attendees. Differences of opinion should be noted in the record. The worker or worker's representative must always be invited to attend the case conference.	
	Note 3: Case conferences conducted by telephone (teleconferencing) are chargeable under this item.	
	Note 4: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.	
WORKSITE ASSESSMENT		
WMG08	General practitioners: Worksite assessment, for the purpose of assessing and reporting the duties that are or can be made available, and the capacity of the worker to undertake these duties.	$267.60 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.	$524.50 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.	$524.50 per hour
	Note 1: A worksite assessment may be requested by a:—claims manager or self-insured employer—worker, worker's representative or advocate.	
	Note 2: At worksite visits it is expected that the employer, worker or worker's representative, claims manager or self-insured employer representative should be present.	
	Note 3: The claims manager or self-insured employer should contact the employer to ensure appropriate access to the worksite and to arrange for an employer representative to be available to help maximise the value of time spent in the workplace.	
	Note 4: The worksite assessment must include an assessment of the physical environment, mental work demands, human behaviour, working conditions, educational requirements and other conditions.	
	Note 5: The report of a worksite assessment is to be completed and distributed by the medical practitioner undertaking the assessment to relevant parties in attendance during the worksite assessment. A copy must also be provided to the claims manager, treating doctor and worker (if not present) within one week of the assessment. No additional fee is payable for completion of the form.	
	Note 6: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.	
THIRD PARTY CONSULTATION		
WMG14	General practitioners: Third party consultation at the doctor's rooms where the worker is usually not present.	$267.60 per hour
WMP14	Consultant physicians: Third party consultation at the doctor's rooms where the worker is usually not present.	$524.50 per hour
WMS14	Specialists in a surgical discipline: Third party consultation at the doctor's rooms where the worker is usually not present.	$524.50 per hour
	Note 1: A third party consultation must involve at least one of the following:—claims manager or self-insured employer—worker, worker's representative or advocate—worker's employer (including the employer's rehabilitation and return to work co-ordinator)—investigator—approved return to work service provider.	
	Note 2: A third party consultation may include a video viewing of a worker's normal duties, alternative duties or other activities.	
	Note 3: It is the responsibility of the claims manager or self-insured employer to ensure a written and signed record is made of the third party consultation that is to be distributed to all attendees. No fee is payable for records made by any medical practitioner during the third party consultation.	
	Note 4: If as a result of the third party consultation the medical practitioner has amended details regarding the worker's limitations to work, capacity, recommendations for facilitating a return to work and/or options for management of the worker, the medical practitioner must consider the worker's input into this decision.	
	Note 5: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.	
ATTENDANCE AT A DISPUTE RESOLUTION		
WMG15	General practitioners: Attendance at a dispute resolution.	$267.60 per hour
WMP15	Consultant physicians: Attendance at a dispute resolution.	$524.50 per hour
WMS15	Specialists in a surgical discipline: Attendance at a dispute resolution.	$524.50 per hour

Item no.	Description	Max fee (excl. GST)
	Note 1: Attendance at a dispute resolution must be at the request of a:—claims manager or self-insured employer—worker, worker's representative or advocate—worker's employer or employer's representative.	
	Note 2: Court attendances can be charged under this item.	
	Note 3: A witness at a dispute resolution proceeding is entitled to reimbursement of any expense that the dispute resolution authority certifies has been, or is likely to be, reasonably incurred by the witness as a consequence of appearing before the authority.	
	Note 4: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.	
TRAVEL TIME: WORKSITE ASSESSMENT, CASE CONFERENCE, DISPUTE RESOLUTION OR THIRD PARTY CONSULTATION		
WMG10	General practitioners: Travel time for the purpose of a worksite assessment, case conference, dispute resolution or third party consultation.	$267.60 per hour
WMP10	Consultant physicians: Travel time for the purpose of a worksite assessment, case conference, dispute resolution or third party consultation.	$524.50 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.	$524.50 per hour
	Note 1: All accounts must include the total time spent travelling plus the distance travelled.	
	Note 2: Where more than one worksite assessment, case conference or dispute resolution is conducted, the travel fee is to be apportioned accordingly.	
	Note 3: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.	
CANCELLATION: CASE CONFERENCE, WORKSITE ASSESSMENT, DISPUTE RESOLUTION OR THIRD PARTY CONSULTATION		
WMG36	General practitioners: Cancellation of case conference, worksite assessment, dispute resolution or third party consultation.	$267.60 per hour
WMP36	Consultant physicians: Cancellation of case conference, worksite assessment, dispute resolution or third party consultation.	$524.50 per hour
WMS36	Specialists in a surgical discipline: Cancellation of case conference, worksite assessment, dispute resolution or third party consultation.	$524.50 per hour
	Note 1: Payment for cancellation will only be made when the attendance was at the request of a:—claims manager or self-insured employer—worker, worker's representative or advocate—employer or employer's representative.	
	Note 2: A cancellation fee is payable only if the cancellation occurs less than 48 hours (excluding weekends and public holidays in South Australia) before the time of the proposed attendance.	
	Note 3: A cancellation fee is not payable if the doctor is responsible for the cancellation.	
	Note 4: If the cancelled appointment is subsequently filled with any other earning activity, no cancellation fee will be payable.	
	Note 5: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.	
JOB ANALYSIS AND/OR RECOMMENDED JOB DESCRIPTION STATEMENT		
WMG56	General practitioners: Formal job analysis and/or recommended job descriptions. Reading of and written recommendations on the suitability of proposals for return to work, expected to be provided within 10 business days of receipt of the initial request.	$102.80 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.	$131.30 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.	$131.30 flat fee
	Note 1: A job analysis and/or job description statement must be requested in writing and may be requested by:—a claims manager or self-insured employer—a worker, worker's representative or advocate—an approved return to work service provider.	
	Note 2: The date of request is taken to be two business days after the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.	
SPECIFIED DUTIES FORM		
WMG23	General practitioners: Completion of a specified duties form.	$23.60 flat fe
WMP23	Consultant physicians: Completion of a specified duties form.	$23.60 flat fee
WMS23	Specialist in a surgical discipline: Completion of a specified duties form.	$23.60 flat fee

Item no.	Description	Max fee (excl. GST)
	Note 1: This form is to be completed at the request of a:—claims manager or self-insured employer—worker, worker's representative or advocate.	
	Note 2: A fee is not payable if the form is completed during a consultation with the worker.	
PHOTOCOPYING		
WMADM	General practitioners, consultant physicians, specialists in a surgical discipline: Administration fee for the time to prepare and provide requested documents, and radiology, including postage. This may include where applicable, scanning and saving documents to a device (e.g. USB, disc), including the cost of the device.	$71.30 flat fee
WMGSP	General practitioners, consultant physicians, specialists in a surgical discipline: Photocopying of medical notes, reports and results of relevant tests e.g. pathology, diagnostic imaging reports. This service includes photocopying/printing costs only. In addition to photocopying, item WMADM can be billed as an administration cost. Note: Where documents are provided via media (e.g. USB, disc, email), only the administration fee applies.	$0.28
	Note 1: A fee is only payable if the photocopying is at the request of a:—claims manager or self-insured employer—worker, worker's representative or advocate—investigator.	
	Note 2: The number of pages should be stated on the account. Any accounts without the number of pages stated will be returned for amendment.	
	Note 3: Accounts must state the name of the doctor providing the photocopied information. Accounts with the practice name only will be returned for amendment.	
TRAVEL TIME—EMERGENCY ATTENDANCE		
WMG58	General practitioners: Travel time, for the purpose of an initial emergency attendance of a compensable injury, at a location other than consulting rooms, hospital or other healthcare institution, when ambulance services are either not readily available or unduly delayed.	$267.60 per hour
WMG59	General practitioners: Travel time, (out of normal business hours) for the purpose of an initial emergency attendance of a compensable injury, at a location other than consulting rooms, hospital or other healthcare institution, when ambulance services are either not readily available or unduly delayed. Out of normal business hours means on a Sunday, public holiday in South Australia, after 1pm on Saturday or between 8pm and 8am on weekdays.	$389.20 per hour
	Note 1: Where more than one worker is treated at the site of the emergency, the travel fee is to be apportioned accordingly.	
	Note 2: All invoices must include the distance travelled, the travel commencement location, place of emergency attendance and a brief reason for the attendance.	
	Note 3: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.	
TRAVEL TIME—EMERGENCY RETRIEVAL TEAM		
WMS51	Specialists: Travel time by a retrieval team doctor in association with a professional attendance relating to item numbers 00160, 00161, 00162, 00163 and 00164, other than 'out of hours' travel (refer to item number WMS52).	$524.50 per hour
WMS52	Specialists: Travel time by a retrieval team doctor on a Sunday, public holiday in South Australia, after 1pm on Saturday or between 8pm and 8am on weekdays, in addition to a professional attendance relating to item numbers 00160, 00161, 00162, 00163 and 00164.	$760.10 per hour
	Note 1: Where more than one worker is treated at the site of the emergency, the travel fee is to be apportioned accordingly.	
	Note 2: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.	
EXTRA-CORPOREAL SHOCK WAVE THERAPY		
WMI11	Specialists: Initial treatment of Extra-Corporeal Shock Wave Therapy provided by a specialist radiology practice.	$149.80 flat fee
WMI12	Specialists: Subsequent treatments of Extra-Corporeal Shock Wave Therapy provided by a specialist radiology practice.	$122.70 flat fee
WMI13	Specialists: Double treatments (bilateral or multiple) of Extra-Corporeal Shock Wave Therapy provided by a specialist radiology practice.	$204.40 flat fee
	Note 1: The I in prefix WMI item number represents the letter 'I' not a numeral one (1).	
	Note 2: This treatment has been approved by ReturnToWorkSA for use in the following conditions:—heel pain/plantar fasciitis—calcific tendonitis of shoulder—lateral epicondylitis (tennis elbow)—medial epicondylitis—non-united fractures—patellar tendinopathy.	
	Note 3: Where Extra-Corporeal Shock Wave Therapy is delivered outside of the approved conditions it is recommended to seek claims manager authorisation prior to the provision of the service.	
	Note 4: Epicondylitis treatment is NOT payable by ReturnToWorkSA for treatment provided within three months or after five years from date of injury.	
SERVICES DELIVERED BY EAR, NOSE AND THROAT SURGEONS		
WME24	Otorhinolaryngologists: Cortical evoked response audiometry—verification.	$349.30 flat fee

Item no.	Description	Max fee (excl. GST)
WME25	Otorhinolaryngologists: Sensonics smell identification test.	$151.80 flat fee
WME2A	Otorhinolaryngologists: Cortical evoked response audiometry—quantification.	$349.30 flat fee
	SERVICES DELIVERED BY MEDICAL PRACTITIONERS	
WMG26	Medical practitioners: Fluids, intravenous drip infusion of—percutaneous.	$60.00 flat fee
WMG27	Medical Practitioners: Fluids, intravenous drip infusion of—open exposure. No te 1: Item WMG26 is only payable where the service is not in association with a surgical procedure.	$99.50 flat fee
	Note 1: Item WMG26 is only payable where the service is not in association with a surgical procedure.	
	SERVICES DELIVERED BY MEDICAL PRACTITIONERS IN THE PRACTICE OF HYPNOTHERAPY	
WMG28	Hypnotherapy at consulting rooms, 16 to 30 minutes.	$89.40 flat fee
WMG29	Hypnotherapy at consulting rooms, 31 to 45 minutes.	$134.30 flat fee
WMG30	Hypnotherapy at consulting rooms, more than 46 minutes.	$182.90 flat fee
WMG31	Hypnotherapy at consulting rooms, not more than 15 minutes.	$51.70 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.	$131.30 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.	$131.30 flat fee
	Note 1: A short medical report must be requested in writing and may be requested by a:—claims manager or self-insured employer—worker, worker's representative or advocate.	
	Note 2: The date of request is taken to be two business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia.	
	Note 3: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified.	
	Note 4: A short report should be 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.	
	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.	$628.90 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.	$628.90 flat fee
	|Note 1: A medical report must be requested in writing and may be requested by a:—claims manager or self-insured employer—worker, worker's representative or advocate. Note 2: The date of request is taken to be two business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia. Note 3: If a medical practitioner believes the incorrect report type has been requested, this should be referred back to the claims manager and clarified. Note 4: 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.	
	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.	$782.60 flat fee

Item no.	Description	Max fee (excl. GST)
	Note 1: A psychiatrists medical report must be requested in writing and may be requested by a:—claims manager or self-insured employer,—worker, worker's representative or advocate. Note 2: The date of request is taken to be two business days after the date the letter of request is posted, or one business day after the request is faxed. A business day is any day, excluding Saturday, Sunday and public holidays in South Australia. Note 3: 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 claims 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.	
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.	$238.40 flat fee
WMS80	Specialists in a surgical discipline: Independent medical examiner consultation, medical review for the preparation of an independent medical examiner report.	$238.40 flat fee
WMY83	Psychiatrists: Independent medical examiner consultation, medical review for the preparation of an independent medical examiner report.	$340.50 flat fee
INDEPENDENT MEDICAL EXAMINER—READING TIME		
WMP32	DERIVED FEE, 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 $122.70 for reading time up to and including 12 pages, plus $9.70 per page thereafter.	DF
WMS32	DERIVED FEE, 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 $122.70 for reading time up to and including 12 pages, plus $9.70 per page thereafter.	DF
WMY32	DERIVED FEE, 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 $159.40 for reading time up to and including 12 pages, plus $9.70 per page thereafter.	DF
	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:—claims manager or self-insured employer—worker, worker's representative or advocate. Note 2: A fee is not payable for the reading of case notes, clinical material or any other material that is not directly supplied or approved by the parties listed in note 1. Note 3: A full page for reading time consists of a whole A4 size page of standard print (12 point font or smaller) of information, full page letters and detailed reports. Examples include: hospital treatment notes, medical reports, investigation reports. A half page of reading time consists of half an A4 page or a full A5 size page of standard print (12 point font or smaller) of information, brief file notes, scattered file notes on a page, letters consisting of one or two paragraphs, results and certificates. Examples include: pathology results, notice of disability, full page of handwritten notes. Note 4: The reading of material supplied by the requestor can only be billed once. No additional charge can be submitted for re-reading of material.	
INDEPENDENT MEDICAL EXAMINER—MEDICAL REPORT CLARIFICATION		
WMP33	Consultant physicians: Independent medical examiner clarification of a medical report, re-examination not required.	$109.50 flat fee
WMS33	Specialists in a surgical discipline: Independent medical examiner clarification of a medical report, re-examination not required.	$109.50 flat fee
	Note 1: A clarification of a medical report must be requested in writing and may be requested by a:—claims manager or self-insured employer—worker, worker's representative or advocate. Note 2: The requestor must specify that he or she is seeking a clarification of a previous medical report. Note 3: A medical report clarification fee is not payable if the clarification is sought as a result of failure by the doctor to address the original questions in the letter of request. Note 4: 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. Note 5: Payment will only be made following submission of the report.	
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.	$524.50 per hour

Item no.	Description	Max fee (excl. GST)
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.	$524.50 per hour
	Note 1: Travel will be approved for independent medical examiner services requested by a:—claims manager or self-insured employer—worker, worker's representative or advocate.	
	Note 2: All accounts must include the total time spent travelling as well as the distance travelled.	
	Note 3: Where more than one service is conducted, the travel fee is to be apportioned accordingly.	
	Note 4: Any part of an hour should be billed proportionately and rounded to the nearest six minutes.	
INDEPENDENT MEDICAL EXAMINER—NON-ATTENDANCE OR CANCELLATION OF AN APPOINTMENT		
WMP34	Consultant physicians: Independent medical examiner non-attendance at, or cancellation less than 48 hours (excluding weekends and public hospitals in South Australia) before an appointment.	$238.40 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.	$238.40 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.	$340.50 flat fee
	Note 1: Fees apply only to the cancellation of medical appointments arranged by a:—claims manager or self-insured employer—worker, worker's representative or advocate.	
	Note 2: If the cancelled appointment or non-attendance is subsequently filled with any other earning activity, no cancellation fee will be payable.	
INDEPENDENT MEDICAL EXAMINER—TRAVEL FOR EXAMINATIONS		
WMP64	Consultant physicians: Independent medical examiner, a full day attendance at the venue more than 100 kilometres from the Adelaide GPO for the purpose of providing an independent medical examiner report.	$153.40 flat fee
WMP65	Consultant physicians: Independent medical examiner cancellation of an attendance at a venue more than 100 kilometres from the Adelaide GPO.	$245.30 flat fee
WMP66	Consultant physicians: Independent medical examiner overnight accommodation including meals and incidentals.	$324.90 flat fee
WMP67	Consultant physicians: Independent medical examiner travel by motor vehicle, to and from a venue for the purposes of an appointment made by the report requestor.	ATO rates
WMP68	Consultant physicians: Independent medical examiner travel by aircraft, to and from a venue for the purposes of an appointment made by the report requestor.	Economy airfare
WMS64	Specialists in a surgical discipline: Independent medical examiner, a full day attendance at a venue more than 100 kilometres from the Adelaide GPO for the purpose of providing an independent medical examiner report.	$153.40 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.	$245.30 flat fee
WMS66	Specialists in a surgical discipline: Independent medical examiner overnight accommodation including meals and incidentals.	$324.90 flat fee
WMS67	Specialists in a surgical discipline: Independent medical examiner travel by motor vehicle, to and from a venue for the purposes of an appointment made by the report requestor.	ATO rates
WMS68	Specialists in a surgical discipline: Independent medical examiner travel by aircraft, to and from a venue for the purposes of an appointment made by the report requestor.	Economy airfare
	Note 1: The first 50 kilometres of any travel is not billable.	
	Note 2: If more than one organisation has requested services from the provider at the travel destination then items WMP/S64, WMP/S66, WMP/S67 and/or WMP/S68 must be apportioned accordingly.	
	Note 3: A full day pursuant to item WMP/S64 refers to a stay of more than six hours at the venue including travel time.	
	Note 4: ATO rates means the rate, applicable to the type of motor vehicle in which the medical expert travelled, published by the Australian Taxation Office as the rate per kilometre that may be claimed as a deduction for business travel expenses incurred in the previous financial year.	
	Note 5: Economy airfare means the amount determined by ReturnToWorkSA to be the reasonable cost of undertaking the travel using a standard economy airfare.	

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.	$1049.00 flat fee
PIA30	Specialists (excluding psychiatrists): permanenant impairment assessor standard report, simple assessment of one body system—reading, examination and report in accordance with the Impairment Assessment Guidelines.	$1049.00 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).	$1311.20 flat fee
	Note 1: Reports will be requested by a claims manager or self-insured employer.	
	Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex or supplementary report is required.	
	Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.	
	Note 4: Corrections and amendments to a report after initial submission are covered in the fee above, and do not attract an additional fee.	
	Note 5: 'Specialist' means a specialist in a surgical discipline or a consultant physician.	
	Note 6: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines.	
PERMANENT IMPAIRMENT ASSESSOR—MODERATELY COMPLEX REPORT		
PIA11	General practitioners: permanent impairment assessor moderately complex report, simple assessment of two body systems or more than one injury to a single body system—reading, examination and report in accordance with the Impairment Assessment Guidelines.	$1311.40 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.	$1311.40 flat fee
	Note 1: Reports will be requested by a claims manager or self-insured employer.	
	Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex or supplementary report is required.	
	Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.	
	Note 4: Corrections and amendments to a report after initial submission are covered in the fee above, and do not attract an additional fee.	
	Note 5: 'Specialist' means a specialist in a surgical discipline or a consultant physician.	
	Note 6: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines.	
PERMANENT IMPAIRMENT ASSESSOR—COMPLEX REPORT		
PIA12	General practitioners: permanent impairment assessor complex report, complex assessment 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.	$1661.00 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.	$1661.00 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).	$1835.20 flat fee

Item no.	Description	Max fee (excl. GST)
	Note 1: Reports will be requested by a claims manager or self-insured employer.	
	Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex or supplementary report is required.	
	Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.	
	Note 4: Corrections and amendments to a report after initial submission are covered in the fee above, and do not attract an additional fee.	
	Note 5: 'Specialist' means a specialist in a surgical discipline or a consultant physician.	
	Note 6: The lead assessor may only bill for the final complete report including the sub-assessor's report(s).	
	Note 7: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines.	
PERMANENT IMPAIRMENT ASSESSOR—ENT REPORT		
PIA50	ENT specialists: permanent impairment assessor ENT report—reading, examination of ear, nose and/or throat only, including audiometric testing and report in accordance with the Impairment Assessment Guidelines.	$1049.00 flat fee
	Note 1: Reports will be requested by a claims manager or self-insured employer.	
	Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex or supplementary report is required.	
	Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.	
	Note 4: Corrections and amendments to a report after initial submission are covered in the fee above, and do not attract an additional fee.	
	Note 5: 'Specialist' means a specialist in a surgical discipline or a consultant physician.	
PERMANENT IMPAIRMENT ASSESSOR—STANDARD REPORT WHERE AN EXAMINATION IS CONDUCTED WITH THE ASSISTANCE OF AN INTERPRETER		
PIA13	General practitioners: permanent impairment assessor standard report with interpreter, simple assessment of one body system—reading, examination conducted with the assistance of an interpreter and report in accordance with the Impairment Assessment Guidelines.	$1311.40 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.	$1311.40 flat fee
PIA43	Psychiatrists: permanent impairment assessor standard report with interpreter, for the assessment of psychiatric disorders; assessment where there is one disorder or condition related to the work injury—reading, examination and report in accordance with the Impairment Assessment Guidelines and using the Guidelines for the Evaluation of Psychiatric Impairment by Clinicians (GEPIC).	$1638.90 flat fee
	Note 1: Reports will be requested by a claims manager or self-insured employer.	
	Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex or supplementary report is required.	
	Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.	
	Note 4: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.	
	Note 5: Corrections and amendments to a report after initial submission are covered in the fee above, and do not attract an additional fee.	
	Note 6: 'Specialist' means a specialist in a surgical discipline or a consultant physician.	
	Note 7: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines.	
PERMANENT IMPAIRMENT ASSESSOR—MODERATELY COMPLEX REPORT WHERE AN EXAMINATION IS CONDUCTED WITH THE ASSISTANCE OF AN INTERPRETER		
PIA14	General practitioners: permanent impairment assessor moderately complex report with interpreter, simple assessment of 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.	$1573.60 flat fee
PIA34	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.	$1573.60 flat fee

Item no.	Description	Max fee (excl. GST)
	Note 1: Reports will be requested by a claims manager or self-insured employer.	
	Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex or supplementary report is required.	
	Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.	
	Note 4: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.	
	Note 5: Corrections and amendments to a report after initial submission are covered in the fee above, and do not attract an additional fee.	
	Note 6: 'Specialist' means a specialist in a surgical discipline or a consultant physician.	
	Note 7: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines.	
PERMANENT IMPAIRMENT ASSESSOR—COMPLEX REPORT WHERE AN EXAMINATION IS CONDUCTED WITH THE ASSISTANCE OF AN INTERPRETER		
PIA15	General practitioners: permanent impairment assessor complex report with interpreter, complex assessment 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.	$1923.30 flat fee
PIA35	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.	$1923.30 flat fee
PIA45	Psychiatrists: permanent impairment assessor complex report, with interpreter, for the assessment of psychiatric disorders; assessment where there is more than one disorder related to the work injury or pre-existing or non-work-related and/or neurological considerations—reading, examination and report in accordance with the Impairment Assessment Guidelines and using the Guidelines for the Evaluation of Psychiatric Impairment by Clinicians (GEPIC).	$2294.00 flat fee
	Note 1: Reports will be requested by a claims manager or self-insured employer.	
	Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex or supplementary report is required.	
	Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.	
	Note 4: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.	
	Note 5: Corrections and amendments to a report after initial submission are covered in the fee above, and do not attract an additional fee.	
	Note 6: 'Specialist' means a specialist in a surgical discipline or a consultant physician.	
	Note 7: The lead assessor may only bill for the final complete report including the sub-assessor's report(s).	
	Note 8: A reference to body system herein means one or more of the 15 body systems in which Impairment Assessors are accredited by the Minister and which correspond with chapters 2 to 16 of the Return to Work Scheme Impairment Assessment Guidelines.	
PERMANENT IMPAIRMENT ASSESSOR—ENT REPORT WHERE AN EXAMINATION IS CONDUCTED WITH THE ASSISTANCE OF AN INTERPRETER		
PIA51	ENT specialists: permanent impairment assessor ENT report with interpreter, reading, 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.	$1311.40 flat fee
	Note 1: Reports will be requested by a claims manager or self-insured employer.	
	Note 2: Permanent impairment assessment reports must be requested in writing, specifying whether a standard, moderately complex, complex or supplementary report is required.	
	Note 3: Reports are to be provided to ReturnToWorkSA within 10 business days of the examination unless the assessor believes there are reasonable grounds for an extension of time and has sought the requestor's prior consent for an extension of time.	
	Note 4: If an interpreter is present at the examination, the medical fee payable is in accordance with the fees set out above.	
	Note 5: Corrections and amendments to a report after initial submission are covered in the fee above, and do not attract an additional fee.	
	Note 6: 'Specialist' means a specialist in a surgical discipline or a consultant physician.	
PERMANENT IMPAIRMENT ASSESSOR—CANCELLATION OF AN APPOINTMENT OR NON-ATTENDANCE		
PIA16	General practitioners: permanent impairment assessor non-attendance at, or cancellation with less than 48 hours notice (excluding weekends or public holidays in South Australia) before an appointment.	$377.80 flat fee

Item no.	Description	Max fee (excl. GST)
PIA36	Specialists: permanent impairment assessor non-attendance at, or cancellation w ith less than 48 hours notice (excluding weekends or public holidays) before an appointment	$377.80 flat fee
	Note 1: A fee for a cancellation with more than 48 hours' notice (excluding weekends and public holidays in South Australia) is not payable.	
	Note 2: A fee for a cancellation or non-attendance does not apply if the appointment is subsequently filled with any other earning activity.	
PERMANENT IMPAIRMENT ASSESSOR—SUPPLEMENTARY REPORT		
PIA17	General practitioners: permanent impairment assessor supplementary report, where additional information is requested by the report requestor.	$262.20 flat fee
PIA37	Specialists (including psychiatrists): permanent impairment assessor supplementary report, where additional information is requested by the report requestor.	$262.20 flat fee
	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.	
	Note 2: A supplementary report fee will only be paid where either ReturnToWorkSA, a claims manager, or a self-insured employer specifically requests a separate report that addresses matters that are additional to the original report request.	
PERMANENT IMPAIRMENT ASSESSOR—ADDITIONAL READING TIME		
PIA18	DERIVED FEE, 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: $9.70 per page over 25 pages.	DF
PIA19	DERIVED FEE, 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: $9.70 per page over 51 pages.	DF
PIA38	DERIVED FEE, 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: $9.70 per page over 25 pages.	DF
PIA39	DERIVED FEE, 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: $9.70 per page over 51 pages.	DF
	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, full page of handwritten notes.	
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.	$153.40 flat fee
PIA62	General practitioners or specialists (including psychiatrists): permanent impairment assessor—cancellation of an attendance at a venue more than 100 kilometres from the Adelaide GPO.	$245.30 flat fee
PIA64	General practitioners or specialists (including psychiatrists): permanent impairment assessor accommodation—overnight accommodation including meals and incidentals.	$324.90 flat fee
PIA66	General practitioners or specialists (including psychiatrists): permanent impairment assessor motor vehicle travel—travel by motor vehicle, to and from a venue for the purpose of an appointment made by the report requestor.	ATO rates
PIA68	General practitioners and specialists (including psychiatrists): permanent impairment assessor aircraft travel—travel by aircraft, to and from a venue for the purpose of an appointment made by the report requestor.	Economy airfare

Item no.	Description	Max fee (excl. GST)
	Note 1: The first 50 kilometres of any travel is not chargeable.	
	Note 2: If an assessor is travelling for the purpose of conducting more than one permanent impairment assessment, the travel fees must be apportioned accordingly.	
	Note 3: 'A full day' as per item PIA60 refers to a stay of more than five hours at the venue including travel time.	
	Note 4: ATO rates means the rate, applicable to the type of motor vehicle in which the assessor travelled, published by the Australian Taxation Office as the rate per kilometre that may be claimed as a deduction for business travel expenses incurred in the previous financial year.	
	Note 5: Economy airfare means the amount determined by ReturnToWorkSA to be the reasonable cost of undertaking the travel using a standard economy airfare.	

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.	$68.30 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.	$119.00 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.	$53.90 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.	$110.90 flat fee
CHIROPRACTIC MANAGEMENT PLAN		
CHMP	Chiropractic management plan. A chiropractic management plan completed and submitted by the treating chiropractor. For claims managed by ReturnToWorkSA or their claims agents, the chiropractor is expected to submit a plan:—prior to the 11th treatment if more than 10 treatments are likely to be required, or—prior to the expiry of an existing chiropractic management plan if additional treatment is required, or—at the request of the claims manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer.	$47.70 flat fee
INDEPENDENT CLINICAL ASSESSMENT AND REPORT		
CH780	Independent clinical assessment and report. An assessment of a worker by a chiropractor, other than the treating chiropractor, and provision of a report for the purpose of providing a clinical opinion on current treatment, comment on the worker's functional ability and make recommendations on future chiropractic management. This service must be requested in writing by the claims manager, self-insured employer, worker or worker's representative. Maximum 4 hours.	$190.30 per hour Max 4 hours
TELEPHONE CALLS		
CH552	Telephone calls relating to the management of the worker's claim,or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator), worker's representative, ReturnToWorkSA advisor, approved return to work service provider* or worker's referring/treating medical practitioner. Any time spent on communication directly related to an independent clinical assessment and report is included within the total time invoiced for that service. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$26.40 flat fee
TREATING CHIROPRACTOR REPORT		
CH820	Treating chiropractor report. A written clinical opinion, statement or response to questions relating to the medical status and treatment of a worker, requested in writing by the claims manager, self-insured employer, worker or worker's representative.	$190.30 flat fee
CASE CONFERENCE		
CH870	Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an approved return to work service provider*. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$190.30 per hour

Item no.	Description	Max fee (excl. GST)
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.	$161.50 per hour
RADIOLOGICAL SERVICES (INCLUDING INTERPRETATION BY A CHIROPRACTOR)		
CHT11	Cervical spine—2 views	$147.70 flat fee
CHT13	Thoracic spine—2 views	$125.50 flat fee
CHT15	Lumbo-sacral spine—3-6 views	$173.20 flat fee
CHT16	Sacro-coccygeal area—2 views	$104.50 flat fee
CHT27	Hip joint	$112.90 flat fee
CHT28	Pelvic girdle	$142.50 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.	$150.90 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).	$150.90 per hour Max 1 hour
GROUP SESSION		
EP103	Group session. A session during which a maximum of 8 participants are constantly and directly supervised and assessed by the exercise physiologist.	$25.10 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: • prior to the 11th treatment if more than 10 treatments are likely to be required and have been approved by the claims manager, or • prior to the expiry of an existing exercise physiology management plan if additional treatment is required and approved by the claims manager, or • at the request of the claims manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer.	$37.80 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 claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator), worker's representative, ReturnToWorkSA advisor, approved return to work service provider or worker's referring/treating medical practitioner. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$20.90 flat fee
TREATING EXERCISE PHYSIOLOGY REPORT		
EP820	Treating exercise physiology report. A written clinical opinion, statement or response to questions relating to the progress and status of a worker's functional and work-related exercise activities, requested in writing by the claims manager, self-insured employer, worker or worker's representative.	$150.90 flat fee

Item no.	Description	Max fee (excl. GST)
CASE CONFERENCE		
EP870	Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an approved return to work service provider*.	$150.90 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 claims manager or self-insured employer.	$128.10 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.	$190.30 per hour
OT205	Subsequent consultation. Re-assessment planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services.	$190.30 per hour
OCCUPATIONAL THERAPY MANAGEMENT PLAN		
OTMP	Occupational therapy management plan. An occupational therapy management plan completed and submitted by the treating occupational therapist. For claims managed by ReturnToWorkSA or their claims agents, the occupational therapist is expected to submit a plan:—prior to the 11th treatment if more than 10 treatments are likely to be required, or—prior to the expiry of an existing occupational therapy management plan if additional treatment is required, or—at the request of the claims manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer.	$47.70 flat fee
WORKPLACE VISIT		
OT216	Workplace visit. Review of the worker and workplace demands in accordance with the Clinical Framework for the Delivery of Health Services, for the purpose of determining ongoing treatment needs and where appropriate, reviewing movement patterns and techniques with work duties. The worker is to be present at the visit and for the best outcomes, the claims manager, supervisor/employer should also be present to facilitate a team approach. Maximum 1 hour.	$190.30 per hour Max 1 hour
CORRECTIVE/SERIAL SPLINTING		
OT300	Fabrication/fitting/adjustment of splint	$190.30 per hour
INDEPENDENT CLINICAL ASSESSMENT AND REPORT		
OT780	Independent clinical assessment and report. An assessment of a worker by an occupational therapist, other than the treating occupational therapist, and provision of a report for the purpose of providing a clinical opinion on current treatment, comment on the worker's functional ability and make recommendations on future occupational therapy management. This service must be requested in writing by the claims manager, self-insured employer, worker or worker's representative. Maximum 4 hours.	$190.30 per hour Max 4 hours
ACTIVITIES OF DAILY LIVING ASSESSMENT AND REPORT		
OT760	Activities of daily living assessment and report. Assessment of a worker's level of functioning in relation to personal care, household tasks, recreational and social activities. This service includes provision of a report and must be requested in writing by the claims manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the claims manager or self-insured employer. Maximum 5 hours.	$190.30 per hour Max 5 hours
ACTIVITIES OF DAILY LIVING IMPLEMENTATION AND REVIEW		
OT762	Activities of daily living: implementation and review. Re-assessment and review of a worker's progress in functional ability, the ongoing need for third party services or hired equipment, therapeutic aids or appliances. This service must be requested in writing by the claims manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the claims manager or self-insured employer. Maximum 2 hours.	$190.30 per hour Max 2 hours
DRIVER ASSESSMENT, REHABILITATION AND REPORT		
OTDVA	Driver assessment and report. Assessment of the impact of a worker's injury/condition on their ability to return to safe and independent driving and where appropriate, develop a driver rehabilitation plan. This service must be requested in writing by the claims manager, self-insured employer or treating medical practitioner. Maximum 5 hours.	$190.30 per hour Max 5 hours
OTDVR	Driver rehabilitation and report. Implementation of a driver rehabilitation plan. This service must be requested in writing by the claims manager, self-insured employer or treating medical practitioner.	$190.30 per hour

Item no.	Description	Max fee (excl. GST)
TELEPHONE CALLS		
OT552	Telephone calls relating to the management of the worker's claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator), worker's representative, ReturnToWorkSA advisor, approved return to work service provider* or worker's referring/treating medical practitioner. Any time spent on communication directly related to an independent clinical assessment and report, activities of daily living assessment and report, an activities of daily living re-assessment or driver assessment/rehabilitation and report, is included within the total time invoiced for that service. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$26.40 flat fee
TREATING OCCUPATIONAL THERAPY REPORT		
OT820	Treating occupational therapist report. A written clinical opinion, statement or response to questions relating to the medical status and treatment of a worker, requested in writing by the claims manager, self-insured employer, worker or worker's representative.	$190.30 flat fee
CASE CONFERENCE		
OT870	Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an approved return to work service provider*. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$190.30 per hour
TRAVEL TIME		
OT905	Travel time. Travel by an occupational therapist for the purpose of a case conference, home, hospital or worksite visit, independent clinical or activities of daily living assessment.	$161.50 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.	$125.20 flat fee
OS220	Subsequent consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services.	$92.40 flat fee
OSTEOPATHY MANAGEMENT PLAN		
OSMP	Osteopathy management plan. An osteopathy management plan completed and submitted by the treating osteopath. For claims managed by ReturnToWorkSA or their claims agents, the osteopath is expected to submit a plan:—prior to the 11th treatment if more than 10 treatments are likely to be required, or—prior to the expiry of an existing osteopathy management plan if additional treatment is required, or—at the request of the claims manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer.	$47.70 flat fee
INDEPENDENT CLINICAL ASSESSMENT AND REPORT		
OS780	Independent clinical assessment and report. An assessment of a worker by an osteopath, other than the treating osteopath, and provision of a report for the purpose of providing a clinical opinion on current treatment, comment on the worker's functional ability and make recommendations on future osteopathy management. This service must be requested in writing by the claims manager, self-insured employer, worker or worker's representative. Maximum 4 hours.	$190.30 per hour Max 4 hours
TELEPHONE CALLS		
OS552	Telephone calls relating to the management of the worker's claim, or to progress their recovery and return to work, made to or received from, a claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator), worker's representative, ReturnToWorkSA advisor, approved return to work service provider* or worker's referring/treating medical practitioner. Any time spent on communication directly related to an independent clinical assessment and report is included within the total time invoiced for that service. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$26.40 flat fee

Item no.	Description	Max fee (excl. GST)
TREATING OSTEOPATH REPORT		
OS820	Treating osteopath report. A written clinical opinion, statement or response to questions relating to the medical status and treatment of a worker, requested in writing by the claims manager, self-insured employer, worker or worker's representative.	$190.30 flat fee
CASE CONFERENCE		
OS870	Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an approved return to work service provider*. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$190.30 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.	$161.50 per hour
RADIOLOGICAL SERVICES (INCLUDING INTERPRETATION BY AN OSTEOPATH)		
OST11	Cervical spine—2 views	$147.70 flat fee
OST13	Thoracic spine—2 views	$125.50 flat fee
OST15	Lumbo-sacral spine 3—6 views	$173.20 flat fee
OST16	Sacro-coccygeal area—2 views	$104.50 flat fee
OST27	Hip joint	$112.90 flat fee
OST28	Pelvic girdle	$142.50 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.	$85.60 flat fee
PT210	Subsequent consultation. Re-assessment, planning education and treatment in accordance with the Clinical Framework for the Delivery of Health Services.	$79.30 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.	$95.30 flat fee
RESTRICTED CONSULTATION		
PT214	Restricted consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Due to the nature of the injury, extra time (up to one hour) is required for history taking, examination, treatment, documenting and liaison. A restricted consultation can only be requested by the treating physiotherapist where a prior consultation has been delivered. Up to 6 sessions may be requested and approval is granted by the claims manager on a case-by-case basis. Maximum 1 hour.	$190.30 per hour Max 1 hour
WORKPLACE VISIT		
PT216	Workplace visit. Review of the worker and workplace demands in accordance with the Clinical Framework for the Delivery of Health Services, for the purposes of determining ongoing treatment needs and where appropriate, review movement patterns and techniques with work duties. The worker is to be present at the visit and for the best outcomes, the claims manager, supervisor/employer should also be present to facilitate a team approach. Maximum 1 hour.	$190.30 per hour Max 1 hour

Item no.	Description	Max fee (excl. GST)
CORRECTIVE/SERIAL SPLINTING		
PT300	Fabrication/fitting/adjustment of a splint.	$190.30 per hour
PT390	Materials used to construct or modify a splint.	Reasonable cost
INDIVIDUAL AQUATIC SESSION		
PT415	Individual aquatic session. A session during which an individual worker is constantly and directly supervised and assessed by the physiotherapist. Maximum 4 sessions.	$66.70 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.	$27.90 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.	$66.70 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.	$19.70 per worker
ENTRY FEE, AQUATIC OR EXERCISE FACILITY		
PT429	Entry fee to an aquatic or exercise facility. Reimbursement to the physiotherapist for an entry fee paid to the aquatic or exercise facility by the physiotherapist, on behalf of a worker. Where a physiotherapist is employed by the facility, item PT429 cannot be charged.	Reasonable cost
PHYSIOTHERAPY MANAGEMENT PLAN		
PTMP	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 claims manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer.	$47.70 flat fee
INDEPENDENT CLINICAL ASSESSMENT AND REPORT		
PT780	Independent clinical assessment and report. An assessment of a worker, by a physiotherapist, other than the treating physiotherapist, and provision of a report for the purpose of providing a clinical opinion on current treatment, comment on the worker's functional ability and make recommendations on future physiotherapy management. This service must be requested in writing by the claims manager, self-insured employer, worker or worker's representative. Maximum 4 hours.	$190.30 per hour Max 4 hours
ACTIVITIES OF DAILY LIVING ASSESSMENT AND REPORT		
PT760	Activities of daily living assessment and report. Assessment of a worker's level of functioning in relation to personal care, household tasks, recreational and social activities. This service includes provision of a report and must be requested in writing by the claims manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the claims manager or self-insured employer. Maximum 5 hours.	$190.30 per hour Max 5 hours
ACTIVITIES OF DAILY LIVING IMPLEMENTATION AND REVIEW		
PT762	Activities of daily living: Implementation and review. Re-assessment and review of a worker's progress in functional ability, the ongoing need for third party services or hired equipment, therapeutic aids or appliances. This service must be requested in writing by the claims manager, self-insured employer or treating medical expert. Where the service is recommended by a medical expert, prior approval must be obtained from the claims manager or self-insured employer. Maximum 2 hours.	$190.30 per hour Max 2 hours
TELEPHONE CALLS		
PT552	Telephone calls relating to the management of the worker's claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator), worker's representative, ReturnToWorkSA advisor, approved return to work service provider* or worker's referring/treating medical practitioner. Any time spent on communication directly related to an independent clinical assessment and report, activities of daily living assessment and report or an activities of daily living re-assessment, is included within the total time invoiced for that service. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$26.40 flat fee

Item no.	Description	Max fee (excl. GST)
TREATING PHYSIOTHERAPY REPORT		
PT820	Treating physiotherapist report. A written clinical opinion, statement or response to questions relating to the medical status and treatment of a worker, requested in writing by the claims manager, self-insured employer, worker or worker's representative.	$190.30 flat fee
CASE CONFERENCE		
PT870	Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an approved return to work service provider*. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$190.30 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.	$161.50 per hour
TRAVEL EXPENSES		
PT907	Travel expenses. Travel expenses incurred for a medical service delivered at the request of the claims manager or self-insured employer, where the provider is required to travel to a destination greater than 100km from the provider's principal place of business or residential address. Car hire can only be charged where the provider travels by aircraft to deliver the service.	Reasonable cost

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.	$190.30 per hour Max 1.5 hours
PS220	Subsequent consultation. Re-assessment, planning, education and treatment in accordance with the Clinical Framework for the Delivery of Health Services. Maximum 1.5 hours.	$190.30 per hour Max 1.5 hours
PSYCHOLOGICAL ASSESSMENT		
PS230	Psychological assessment. Clinical or psychometric assessment and interpretation of results. Maximum 2 hours.	$190.30 per hour Max 2 hours
NEUROPSYCHOLOGICAL ASSESSMENT AND REPORT		
PS232	Neuropsychological assessment and report. Neuropsychological assessment of a worker and provision of a report by a clinical neuropsychologist. This service must be requested in writing by the claims manager or self-insured employer. Maximum 12 hours.	$190.30 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.	$190.30 per hour Max 1.5 hours
GROUP THERAPY		
PS250	Group therapy. Treatment in a group context where attendance includes a group of workers or family members under the continuous and direct supervision of a psychologist. 'Group' means attendance by a minimum of 2 persons and maximum of 15 persons.	$37.70 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 additional treatment is required, or—at the request of the claims manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer.	$47.70 flat fee
INDEPENDENT CLINICAL ASSESSMENT AND REPORT		
PS780	Independent clinical assessment and report. An assessment of a worker by a psychologist, other than the treating psychologist, and provision of a report for the purpose of providing a clinical opinion on current treatment, comment on the worker's functional ability and make recommendations on future psychology managment. This service must be requested in writing by the claims manager, self-insured employer, worker or worker's representative.	$190.30 per hour

Item no.	Description	Max fee (excl. GST)
TELEPHONE CALLS		
PS552	Telephone calls. Telephone calls relating to the management of the worker's claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator), worker's representative, ReturnToWorkSA advisor, approved return to work service provider* or worker's referring/treating medical practitioner. Any time spent on communication directly related to an independent clinical assessment and report is included within the total time invoiced for that service. Maximum 0.5 hours. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$190.30 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 claims manager, self-insured employer, worker or worker s representative. Maximum 4 hours.	$190.30 per hour Max 4 hours
PS820	Treating psychologist summary report. A brief written clinical opinion, statement or response to a limited number of questions relating to the diagnosis, medical status and treatment of a worker, requested in writing by the claims manager, self-insured employer, worker or worker s representative.	$190.30 flat fee
CASE CONFERENCE		
PS870	Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an approved return to work service provider*. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$190.30 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.	$190.30 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.	$190.30 per hour Max 1 hour
SPEECH PATHOLOGY MANAGEMENT PLAN		
E0MP	Speech pathology management plan. A speech pathology management plan completed and submitted by the treating speech pathologist. For claims managed by ReturnToWorkSA or their claims agents, the speech pathologist is expected to submit a plan: - prior to the 11th treatment if more than 10 treatments are likely to be required, or - prior to the expiry of an existing speech pathology management plan if additional treatment is required, or - at the request of the claims manager. For claims managed by self-insured employers, the plan must be requested by the self-insured employer.	$47.70 flat fee

Item no.	Description	Max fee (excl. GST)
TELEPHONE CALLS		
E0552	Telephone calls relating to the management of the worker's claim, or to progress their recovery and return to work, made to or received from, the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator), worker's representative, ReturnToWorkSA advisor, approved return to work service provider* or worker's referring/treating medical practitioner. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$26.40 flat fee
TREATING SPEECH PATHOLOGY REPORT		
E0820	Treating speech pathologist report. A written clinical opinion, statement or response to questions relating to the medical status and treatment of a worker, requested in writing by the claims manager, self-insured employer, worker or worker's representative.	$285.50 flat fee
CASE CONFERENCE		
E0870	Case conference. Attendance at a case conference as requested in writing by the claims manager or self-insured employer, worker's employer (including the employer's return to work coordinator) or an approved return to work service provider*. *An approved return to work service provider means a provider approved by RTWSA to deliver specific recovery/return to work services (e.g. pre-injury employer, fit for work, restoration to the community and return to work assessment) in accordance with conditions set out in the Application for Approval as a South Australian Return to Work Service Provider.	$190.30 per hour
TRAVEL TIME		
E0905	Travel time. Travel by a speech pathologist for the purpose of case conference, home or hospital visit.	$161.50 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 claims 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: $198.20 flat fee Audiometrist: $177.80
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.	$726.80 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.	$1066.90 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	$2020.00 maximum
REHABILITATION AND ADJUSTMENT		
AU104	Rehabilitation and adjustment: The monaural or binaural initial package fee covers rehabilitation and adjustment for 1 year following the initial fitting. Following this period, audiological services may be provided for hearing aid adjustment or rehabilitation to ensure optimal recovery and transition following the previous intervention. Only applicable 12 months after the fitting of a hearing device for a maximum of up to 6 hours of service during the life of the hearing aid, a brief summary of rehabilitation/adjustment to be provided to the claims manager and each service to be rounded to the nearest 6 minutes.	Audiologist $198.20 per hour Audiometrist $177.80 per hour Max 6 hours

Item no.	Description	Max fee (excl. GST)
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., Maximum $100 per hearing device/year	$101.00 maximum
REPORT		
AU105	Standard report: A standard report can only be requested by the claims manager, and should be provided within 10 days of the request. The report should be based on the provider's notes/assessments carried out and would not usually require consultation with the patient.	Audiologist $198.20 flat fee Audiometrist $177.80 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:

Maximum Charge = Rate per day x LOS

where—

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

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

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

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

where—

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

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

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

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

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

PART 3—DAY SURGERY FACILITY SERVICES

4—Day Surgery Facility Services

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

PART 4—TABLES

Table 1

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

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

Item no.	Description	Max fee (excl. GST)
HOSPITAL REHABILITATION SERVICES		
	Rehabilitation orthopaedic program for inpatients	
	Orthopaedic programs involve referral and assessment by the rehabilitation coordinator of the program. It is a defined program with intense service provision. Rapid improvement is expected and there are specific outcome goals. The program includes physiotherapy, aquatic therapy, occupational therapy, case conferences and discharge planning.	
PR600	Rehabilitation orthopaedic program: 1 or more days but not more than 16 days	$844.30
PR605	Rehabilitation orthopaedic program: 17 or more days	$707.90
	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	$1006.80
PR615	Rehabilitation trauma program: 21 or more days	$908.90
PSYCHIATRIC SERVICES		
	Inpatient services	
PR800	Psych inpatient: 1 or more days but not more than 14 days	$810.00
PR803	Psych inpatient: 15 or more days	$623.30
PR822	Psych inpatient: Electro-convulsive therapy (ECT)	$346.70
PR850	Psych inpatient private room allocated on the basis of clinical need	$20.20
	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	$918.30
PR991	Drug & alcohol program—inpatient, 11 or more days	$672.10
	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	$110.50
PRO82	Psych same day ECT day program	$575.70
PRO83	Psych same day half-day program	$294.80
PRO84	Psych same day—day program	$466.50
PRO95	Psych same day outreach	$266.30
OTHER SERVICES		
	Inpatient pain assessment/management	
PR700	Inpatient pain assess/mgmt: 1 or more days but not more than 7 days	$740.90
PR705	Inpatient pain assess/mgmt: 8 or more days but not more than 14 days	$696.10
PR710	Inpatient pain assess/mgmt: 15 or more days	$452.50
	Pain pumps for non-admitted patients	
PR720	Implanted infusion pump, refilling of reservoir, with a therapeutic agent or ag ents, for infusion to the subarachnoid or epidural space, with or without re-pr ogramming of a programmable pump, for the management of chronic intractable pai n for a non-admitted patient.	$257.10

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 (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
801A	OR Procedures Unrelated to Principal Diagnosis, Major Complexity	$19,799.90	7	35	$903.30
801B	OR Procedures Unrelated to Principal Diagnosis, Intermediate Complexity	$9,467.90	3	17	$1,038.30
801C	OR Procedures Unrelated to Principal Diagnosis, Minor Complexity	$3,947.30	0	5	$1,382.60
960Z	Ungroupable	$186.60	0	5	$54.90
961Z	Unacceptable Principal Diagnosis	$1,756.90	0	4	$655.00
A06A	Tracheostomy and/or Ventilation >=96hours, Major Complexity	$131,615.10	17	35	$1,400.00
A06B	Tracheostomy and/or Ventilation >=96hours, Intermediate Complexity	$74,352.50	11	35	$1,400.00
A06C	Tracheostomy and/or Ventilation >=96hours, Minor Complexity	$49,321.00	7	35	$1,400.00
A08A	Autologous Bone Marrow Transplant, Major Complexity	$27,919.00	8	35	$1,187.80
A08B	Autologous Bone Marrow Transplant, Minor Complexity	$7,297.00	2	12	$1,059.60
A11A	Insertion of Implantable Spinal Infusion Device, Major Complexity	$11,096.70	5	30	$701.30
A11B	Insertion of Implantable Spinal Infusion Device, Minor Complexity	$6,010.60	2	11	$1,049.80
A12Z	Insertion of Neurostimulator Device	$5,173.20	0	5	$1,400.00
A40B	ECMO, Minor Complexity	$28,548.30	2	11	$1,400.00
B01A	Ventricular Shunt Revision, Major Complexity	$13,097.50	4	23	$1,054.90
B01B	Ventricular Shunt Revision, Minor Complexity	$7,680.30	2	10	$1,400.00
B02A	Cranial Procedures, Major Complexity	$49,204.10	6	35	$1,400.00
B02B	Cranial Procedures, Intermediate Complexity	$27,866.70	5	32	$1,400.00
B02C	Cranial Procedures, Minor Complexity	$15,101.30	2	14	$1,400.00
B03A	Spinal Procedures, Major Complexity	$15,189.50	3	18	$1,400.00
B03B	Spinal Procedures, Intermediate Complexity	$7,522.50	1	7	$1,400.00
B04A	Extracranial Vascular Procedures, Major Complexity	$16,483.00	3	19	$1,400.00
B04B	Extracranial Vascular Procedures, Intermediate Complexity	$9,175.80	1	8	$1,400.00
B05Z	Carpal Tunnel Release	$1,425.80	0	4	$943.00
B06A	Procedures for Cerebral Palsy, Muscular Dystrophy and Neuropathy, Major Comp	$13,043.10	4	23	$1,101.10
B06B	Procedures for Cerebral Palsy, Muscular Dystrophy and Neuropathy, Interm Comp	$3,548.60	0	4	$1,400.00
B06C	Procedures for Cerebral Palsy, Muscular Dystrophy and Neuropathy, Minor Comp	$1,735.30	1	1	
B07A	Cranial or Peripheral Nerve and Other Nervous System Procedures, Major Comp	$11,689.10	4	22	$965.90
B07B	Cranial or Peripheral Nerve and Other Nervous System Procedures, Minor Comp	$2,813.60	0	4	$1,266.00
B40Z	Plasmapheresis W Neurological Disease, Sameday	$674.50	1	1	
B41Z	Telemetric EEG Monitoring	$2,479.50	0	6	$876.40

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
B42A	Nervous System Disorders W Ventilator Support, Major Complexity	$21,147.80	5	27	$1,400.00
B42B	Nervous System Disorders W Ventilator Support, Minor Complexity	$16,828.50	4	22	$1,400.00
B60A	Acute Paraplegia and Quadriplegia W or W/O OR Procedures, Major Complexity	$32,237.30	10	35	$1,072.10
B60B	Acute Paraplegia and Quadriplegia W or W/O OR Procedures, Minor Complexity	$7,102.20	3	17	$844.00
B61A	Spinal Cord Conditions W or W/O OR Procedures, Major Complexity	$14,412.50	5	29	$938.20
B61B	Spinal Cord Conditions W or W/O OR Procedures, Minor Complexity	$4,085.70	1	7	$928.70
B63Z	Dementia and Other Chronic Disturbances of Cerebral Function	$6,131.60	3	18	$688.20
B64A	Delirium, Major Complexity	$11,677.80	5	31	$752.30
B64B	Delirium, Minor Complexity	$5,174.20	2	14	$781.70
B65A	Cerebral Palsy, Major Complexity	$2,717.30	2	11	$522.60
B65B	Cerebral Palsy, Minor Complexity	$339.30	1	1	
B66A	Nervous System Neoplasms, Major Complexity	$12,039.70	6	35	$702.40
B66B	Nervous System Neoplasms, Minor Complexity	$9,346.00	4	24	$790.60
B66C	Nervous System Neoplasms W/O Radiotherapy W/O Catastrophic or Severe CC	$2,765.50	1	9	$621.70
B67A	Degenerative Nervous System Disorders, Major Complexity	$12,838.10	5	33	$785.50
B67B	Degenerative Nervous System Disorders, Intermediate Complexity	$6,511.80	3	17	$771.50
B67C	Degenerative Nervous System Disorders, Minor Complexity	$335.20	1	1	
B68A	Multiple Sclerosis and Cerebellar Ataxia, Major Complexity	$5,277.70	2	15	$716.10
B68B	Multiple Sclerosis and Cerebellar Ataxia, Minor Complexity	$642.70	0	4	$489.70
B69A	TIA and Precerebral Occlusion, Major Complexity	$6,540.50	3	16	$819.30
B69B	TIA and Precerebral Occlusion, Minor Complexity	$2,497.90	0	6	$842.30
B70A	Stroke and Other Cerebrovascular Disorders, Major Complexity	$12,974.50	6	34	$780.00
B70B	Stroke and Other Cerebrovascular Disorders, Intermediate Complexity	$3,883.70	2	11	$745.20
B70C	Stroke and Other Cerebrovascular Disorders, Minor Complexity	$2,130.00	1	6	$700.40
B70D	Stroke and Other Cerebrovascular Disorders, Transferred <5 Days	$1,975.20	0	5	$894.20
B71A	Cranial and Peripheral Nerve Disorders, Major Complexity	$8,799.60	4	22	$793.70
B71B	Cranial and Peripheral Nerve Disorders, Minor Complexity	$4,780.60	2	12	$782.90
B71C	Cranial and Peripheral Nerve Disorders, Sameday	$508.40	1	1	
B72A	Nervous System Infection Except Viral Meningitis, Major Complexity	$11,363.20	5	28	$809.10
B72B	Nervous System Infection Except Viral Meningitis, Minor Complexity	$2,297.00	1	6	$756.90
B73Z	Viral Meningitis	$3,432.70	1	8	$876.80
B74A	Nontraumatic Stupor and Coma, Major Complexity	$5,821.00	3	19	$625.90
B74B	Nontraumatic Stupor and Coma, Minor Complexity	$1,504.70	0	4	$785.50
B75Z	Febrile Convulsions	$1,107.00	0	4	$1,006.80

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
B76A	Seizures, Major Complexity	$6,256.60	3	18	$693.90
B76B	Seizures, Minor Complexity	$3,355.90	1	8	$836.10
B76C	Seizures, Sameday	$400.80	1	1	
B77Z	Headache	$2,460.00	0	6	$781.80
B78A	Intracranial Injuries, Major Complexity	$13,214.30	5	31	$867.90
B78B	Intracranial Injuries, Minor Complexity	$4,254.80	2	11	$787.20
B78C	Intracranial Injuries, Transferred <5 Days	$3,003.30	0	5	$1,364.90
B79A	Skull Fractures, Major Complexity	$14,334.60	6	34	$853.30
B79B	Skull Fractures, Minor Complexity	$2,149.40	0	6	$737.70
B80A	Other Head Injuries, Major Complexity	$7,362.60	3	20	$755.80
B80B	Other Head Injuries, Minor Complexity	$2,205.80	1	6	$731.50
B81A	Other Disorders of the Nervous System, Major Complexity	$7,530.70	3	21	$736.10
B81B	Other Disorders of the Nervous System, Minor Complexity	$1,607.20	0	5	$636.00
B82A	Chronic & Unspec Para/Quadriplegia W or W/O OR Proc, Major Complexity	$27,069.20	14	35	$605.40
B82B	Chronic & Unspec Para/Quadriplegia W or W/O OR Proc, Intermediate Complexity	$23,718.50	9	35	$855.00
B82C	Chronic & Unspec Para/Quadriplegia W or W/O OR Proc, Minor Complexity	$3,798.70	2	10	$782.40
C01Z	Procedures for Penetrating Eye Injury	$2,788.00	0	4	$1,227.30
C02Z	Enucleations and Orbital Procedures	$3,442.00	0	4	$1,400.00
C03Z	Retinal Procedures	$1,395.00	0	4	$826.20
C04Z	Major Corneal, Scleral and Conjunctival Procedures	$3,120.10	0	4	$1,400.00
C05Z	Dacryocystorhinostomy	$2,307.30	0	4	$1,313.20
C10Z	Strabismus Procedures	$1,726.10	0	4	$1,023.30
C11Z	Eyelid Procedures	$1,856.30	0	4	$1,005.00
C12Z	Other Corneal, Scleral and Conjunctival Procedures	$1,319.20	0	4	$801.30
C13Z	Lacrimal Procedures	$1,000.40	0	4	$536.90
C14Z	Other Eye Procedures	$1,127.50	0	4	$529.90
C15Z	Glaucoma and Complex Cataract Procedures	$2,065.40	0	4	$1,107.20
C16Z	Lens Procedures	$1,814.30	0	4	$1,394.50
C60A	Acute and Major Eye Infections, Major Complexity	$9,194.30	4	25	$739.00
C60B	Acute and Major Eye Infections, Minor Complexity	$3,227.70	1	8	$871.80
C61A	Neurological and Vascular Disorders of the Eye, Major Complexity	$4,522.30	2	12	$769.00
C61B	Neurological and Vascular Disorders of the Eye, Minor Complexity	$1,992.60	0	5	$802.80
C62A	Hyphaema and Medically Managed Trauma to the Eye, Major Complexity	$4,304.00	2	12	$708.60
C62B	Hyphaema and Medically Managed Trauma to the Eye, Minor Complexity	$2,189.40	0	6	$754.70
C63A	Other Disorders of the Eye, Major Complexity	$2,055.10	0	6	$719.70
C63B	Other Disorders of the Eye, Intermediate Complexity	$1,118.30	1	7	$321.80
D01Z	Cochlear Implant	$6,224.80	0	4	$1,400.00
D02A	Head and Neck Procedures, Major Complexity	$14,772.30	2	15	$1,400.00
D02B	Head and Neck Procedures, Intermediate Complexity	$6,256.60	0	6	$1,400.00
D02C	Head and Neck Procedures, Minor Complexity	$3,385.60	0	4	$1,400.00
D03Z	Surgical Repair for Cleft Lip and Palate Disorders	$4,327.60	0	4	$1,400.00
D04Z	Maxillo Surgery	$3,296.40	0	4	$1,400.00

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
D05Z	Parotid Gland Procedures	$5,492.00	0	4	$1,400.00
D06Z	Sinus and Complex Middle Ear Procedures	$3,019.70	0	4	$1,400.00
D10Z	Nasal Procedures	$2,492.80	0	4	$1,693.20
D11Z	Tonsillectomy and Adenoidectomy	$1,799.90	0	4	$1,397.00
D12A	Other Ear, Nose, Mouth and Throat Procedures, Major Complexity	$3,590.60	0	5	$1,105.60
D12B	Other Ear, Nose, Mouth and Throat Procedures, Minor Complexity	$2,063.30	0	4	$1,180.90
D13Z	Myringotomy W Tube Insertion	$1,179.80	0	4	$828.90
D14A	Mouth and Salivary Gland Procedures, Major Complexity	$2,392.40	0	4	$1,042.90
D14B	Mouth and Salivary Gland Procedures, Minor Complexity	$1,528.30	0	4	$1,079.90
D15Z	Mastoid Procedures	$4,125.60	0	4	$1,400.00
D40Z	Dental Extractions and Restorations	$1,085.50	0	4	$944.50
D60A	Ear, Nose, Mouth and Throat Malignancy, Major Complexity	$10,601.60	5	30	$715.70
D60B	Ear, Nose, Mouth and Throat Malignancy, Minor Complexity	$4,719.10	2	12	$753.10
D60C	Ear, Nose, Mouth and Throat Malignancy, Sameday	$1,159.30	1	1	
D61A	Dysequilibrium, Major Complexity	$5,030.70	2	14	$725.70
D61B	Dysequilibrium, Minor Complexity	$3,037.10	1	8	$835.30
D61C	Dysequilibrium, Sameday	$513.50	1	1	
D62A	Epistaxis, Major Complexity	$2,519.50	1	6	$820.60
D62B	Epistaxis, Minor Complexity	$1,130.60	1	1	
D63A	Otitis Media and Upper Respiratory Infections, Major Complexity	$4,976.40	2	13	$799.50
D63B	Otitis Media and Upper Respiratory Infections, Minor Complexity	$2,632.20	1	6	$867.70
D63C	Otitis Media and Upper Respiratory Infections, Sameday	$766.70	1	1	
D64Z	Laryngotracheitis and Epiglottitis	$1,188.00	0	4	$819.50
D65Z	Nasal Trauma and Deformity	$1,630.80	0	4	$705.10
D66A	Other Ear, Nose, Mouth and Throat Disorders, Major Complexity	$3,876.60	2	10	$823.30
D66B	Other Ear, Nose, Mouth and Throat Disorders, Minor Complexity	$986.10	0	4	$724.20
D66C	Other Ear, Nose, Mouth and Throat Disorders, Sameday	$1,062.90	1	1	
D67A	Oral and Dental Disorders, Major Complexity	$4,255.80	2	10	$836.70
D67B	Oral and Dental Disorders, Minor Complexity	$892.80	1	1	
E01A	Major Chest Procedures, Major Complexity	$20,648.60	4	27	$1,400.00
E01B	Major Chest Procedures, Intermediate Complexity	$11,700.40	2	14	$1,400.00
E02A	Other Respiratory System OR Procedures, Major Complexity	$15,593.30	4	25	$1,188.90
E02B	Other Respiratory System OR Procedures, Intermediate Complexity	$6,239.20	1	7	$1,400.00
E02C	Other Respiratory System OR Procedures, Minor Complexity	$2,553.30	0	4	$1,400.00
E40A	Respiratory System Disorders W Ventilator Support, Major Complexity	$26,227.70	6	35	$1,400.00
E40B	Respiratory System Disorders W Ventilator Support, Minor Complexity	$15,114.70	0	6	$1,400.00

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
E41A	Respiratory System Disorders W Non-Invasive Ventilation, Major Complexity	$18,590.40	5	32	$1,185.80
E41B	Respiratory System Disorders W Non-Invasive Ventilation, Minor Complexity	$11,435.90	3	18	$1,294.90
E42A	Bronchoscopy, Major Complexity	$13,666.30	5	32	$846.80
E42B	Bronchoscopy, Minor Complexity	$5,855.80	2	13	$915.40
E42C	Bronchoscopy, Sameday	$1,235.10	1	1	
E60B	Cystic Fibrosis, Minor Complexity	$6,328.40	2	14	$919.30
E61A	Pulmonary Embolism, Major Complexity	$9,233.20	4	23	$804.50
E61B	Pulmonary Embolism, Minor Complexity	$4,547.90	2	10	$918.30
E62A	Respiratory Infections and Inflammations, Major Complexity	$9,644.20	4	24	$806.20
E62B	Respiratory Infections and Inflammations, Minor Complexity	$5,788.20	2	14	$834.60
E62C	Respiratory Infections/Inflammations W/O CC	$3,636.70	1	9	$824.70
E63Z	Sleep Apnoea	$652.90	0	4	$588.00
E64A	Pulmonary Oedema and Respiratory Failure, Major Complexity	$7,770.50	3	18	$871.00
E64B	Pulmonary Oedema and Respiratory Failure, Minor Complexity	$2,976.60	0	4	$1,400.00
E65A	Chronic Obstructive Airways Disease, Major Complexity	$9,208.60	4	25	$754.50
E65B	Chronic Obstructive Airways Disease, Minor Complexity	$4,489.50	2	12	$782.60
E66A	Major Chest Trauma, Major Complexity	$10,268.50	4	26	$795.00
E66B	Major Chest Trauma, Minor Complexity	$5,079.90	2	14	$768.40
E66C	Major Chest Trauma W/O CC	$3,427.60	2	10	$744.10
E67A	Respiratory Signs and Symptoms, Major Complexity	$4,536.70	2	11	$804.50
E67B	Respiratory Signs and Symptoms, Minor Complexity	$1,649.20	0	4	$1,161.60
E68A	Pneumothorax, Major Complexity	$6,150.00	3	18	$704.00
E68B	Pneumothorax, Minor Complexity	$2,620.90	0	6	$894.20
E69A	Bronchitis and Asthma, Major Complexity	$5,713.40	2	15	$801.10
E69B	Bronchitis and Asthma, Minor Complexity	$2,405.70	1	6	$799.80
E70A	Whooping Cough and Acute Bronchiolitis, Major Complexity	$6,394.00	2	14	$968.80
E70B	Whooping Cough and Acute Bronchiolitis, Minor Complexity	$2,651.70	0	5	$1,261.10
E71A	Respiratory Neoplasms, Major Complexity	$9,670.90	4	25	$781.20
E71B	Respiratory Neoplasms, Minor Complexity	$5,142.40	2	14	$738.00
E71C	Respiratory Neoplasms, Sameday	$638.60	1	1	
E72Z	Respiratory Problems Arising from Neonatal Period	$1,822.50	0	4	$1,400.00
E73A	Pleural Effusion, Major Complexity	$9,151.20	4	23	$799.80
E73B	Pleural Effusion, Intermediate Complexity	$4,706.80	2	12	$815.10
E73C	Pleural Effusion, Minor Complexity	$2,289.90	0	6	$801.50
E74A	Interstitial Lung Disease, Major Complexity	$11,214.50	5	30	$749.70
E74B	Interstitial Lung Disease, Minor Complexity	$5,100.40	2	14	$746.00
E74C	Interstitial Lung Disease W/O CC	$2,298.10	1	7	$723.80
E75A	Other Respiratory System Disorders, Major Complexity	$6,185.90	3	16	$810.20
E75B	Other Respiratory System Disorders, Minor Complexity	$3,185.70	1	8	$831.50

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
F01A	Implantation and Replacement of AICD, Total System, Major Complexity	$18,520.70	3	19	$1,400.00
F01B	Implantation and Replacement of AICD, Total System, Minor Complexity	$9,312.10	0	5	$1,400.00
F02Z	Other AICD Procedures	$7,589.10	0	6	$1,400.00
F03A	Cardiac Valve Procedures W CPB Pump W Invasive Cardiac Investigation, Major Comp	$42,599.00	6	35	$1,400.00
F03B	Cardiac Valve Procedures W CPB Pump W Invasive Cardiac Investigation, Minor Comp	$29,323.20	3	20	$1,400.00
F04A	Cardiac Valve Procedures W CPB Pump W/O Invasive Cardiac Invest, Major Comp	$33,858.80	4	25	$1,400.00
F04B	Cardiac Valve Procedures W CPB Pump W/O Invasive Cardiac Invest, Interm Comp	$22,696.60	2	15	$1,400.00
F05A	Coronary Bypass W Invasive Cardiac Investigation, Major Complexity	$38,399.60	5	31	$1,400.00
F05B	Coronary Bypass W Invasive Cardiac Investigation, Minor Complexity	$30,069.40	4	23	$1,400.00
F06A	Coronary Bypass W/O Invasive Cardiac Investigation, Major Complexity	$29,653.30	4	24	$1,400.00
F06B	Coronary Bypass W/O Invasive Cardiac Investigation, Minor Complexity	$25,157.60	3	18	$1,400.00
F07A	Other Cardiothoracic/Vascular Procedures W CPB Pump, Major Complexity	$34,553.80	4	26	$1,400.00
F07B	Other Cardiothoracic/Vascular Procedures W CPB Pump, Intermediate Complexity	$24,863.40	3	18	$1,400.00
F08A	Major Reconstructive Vascular Procedures W/O CPB Pump, Major Complexity	$26,794.50	5	30	$1,400.00
F08B	Major Reconstructive Vascular Procedures W/O CPB Pump, Intermediate Complexity	$12,672.10	2	11	$1,400.00
F09A	Other Cardiothoracic Procedures W/O CPB Pump, Major Complexity	$24,772.20	5	28	$1,400.00
F09B	Other Cardiothoracic Procedures W/O CPB Pump, Intermediate Complexity	$10,254.10	1	7	$1,400.00
F09C	Other Cardiothoracic Procedures W/O CPB Pump, Minor Complexity	$11,490.30	0	4	$1,400.00
F10A	Interventional Coronary Procedures, Admitted for AMI, Major Complexity	$17,839.10	3	18	$1,400.00
F10B	Interventional Coronary Procedures, Admitted for AMI, Minor Complexity	$11,198.10	1	7	$1,400.00
F11A	Amputation, Except Upper Limb and Toe, for Circulatory Disorders, Major Comp	$31,354.80	9	35	$1,058.50
F11B	Amputation, Except Upper Limb and Toe, for Circulatory Disorders, Minor Comp	$20,720.40	6	35	$1,128.90
F12A	Implantation and Replacement of Pacemaker, Total System, Major Complexity	$15,053.20	4	25	$1,108.30
F12B	Implantation and Replacement of Pacemaker, Total System, Minor Complexity	$6,984.40	0	6	$1,400.00
F13A	Amputation, Upper Limb and Toe, for Circulatory Disorders, Major Complexity	$18,586.30	6	35	$917.50
F13B	Amputation, Upper Limb and Toe, for Circulatory Disorders, Minor Complexity	$10,040.90	2	14	$1,315.10
F14A	Vascular Procedures, Except Major Reconstruction, W/O CPB Pump, Major Complexity	$18,070.80	4	24	$1,328.60
F14B	Vascular Procedures, Except Major Reconstruction, W/O CPB Pump, Interm Comp	$7,894.60	0	6	$1,400.00
F14C	Vascular Procedures, Except Major Reconstruction, W/O CPB Pump, Minor Complexity	$5,878.40	0	4	$1,400.00
F15A	Interventional Coronary Procs, Not Adm for AMI, W Stent Implant, Major Comp	$12,259.00	1	8	$1,400.00

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
F15B	Interventional Coronary Procs, Not Adm for AMI, W Stent Implant, Minor Comp	$10,516.50	0	4	$1,400.00
F16A	Interventional Coronary Procs, Not Adm for AMI, W/O Stent Implant, Major Comp	$9,501.80	1	6	$1,400.00
F16B	Interventional Coronary Procs, Not Adm for AMI, W/O Stent Implant, Minor Comp	$8,245.10	0	4	$1,400.00
F17Z	Insertion or Replacement of Pacemaker Generator	$3,553.70	0	4	$1,400.00
F18A	Other Pacemaker Procedures, Major Complexity	$8,940.10	2	12	$1,286.90
F18B	Other Pacemaker Procedures, Minor Complexity	$4,721.20	0	4	$1,400.00
F19A	Trans-Vascular Percutaneous Cardiac Intervention, Major Complexity	$10,674.40	2	11	$1,400.00
F19B	Trans-Vascular Percutaneous Cardiac Intervention, Minor Complexity	$6,607.20	0	4	$1,400.00
F20Z	Vein Ligation and Stripping	$3,678.70	0	4	$1,400.00
F21A	Other Circulatory System OR Procedures, Major Complexity	$20,545.10	7	35	$904.10
F21B	Other Circulatory System OR Procedures, Intermediate Complexity	$6,616.40	2	11	$1,013.60
F40A	Circulatory Disorders W Ventilator Support, Major Complexity	$30,811.50	5	27	$1,400.00
F41A	Circulatory Disorders, Adm for AMI W Invasive Cardiac Inves Proc, Major Comp	$9,570.40	2	14	$1,212.80
F41B	Circulatory Disorders, Adm for AMI W Invasive Cardiac Inves Proc, Minor Comp	$5,785.10	0	6	$1,400.00
F42A	Circulatory Dsrds, Not Adm for AMI W Invasive Cardiac Inves Proc, Major Comp	$8,169.30	2	13	$1,100.60
F42B	Circulatory Dsrds, Not Adm for AMI W Invasive Cardiac Inves Proc, Minor Comp	$5,533.00	0	4	$1,400.00
F42C	Circulatory Dsrds, Not Adm for AMI W Invasive Cardiac Inves, Sameday	$3,303.60	1	1	
F43Z	Circulatory Disorders W Non-Invasive Ventilation	$17,201.60	5	28	$1,239.70
F60A	Circulatory Dsrd, Adm for AMI W/O Invas Card Inves Proc	$3,675.70	2	10	$746.80
F60B	Circulatory Dsrd, Adm for AMI W/O Invas Card Inves Proc, Transf <5 Days	$2,486.70	0	4	$1,400.00
F61A	Infective Endocarditis, Major Complexity	$14,646.20	6	35	$789.10
F61B	Infective Endocarditis, Minor Complexity	$6,869.60	3	17	$828.00
F62A	Heart Failure and Shock, Major Complexity	$11,158.20	4	27	$831.30
F62B	Heart Failure and Shock, Minor Complexity	$5,740.00	2	13	$881.80
F62C	Heart Failure and Shock, Transferred <5 Days	$3,532.20	0	5	$1,400.00
F63A	Venous Thrombosis, Major Complexity	$7,271.40	3	19	$768.20
F63B	Venous Thrombosis, Minor Complexity	$3,066.80	1	8	$839.40
F64A	Skin Ulcers in Circulatory Disorders, Major Complexity	$11,778.30	5	33	$729.30
F64B	Skin Ulcers in Circulatory Disorders, Intermediate Complexity	$5,992.20	3	17	$723.50
F65A	Peripheral Vascular Disorders, Major Complexity	$9,066.10	4	24	$766.70
F65B	Peripheral Vascular Disorders, Minor Complexity	$1,911.60	0	5	$748.60
F66A	Coronary Atherosclerosis, Major Complexity	$4,044.70	2	12	$720.80
F66B	Coronary Atherosclerosis, Minor Complexity	$924.60	0	4	$539.10
F67A	Hypertension, Major Complexity	$5,971.70	2	15	$827.90
F67B	Hypertension, Minor Complexity	$2,967.40	1	8	$819.60
F68Z	Congenital Heart Disease	$1,164.40	0	4	$775.40
F69A	Valvular Disorders, Major Complexity	$6,135.70	3	17	$735.40

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
F69B	Valvular Disorders, Minor Complexity	$1,454.50	0	5	$661.80
F72A	Unstable Angina, Major Complexity	$5,174.20	2	12	$858.00
F72B	Unstable Angina, Minor Complexity	$2,061.30	0	5	$853.00
F73A	Syncope and Collapse, Major Complexity	$7,083.80	3	18	$783.10
F73B	Syncope and Collapse, Minor Complexity	$3,355.90	1	8	$829.80
F73C	Syncope and Collapse, Sameday	$1,299.70	1	1	
F74A	Chest Pain, Major Complexity	$3,077.10	1	8	$786.00
F74B	Chest Pain, Minor Complexity	$1,129.60	0	4	$1,112.70
F75A	Other Circulatory Disorders, Major Complexity	$10,635.40	4	25	$865.60
F75B	Other Circulatory Disorders, Intermediate Complexity	$4,668.90	2	10	$939.00
F75C	Other Circulatory Disorders, Minor Complexity	$1,882.90	0	4	$886.70
F76A	Arrhythmia, Cardiac Arrest and Conduction Disorders, Major Complexity	$7,011.00	3	17	$851.80
F76B	Arrhythmia, Cardiac Arrest and Conduction Disorders, Minor Complexity	$3,027.90	0	6	$1,033.40
F76C	Arrhythmia, Cardiac Arrest and Conduction Disorders, Sameday	$719.60	1	1	
G01A	Rectal Resection, Major Complexity	$23,102.50	5	31	$1,400.00
G01B	Rectal Resection, Intermediate Complexity	$12,317.40	2	14	$1,400.00
G02A	Major Small and Large Bowel Procedures, Major Complexity	$21,192.90	5	29	$1,400.00
G02B	Major Small and Large Bowel Procedures, Intermediate Complexity	$8,575.20	2	10	$1,400.00
G03A	Stomach, Oesophageal and Duodenal Procedures, Major Complexity	$20,858.80	4	23	$1,400.00
G03B	Stomach, Oesophageal and Duodenal Procedures, Intermediate Complexity	$9,185.00	1	7	$1,400.00
G03C	Stomach, Oesophageal and Duodenal Procedures, Minor Complexity	$5,758.50	0	5	$1,400.00
G04A	Peritoneal Adhesiolysis, Major Complexity	$16,646.00	4	26	$1,221.90
G04B	Peritoneal Adhesiolysis, Intermediate Complexity	$9,075.40	1	9	$1,400.00
G04C	Peritoneal Adhesiolysis, Minor Complexity	$5,295.20	0	5	$1,400.00
G05A	Minor Small and Large Bowel Procedures, Major Complexity	$12,539.90	4	25	$969.60
G05B	Minor Small and Large Bowel Procedures, Minor Complexity	$8,343.50	2	13	$1,190.30
G05C	Minor Small and Large Bowel Procedures W/O CC	$5,546.30	1	9	$1,191.10
G07A	Appendicectomy, Major Complexity	$5,237.80	1	7	$1,400.00
G07B	Appendicectomy, Minor Complexity	$3,845.80	0	4	$1,400.00
G10A	Hernia Procedures, Major Complexity	$4,805.20	1	6	$1,343.90
G10B	Hernia Procedures, Minor Complexity	$2,890.50	0	4	$1,400.00
G11Z	Anal and Stomal Procedures	$1,978.30	0	4	$1,041.90
G12A	Other Digestive System OR Procedures, Major Complexity	$16,106.90	6	34	$910.70
G12B	Other Digestive System OR Procedures, Intermediate Complexity	$6,409.30	2	10	$1,196.60
G12C	Other Digestive System OR Procedures, Minor Complexity	$3,085.30	0	5	$1,190.20
G46A	Complex Endoscopy, Major Complexity	$12,163.70	5	30	$792.80
G46B	Complex Endoscopy, Minor Complexity	$3,449.10	0	6	$1,156.20
G46C	Complex Endoscopy, Sameday	$973.80	1	1	
G47A	Gastroscopy, Major Complexity	$10,902.90	5	29	$742.30

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
G47B	Gastroscopy, Intermediate Complexity	$3,632.60	1	8	$973.00
G47C	Gastroscopy, Minor Complexity	$666.30	1	1	
G48A	Colonoscopy, Major Complexity	$7,235.50	3	16	$914.90
G48B	Colonoscopy, Minor Complexity	$2,353.40	0	4	$1,106.00
G48C	Colonoscopy, Sameday	$866.10	1	1	
G60A	Digestive Malignancy, Major Complexity	$8,770.90	4	24	$742.30
G60B	Digestive Malignancy, Minor Complexity	$3,142.70	2	9	$685.00
G61A	Gastrointestinal Haemorrhage, Major Complexity	$6,656.40	3	18	$743.90
G61B	Gastrointestinal Haemorrhage, Minor Complexity	$2,479.50	0	6	$846.50
G64A	Inflammatory Bowel Disease, Major Complexity	$2,973.50	1	7	$843.80
G64B	Inflammatory Bowel Disease, Minor Complexity	$487.90	0	4	$438.50
G65A	Gastrointestinal Obstruction, Major Complexity	$7,151.40	3	19	$773.70
G65B	Gastrointestinal Obstruction, Minor Complexity	$3,241.10	1	8	$849.40
G66A	Abdominal Pain and Mesenteric Adenitis, Major Complexity	$2,532.80	1	7	$806.10
G66B	Abdominal Pain and Mesenteric Adenitis, Minor Complexity	$725.70	1	1	
G67A	Oesophagitis and Gastroenteritis, Major Complexity	$6,267.90	3	16	$811.20
G67B	Oesophagitis and Gastroenteritis, Minor Complexity	$2,427.20	1	6	$805.10
G70A	Other Digestive System Disorders, Major Complexity	$6,626.60	3	17	$775.20
G70B	Other Digestive System Disorders, Minor Complexity	$2,935.60	1	8	$807.90
G70C	Other Digestive System Disorders, Sameday	$807.70	1	1	
H01A	Pancreas, Liver and Shunt Procedures, Major Complexity	$27,214.80	5	31	$1,400.00
H01B	Pancreas, Liver and Shunt Procedures, Intermediate Complexity	$12,086.80	2	11	$1,400.00
H02A	Major Biliary Tract Procedures, Major Complexity	$22,428.00	5	33	$1,267.00
H02B	Major Biliary Tract Procedures, Minor Complexity	$8,119.00	2	10	$1,376.40
H05A	Hepatobiliary Diagnostic Procedures, Major Complexity	$15,707.10	5	30	$1,004.30
H05B	Hepatobiliary Diagnostic Procedures, Minor Complexity	$3,470.70	0	4	$1,400.00
H06A	Other Hepatobiliary and Pancreas OR Procedures, Major Complexity	$12,550.10	4	22	$1,094.60
H06B	Other Hepatobiliary and Pancreas OR Procedures, Intermediate Complexity	$5,973.70	0	5	$1,400.00
H07A	Open Cholecystectomy, Major Complexity	$19,063.00	5	30	$1,237.80
H07B	Open Cholecystectomy, Intermediate Complexity	$8,461.40	2	10	$1,400.00
H08A	Laparoscopic Cholecystectomy, Major Complexity	$7,486.60	1	9	$1,400.00
H08B	Laparoscopic Cholecystectomy, Minor Complexity	$4,232.20	0	4	$1,400.00
H40A	Endoscopic Procedures for Bleeding Oesophageal Varices, Major Complexity	$10,414.00	3	19	$1,125.20
H40B	Endoscopic Procedures for Bleeding Oesophageal Varices, Intermediate Complexity	$3,613.10	1	6	$1,165.70
H43A	ERCP Procedures, Major Complexity	$9,633.00	3	19	$937.00
H43B	ERCP Procedures, Intermediate Complexity	$3,897.10	0	6	$1,157.80
H43C	ERCP Procedures, Minor Complexity	$2,256.00	1	1	
H60A	Cirrhosis and Alcoholic Hepatitis, Major Complexity	$11,795.70	5	30	$786.20
H60B	Cirrhosis and Alcoholic Hepatitis, Intermediate Complexity	$5,343.30	2	13	$826.20
H60C	Cirrhosis and Alcoholic Hepatitis, Minor Complexity	$661.10	1	1	

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
H61A	Malignancy of Hepatobiliary System and Pancreas, Major Complexity	$9,347.00	4	25	$752.70
H61B	Malignancy of Hepatobiliary System and Pancreas, Minor Complexity	$5,069.70	2	15	$703.80
H61C	Malignancy of Hepatobiliary System and Pancreas, Sameday	$942.00	1	1	
H62A	Disorders of Pancreas, Except Malignancy, Major Complexity	$8,312.80	3	19	$901.60
H62B	Disorders of Pancreas, Except Malignancy, Minor Complexity	$2,388.30	0	6	$831.20
H63A	Other Disorders of Liver, Major Complexity	$8,319.90	3	21	$803.00
H63B	Other Disorders of Liver, Intermediate Complexity	$4,325.50	2	11	$798.10
H63C	Other Disorders of Liver, Minor Complexity	$747.20	1	1	
H64A	Disorders of the Biliary Tract, Major Complexity	$6,556.90	3	17	$762.10
H64B	Disorders of the Biliary Tract, Minor Complexity	$2,808.50	1	7	$863.10
H64C	Disorders of the Biliary Tract, Sameday	$701.10	1	1	
I01A	Bilateral and Multiple Major Joint Procedures of Lower Limb, Major Complexity	$23,212.20	6	34	$1,173.30
I01B	Bilateral and Multiple Major Joint Procedures of Lower Limb, Minor Complexity	$13,887.70	2	12	$1,400.00
I02A	Microvascular Tissue Transfers or Skin Grafts, Excluding Hand, Major Complexity	$25,710.10	7	35	$1,035.30
I02B	Microvascular Tissue Transfers or Skin Grafts, Excluding Hand, Intermediate Comp	$5,526.80	1	7	$1,317.50
I03A	Hip Replacement, Major Complexity	$17,473.20	4	25	$1,325.50
I03B	Hip Replacement, Minor Complexity	$10,972.60	2	10	$1,400.00
I04A	Knee Replacement, Major Complexity	$12,499.90	2	15	$1,400.00
I04B	Knee Replacement, Minor Complexity	$10,141.40	2	10	$1,400.00
I05A	Other Joint Replacement, Major Complexity	$11,492.30	3	16	$1,351.50
I05B	Other Joint Replacement, Minor Complexity	$7,563.50	1	7	$1,400.00
I06Z	Spinal Fusion for Deformity	$22,520.30	3	21	$1,400.00
I07Z	Amputation	$18,047.20	5	32	$1,079.50
I08A	Other Hip and Femur Procedures, Major Complexity	$19,203.40	6	35	$1,020.00
I08B	Other Hip and Femur Procedures, Minor Complexity	$6,988.50	1	9	$1,400.00
I09A	Spinal Fusion, Major Complexity	$24,257.70	5	29	$1,400.00
I09B	Spinal Fusion, Intermediate Complexity	$13,361.90	2	12	$1,400.00
I10A	Other Back and Neck Procedures, Major Complexity	$11,570.20	2	14	$1,400.00
I10B	Other Back and Neck Procedures, Minor Complexity	$7,019.20	1	6	$1,400.00
I11Z	Limb Lengthening Procedures	$7,644.50	1	9	$1,400.00
I12A	Misc Musculoskeletal Procs for Infect/Inflam of Bone/Joint, Major Complexity	$20,431.30	7	35	$923.70
I12B	Misc Musculoskeletal Procs for Infect/Inflam of Bone/Joint, Intermediate Comp	$10,357.60	3	20	$935.50
I12C	Misc Musculoskeletal Procs for Infect/Inflam of Bone/Joint, Minor Complexity	$4,390.10	1	7	$1,137.10
I13A	Humerus, Tibia, Fibula and Ankle Procedures, Major Complexity	$9,143.00	2	15	$1,110.90
I13B	Humerus, Tibia, Fibula and Ankle Procedures, Minor Complexity	$4,153.30	0	5	$1,400.00
I13C	Humerus, Tibia, Fibula and Ankle Procedures W/O CC, Age <17	$3,504.50	0	4	$1,400.00
I15Z	Cranio-Facial Surgery	$10,560.60	2	11	$1,400.00
I16Z	Other Shoulder Procedures	$3,735.20	0	4	$1,400.00

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
I17A	Maxillo-Facial Surgery, Major Complexity	$6,517.00	1	7	$1,400.00
I17B	Maxillo-Facial Surgery, Minor Complexity	$4,375.70	0	4	$1,400.00
I18Z	Other Knee Procedures	$2,120.70	0	4	$1,355.30
I19A	Other Elbow and Forearm Procedures, Major Complexity	$5,836.40	2	9	$1,109.50
I19B	Other Elbow and Forearm Procedures, Minor Complexity	$3,199.00	0	4	$1,400.00
I20Z	Other Foot Procedures	$3,102.70	0	4	$1,400.00
I21Z	Local Excision and Removal of Internal Fixation Devices of Hip and Femur	$2,521.50	0	4	$1,400.00
I23Z	Local Excision and Removal of Internal Fixation Devices, Except Hip and Femur	$1,851.20	0	4	$1,008.90
I24Z	Arthroscopy	$2,350.30	0	4	$1,216.70
I25A	Bone and Joint Diagnostic Procedures Including Biopsy, Major Complexity	$9,041.50	4	22	$812.30
I25B	Bone and Joint Diagnostic Procedures Including Biopsy, Minor Complexity	$2,552.30	0	4	$1,076.80
I27A	Soft Tissue Procedures, Major Complexity	$10,285.90	3	21	$910.30
I27B	Soft Tissue Procedures, Minor Complexity	$3,409.20	0	4	$1,400.00
I27C	Soft Tissue Procedures, Sameday	$1,757.90	1	1	
I28A	Other Musculoskeletal Procedures, Major Complexity	$10,138.30	3	19	$1,001.00
I28B	Other Musculoskeletal Procedures, Intermediate Complexity	$2,963.30	0	4	$1,400.00
I29Z	Knee Reconstructions, and Revisions of Reconstructions	$3,450.20	0	4	$1,400.00
I30Z	Hand Procedures	$2,019.30	0	4	$1,095.90
I31A	Revision of Hip Replacement, Major Complexity	$23,811.80	6	35	$1,184.60
I31B	Revision of Hip Replacement, Intermediate Complexity	$14,289.50	2	14	$1,400.00
I32A	Revision of Knee Replacement, Major Complexity	$18,923.60	6	34	$1,024.60
I32B	Revision of Knee Replacement, Minor Complexity	$10,920.40	2	11	$1,400.00
I40Z	Infusions for Musculoskeletal Disorders, Sameday	$897.90	1	1	
I60Z	Femoral Shaft Fractures	$14,704.70	7	35	$728.00
I61A	Distal Femoral Fractures, Major Complexity	$17,026.30	8	35	$678.20
I61B	Distal Femoral Fractures, Minor Complexity	$11,262.70	5	32	$703.10
I63A	Sprains, Strains and Dislocations of Hip, Pelvis and Thigh, Major Complexity	$8,874.50	4	26	$701.30
I63B	Sprains, Strains and Dislocations of Hip, Pelvis and Thigh, Minor Complexity	$4,685.30	2	12	$787.60
I64A	Osteomyelitis, Major Complexity	$12,207.80	6	35	$699.00
I64B	Osteomyelitis, Minor Complexity	$8,055.50	4	22	$738.60
I65A	Musculoskeletal Malignant Neoplasms, Major Complexity	$12,442.50	6	34	$737.40
I65B	Musculoskeletal Malignant Neoplasms, Minor Complexity	$7,087.90	3	18	$811.90
I66A	Inflammatory Musculoskeletal Disorders, Major Complexity	$10,637.50	5	28	$762.30
I66B	Inflammatory Musculoskeletal Disorders, Intermediate Complexity	$5,341.30	2	14	$773.40
I67A	Septic Arthritis, Major Complexity	$11,983.30	6	35	$676.00
I67B	Septic Arthritis, Minor Complexity	$7,385.10	4	21	$695.10
I68A	Non-surgical Spinal Disorders, Major Complexity	$9,912.80	4	26	$758.60

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
I68B	Non-surgical Spinal Disorders, Minor Complexity	$5,490.90	2	14	$800.10
I69A	Bone Diseases and Arthropathies, Major Complexity	$9,563.30	4	26	$740.50
I69B	Bone Diseases and Arthropathies, Minor Complexity	$7,187.30	3	19	$755.70
I71A	Other Musculotendinous Disorders, Major Complexity	$8,316.90	4	24	$714.20
I71B	Other Musculotendinous Disorders, Minor Complexity	$4,374.70	2	12	$747.80
I72A	Specific Musculotendinous Disorders, Major Complexity	$11,256.60	5	32	$720.40
I72B	Specific Musculotendinous Disorders, Minor Complexity	$6,281.20	3	17	$734.70
I73A	Aftercare of Musculoskeletal Implants or Prostheses, Major Complexity	$12,323.60	6	35	$646.50
I73B	Aftercare of Musculoskeletal Implants or Prostheses, Minor Complexity	$6,632.80	3	19	$713.40
I74A	Injuries to Forearm, Wrist, Hand and Foot, Major Complexity	$11,369.30	5	31	$736.40
I74B	Injuries to Forearm, Wrist, Hand and Foot, Minor Complexity	$5,019.40	2	13	$756.60
I75A	Injuries to Shoulder, Arm, Elbow, Knee, Leg and Ankle, Major Complexity	$13,102.60	6	35	$715.10
I75B	Injuries to Shoulder, Arm, Elbow, Knee, Leg and Ankle, Minor Complexity	$7,698.80	3	21	$743.90
I76A	Other Musculoskeletal Disorders, Major Complexity	$11,908.50	5	32	$762.30
I76B	Other Musculoskeletal Disorders, Intermediate Complexity	$6,827.50	3	18	$767.60
I77A	Fractures of Pelvis, Major Complexity	$13,779.10	6	35	$752.40
I77B	Fractures of Pelvis, Minor Complexity	$9,838.00	4	26	$768.50
I78A	Fractures of Neck of Femur, Major Complexity	$15,523.60	7	35	$696.00
I78B	Fractures of Neck of Femur, Minor Complexity	$11,806.00	5	33	$724.00
I79A	Pathological Fractures, Major Complexity	$12,522.40	6	35	$703.80
I79B	Pathological Fractures, Minor Complexity	$8,599.80	4	23	$746.00
I80Z	Femoral Fractures, Transferred to Acute Facility <2 Days	$1,302.80	0	4	$1,302.70
I81Z	Musculoskeletal Injuries, Sameday	$266.50	1	1	
I82Z	Other Sameday Treatment for Musculoskeletal Disorders	$348.50	1	1	
J01A	Microvas Tiss Transf for Skin, Subcut Tiss & Breast Dsrds, Major Complexity	$21,652.10	4	22	$1,400.00
J01B	Microvas Tiss Transf for Skin, Subcut Tiss & Breast Dsrds, Minor Complexity	$17,228.20	2	14	$1,400.00
J06A	Major Procedures for Breast Disorders, Major Complexity	$5,168.10	0	5	$1,400.00
J06B	Major Procedures for Breast Disorders, Minor Complexity	$3,923.70	0	4	$1,400.00
J07A	Minor Procedures for Breast Disorders, Major Complexity	$2,397.50	0	4	$1,234.60
J07B	Minor Procedures for Breast Disorders, Minor Complexity	$1,847.10	0	4	$1,090.70
J08A	Other Skin Grafts and Debridement Procedures, Major Complexity	$8,921.60	3	16	$1,016.40
J08B	Other Skin Grafts and Debridement Procedures, Intermediate Complexity	$3,477.80	0	5	$1,292.40
J08C	Other Skin Grafts and Debridement Procedures, Minor Complexity	$1,932.10	1	1	
J09Z	Perianal and Pilonidal Procedures	$2,091.00	0	4	$937.40

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
J10Z	Plastic OR Procedures for Skin, Subcutaneous Tissue and Breast Disorders	$2,463.10	0	4	$1,132.30
J11Z	Other Skin, Subcutaneous Tissue and Breast Procedures	$1,452.40	0	4	$762.30
J12A	Lower Limb Procedures W Ulcer or Cellulitis, Major Complexity	$22,348.10	8	35	$944.30
J12B	Lower Limb Procedures W Ulcer or Cellulitis, Minor Complexity	$11,495.40	4	23	$906.60
J12C	Lower Limb Procs W Ulcer/Cellulitis W/O Cat CC W/O Skin Graft/Flap Repair	$8,192.80	2	14	$1,076.60
J13A	Lower Limb Procedures W/O Ulcer or Cellulitis, Major Complexity	$9,775.40	3	21	$857.50
J13B	Lower Limb Procedures W/O Ulcer or Cellulitis, Minor Complexity	$3,632.60	0	6	$1,038.80
J14Z	Major Breast Reconstructions	$9,751.90	2	11	$1,400.00
J60A	Skin Ulcers, Major Complexity	$12,551.10	6	35	$673.30
J60B	Skin Ulcers, Intermediate Complexity	$8,662.30	4	22	$792.30
J60C	Skin Ulcers, Minor Complexity	$347.50	1	1	
J62A	Malignant Breast Disorders, Major Complexity	$4,571.50	2	14	$657.80
J62B	Malignant Breast Disorders, Minor Complexity	$248.10	1	1	
J63A	Non-Malignant Breast Disorders, Major Complexity	$3,247.20	1	8	$796.20
J63B	Non-Malignant Breast Disorders, Minor Complexity	$813.90	1	1	
J64A	Cellulitis, Major Complexity	$8,711.50	4	23	$780.30
J64B	Cellulitis, Minor Complexity	$4,039.50	2	10	$805.10
J65A	Trauma to Skin, Subcutaneous Tissue and Breast, Major Complexity	$8,367.10	4	23	$725.00
J65B	Trauma to Skin, Subcutaneous Tissue and Breast, Minor Complexity	$4,584.80	2	11	$820.70
J65C	Trauma to Skin, Subcutaneous Tissue and Breast, Sameday	$538.10	1	1	
J67A	Minor Skin Disorders, Major Complexity	$5,867.10	2	15	$809.70
J67B	Minor Skin Disorders, Minor Complexity	$779.00	1	1	
J68A	Major Skin Disorders, Major Complexity	$8,454.20	4	23	$757.60
J68B	Major Skin Disorders, Minor Complexity	$4,701.70	2	11	$917.10
J68C	Major Skin Disorders, Sameday	$396.70	1	1	
J69A	Skin Malignancy, Major Complexity	$11,759.80	5	32	$742.00
J69B	Skin Malignancy, Intermediate Complexity	$7,198.60	4	22	$676.30
J69C	Skin Malignancy, Minor Complexity	$393.60	1	1	
K01A	OR Procedures for Diabetic Complications, Major Complexity	$30,620.90	11	35	$865.90
K01B	OR Procedures for Diabetic Complications, Intermediate Complexity	$14,366.40	4	22	$1,246.40
K02A	Pituitary Procedures, Major Complexity	$16,176.60	3	16	$1,400.00
K02B	Pituitary Procedures, Minor Complexity	$13,480.80	2	11	$1,400.00
K03Z	Adrenal Procedures	$9,465.90	1	7	$1,400.00
K05A	Parathyroid Procedures, Major Complexity	$6,476.00	1	8	$1,400.00
K05B	Parathyroid Procedures, Minor Complexity	$4,016.00	0	4	$1,400.00
K06A	Thyroid Procedures, Major Complexity	$6,632.80	0	6	$1,400.00
K06B	Thyroid Procedures, Minor Complexity	$4,642.20	0	4	$1,400.00
K08Z	Thyroglossal Procedures	$3,238.00	0	4	$1,400.00
K09A	Other Endocrine, Nutritional and Metabolic OR Procedures, Major Complexity	$17,332.80	6	35	$878.30

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
K09B	Other Endocrine, Nutritional and Metabolic OR Procedures, Minor Complexity	$11,812.10	3	17	$1,309.00
K09C	Other Endocrine, Nutritional and Metabolic OR Procs W/O CC	$7,501.00	1	7	$1,400.00
K10A	Revisional and Open Bariatric Procedures, Major Complexity	$7,403.60	1	7	$1,400.00
K10B	Revisional and Open Bariatric Procedures, Minor Complexity	$6,329.40	0	5	$1,400.00
K11A	Major Laparoscopic Bariatric Procedures, Major Complexity	$7,061.20	0	6	$1,400.00
K11B	Major Laparoscopic Bariatric Procedures, Minor Complexity	$6,134.60	0	5	$1,400.00
K12Z	Other Bariatric Procedures	$4,886.20	0	4	$1,400.00
K13Z	Plastic OR Procedures for Endocrine, Nutritional and Metabolic Disorders	$6,822.40	1	8	$1,367.60
K40A	Endoscopic and Investigative Procedures for Metabolic Disorders, Major Comp	$12,764.30	6	34	$745.90
K40B	Endoscopic and Investigative Procedures for Metabolic Disorders, Minor Comp	$3,332.30	0	6	$1,094.30
K40C	Endoscopic and Investigative Procs for Metabolic Disorders, Sameday	$927.60	1	1	
K60A	Diabetes, Major Complexity	$9,770.30	4	24	$807.50
K60B	Diabetes, Minor Complexity	$4,863.60	2	12	$806.10
K60C	Diabetes, Sameday	$452.00	1	1	
K61Z	Severe Nutritional Disturbance	$8,253.30	3	20	$845.70
K62A	Miscellaneous Metabolic Disorders, Major Complexity	$7,593.20	3	19	$804.20
K62B	Miscellaneous Metabolic Disorders, Intermediate Complexity	$3,592.60	1	8	$895.00
K62C	Miscellaneous Metabolic Disorders, Minor Complexity	$452.00	1	1	
K63A	Inborn Errors of Metabolism, Major Complexity	$10,872.20	4	26	$846.90
K63B	Inborn Errors of Metabolism, Minor Complexity	$1,383.80	0	4	$940.10
K64A	Endocrine Disorders, Major Complexity	$8,268.70	3	21	$801.30
K64B	Endocrine Disorders, Minor Complexity	$3,598.80	2	9	$797.10
K64C	Endocrine Disorders, Sameday	$316.70	1	1	
L02A	Operative Insertion of Peritoneal Catheter for Dialysis, Major Complexity	$9,131.70	2	15	$1,176.20
L02B	Operative Insertion of Peritoneal Catheter for Dialysis, Minor Complexity	$3,103.70	0	4	$1,400.00
L03A	Kidney, Ureter and Major Bladder Procedures for Neoplasm, Major Complexity	$21,451.20	4	26	$1,400.00
L03B	Kidney, Ureter and Major Bladder Procedures for Neoplasm, Intermediate Comp	$14,507.90	2	13	$1,400.00
L03C	Kidney, Ureter and Major Bladder Procedures for Neoplasm, Minor Complexity	$8,879.60	1	8	$1,400.00
L04A	Kidney, Ureter and Major Bladder Procedures for Non-Neoplasm, Major Complexity	$15,627.20	4	27	$1,107.10
L04B	Kidney, Ureter and Major Bladder Procedures for Non-Neoplasm, Intermediate Comp	$4,611.50	0	4	$1,400.00
L04C	Kidney, Ureter and Major Bladder Procedures for Non-Neoplasm, Minor Complexity	$1,877.80	1	1	
L05A	Transurethral Prostatectomy for Urinary Disorder, Major Complexity	$10,722.50	3	18	$1,142.10
L05B	Transurethral Prostatectomy for Urinary Disorder, Minor Complexity	$4,626.90	0	6	$1,400.00

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
L06A	Minor Bladder Procedures, Major Complexity	$8,712.50	3	17	$989.10
L06B	Minor Bladder Procedures, Intermediate Complexity	$2,819.80	0	4	$1,283.60
L07A	Other Transurethral Procedures, Major Complexity	$3,421.50	0	6	$1,024.50
L07B	Other Transurethral Procedures, Minor Complexity	$1,911.60	0	4	$1,223.20
L08A	Urethral Procedures, Major Complexity	$3,200.10	0	5	$1,172.40
L08B	Urethral Procedures, Minor Complexity	$2,009.00	0	4	$1,220.40
L09A	Other Procedures for Kidney and Urinary Tract Disorders, Major Complexity	$21,975.00	6	35	$1,153.30
L09B	Other Procedures for Kidney and Urinary Tract Disorders, Intermediate Complexity	$5,483.80	1	7	$1,400.00
L09C	Other Procedures for Kidney and Urinary Tract Disorders, Minor Complexity	$2,901.80	0	4	$1,400.00
L40Z	Ureteroscopy	$2,234.50	0	4	$1,091.90
L41Z	Cystourethroscopy for Urinary Disorder, Sameday	$911.20	1	1	
L42Z	ESW Lithotripsy	$2,768.50	0	4	$2,652.00
L60A	Kidney Failure, Major Complexity	$12,349.20	4	27	$920.00
L60B	Kidney Failure, Intermediate Complexity	$6,158.20	2	15	$838.10
L60C	Kidney Failure, Minor Complexity	$3,365.10	1	8	$830.20
L61Z	Haemodialysis	$963.50	0	4	$960.50
L62A	Kidney and Urinary Tract Neoplasms, Major Complexity	$6,556.90	3	19	$713.60
L62B	Kidney and Urinary Tract Neoplasms, Minor Complexity	$1,823.50	0	6	$640.50
L63A	Kidney and Urinary Tract Infections, Major Complexity	$7,301.10	3	19	$789.30
L63B	Kidney and Urinary Tract Infections, Minor Complexity	$3,615.20	1	9	$833.10
L64A	Urinary Stones and Obstruction, Major Complexity	$4,711.90	2	13	$685.00
L64B	Urinary Stones and Obstruction, Minor Complexity	$2,041.80	0	4	$989.80
L64C	Urinary Stones and Obstruction, Sameday	$911.20	1	1	
L65A	Kidney and Urinary Tract Signs and Symptoms, Major Complexity	$6,811.10	3	17	$819.10
L65B	Kidney and Urinary Tract Signs and Symptoms, Minor Complexity	$1,926.00	0	5	$784.50
L66Z	Urethral Stricture	$1,820.40	0	4	$947.40
L67A	Other Kidney and Urinary Tract Disorders, Major Complexity	$6,833.70	3	16	$834.90
L67B	Other Kidney and Urinary Tract Disorders, Intermediate Complexity	$2,098.20	0	5	$848.90
L67C	Other Kidney and Urinary Tract Disorders, Minor Complexity	$504.30	1	1	
L68Z	Peritoneal Dialysis	$0.00	0	4	$0.00
M01A	Major Male Pelvic Procedures, Major Complexity	$11,331.40	2	10	$1,400.00
M01B	Major Male Pelvic Procedures, Minor Complexity	$9,097.90	0	5	$1,400.00
M02A	Transurethral Prostatectomy for Reproductive System Disorder, Major Complexity	$7,866.90	2	12	$1,242.90
M02B	Transurethral Prostatectomy for Reproductive System Disorder, Minor Complexity	$4,316.30	0	5	$1,400.00
M03Z	Penis Procedures	$2,622.00	0	4	$1,368.10
M04Z	Testes Procedures	$1,985.40	0	4	$1,139.60
M05Z	Circumcision	$1,262.80	0	4	$823.90
M06A	Other Male Reproductive System OR Procedures, Major Complexity	$4,388.00	1	6	$1,156.10

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
M06B	Other Male Reproductive System OR Procedures, Minor Complexity	$3,143.70	0	4	$1,400.00
M40Z	Cystourethroscopy for Male Reproductive System Disorder, Sameday	$914.30	1	1	
M60A	Male Reproductive System Malignancy, Major Complexity	$7,110.40	3	19	$749.30
M60B	Male Reproductive System Malignancy, Minor Complexity	$1,068.10	0	4	$639.30
M61A	Benign Prostatic Hypertrophy, Major Complexity	$4,937.40	2	13	$778.30
M61B	Benign Prostatic Hypertrophy, Minor Complexity	$1,198.20	0	4	$719.60
M62A	Male Reproductive System Inflammation, Major Complexity	$5,267.50	2	14	$739.00
M62B	Male Reproductive System Inflammation, Minor Complexity	$2,284.70	0	6	$823.90
M63Z	Male Sterilisation Procedures	$1,043.50	0	4	$788.60
M64Z	Other Male Reproductive System Disorders	$1,080.40	0	4	$648.30
N01A	Pelvic Evisceration and Radical Vulvectomy, Major Complexity	$14,003.60	3	18	$1,400.00
N01B	Pelvic Evisceration and Radical Vulvectomy, Minor Complexity	$9,131.70	1	8	$1,400.00
N04A	Hysterectomy for Non-Malignancy, Major Complexity	$7,387.20	1	9	$1,400.00
N04B	Hysterectomy for Non-Malignancy, Minor Complexity	$5,984.00	0	6	$1,400.00
N05A	Oophorectomy and Complex Fallopian Tube Procedures for Non-Malignancy, Maj Comp	$6,969.00	1	7	$1,400.00
N05B	Oophorectomy and Complex Fallopian Tube Procedures for Non-Malignancy, Min Comp	$3,878.60	0	4	$1,400.00
N06Z	Female Reproductive System Reconstructive Procedures	$4,419.80	0	5	$1,400.00
N07A	Other Uterus and Adnexa Procedures for Non-Malignancy, Major Complexity	$3,397.90	0	4	$1,400.00
N07B	Other Uterus and Adnexa Procedures for Non-Malignancy, Minor Complexity	$1,711.80	1	1	
N08Z	Endoscopic and Laparoscopic Procedures, Female Reproductive System	$2,483.60	0	4	$1,400.00
N09Z	Other Vagina, Cervix and Vulva Procedures	$1,367.40	0	4	$825.40
N10Z	Diagnostic Curettage and Diagnostic Hysteroscopy	$1,194.10	0	4	$902.40
N11Z	Other Female Reproductive System OR Procedures	$646.80	0	4	$499.50
N12A	Uterus and Adnexa Procedures for Malignancy, Major Complexity	$14,509.90	3	18	$1,400.00
N12B	Uterus and Adnexa Procedures for Malignancy, Intermediate Complexity	$6,918.80	1	6	$1,400.00
N60A	Female Reproductive System Malignancy, Major Complexity	$9,500.70	4	26	$728.00
N60B	Female Reproductive System Malignancy, Minor Complexity	$2,980.70	2	10	$636.80
N61Z	Female Reproductive System Infections	$3,025.80	1	8	$797.10
N62Z	Menstrual and Other Female Reproductive System Disorders	$1,075.20	0	4	$656.00
O01A	Caesarean Delivery, Major Complexity	$10,596.50	3	18	$1,167.60
O01B	Caesarean Delivery, Intermediate Complexity	$8,119.00	2	12	$1,396.50
O01C	Caesarean Delivery, Minor Complexity	$7,264.20	2	10	$1,400.00
O02A	Vaginal Delivery W OR Procedures, Major Complexity	$7,713.10	2	11	$1,400.00

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
O02B	Vaginal Delivery W OR Procedures, Minor Complexity	$6,436.00	2	10	$1,376.60
O03A	Ectopic Pregnancy, Major Complexity	$3,480.90	0	4	$1,400.00
O03B	Ectopic Pregnancy, Minor Complexity	$2,812.60	0	4	$1,400.00
O04A	Postpartum and Post Abortion W OR Procedures, Major Complexity	$4,811.40	2	9	$974.20
O04B	Postpartum and Post Abortion W OR Procedures, Minor Complexity	$3,059.60	0	5	$1,169.20
O04C	Postpartum and Post Abortion W OR Procedures, Sameday	$1,340.70	1	1	
O05Z	Abortion W OR Procedures	$1,032.20	0	4	$848.80
O60A	Vaginal Delivery, Major Complexity	$6,102.90	2	11	$1,142.90
O60B	Vaginal Delivery, Intermediate Complexity	$5,449.90	1	9	$1,231.50
O60C	Vaginal Delivery, Minor Complexity	$5,181.40	1	8	$1,321.30
O61Z	Postpartum and Post Abortion W/O OR Procedures	$2,412.90	1	6	$801.10
O63Z	Abortion W/O OR Procedures	$910.20	0	4	$736.20
O66A	Antenatal and Other Obstetric Admissions, Major Complexity	$3,165.20	1	8	$781.10
O66B	Antenatal and Other Obstetric Admissions, Minor Complexity	$1,955.70	0	4	$1,024.90
O66C	Antenatal and Other Obstetric Admissions, Sameday	$353.60	1	1	
P03B	Neonate, AdmWt 1000-1499g W Significant OR Proc/Vent>=96hrs, Minor Complexity	$35,601.30	8	35	$1,400.00
P04A	Neonate, AdmWt 1500-1999g W Significant OR Proc/Vent>=96hrs, Major Complexity	$89,382.10	17	35	$1,400.00
P04B	Neonate, AdmWt 1500-1999g W Significant OR Proc/Vent>=96hrs, Minor Complexity	$36,984.10	10	35	$1,188.70
P05B	Neonate, AdmWt 2000-2499g W Significant OR Proc/Vent>=96hrs, Minor Complexity	$17,276.40	9	35	$677.50
P06A	Neonate, AdmWt >=2500g W Significant OR Proc/Vent>=96hrs, Major Complexity	$26,552.60	5	31	$1,400.00
P06B	Neonate, AdmWt >=2500g W Significant OR Proc/Vent>=96hrs, Minor Complexity	$16,127.40	4	22	$1,400.00
P60A	Neonate W/O Sig OR/Vent>=96hrs, Died/Transfer Acute Facility <5 Days, MajC	$2,039.80	0	4	$1,274.70
P60B	Neonate W/O Sig OR/Vent>=96hrs, Died/Transfer Acute Facility <5 Days, MinC	$294.20	1	1	
P63B	Neonate, AdmWt 1000-1249g W/O Significant OR Proc/Vent>=96hrs, Minor Complexity	$7,594.20	2	15	$1,024.60
P64A	Neonate, AdmWt 1250-1499g W/O Significant OR Proc/Vent>=96hrs, Major Complexity	$22,037.50	9	35	$844.30
P64B	Neonate, AdmWt 1250-1499g W/O Significant OR Proc/Vent>=96hrs, Minor Complexity	$27,271.20	10	35	$909.00
P65A	Neonate, AdmWt 1500-1999g W/O Significant OR Proc/Vent>=96hrs, Extreme Comp	$29,546.70	10	35	$1,029.50
P65B	Neonate, AdmWt 1500-1999g W/O Significant OR Proc/Vent>=96hrs, Major Complexity	$20,672.20	9	35	$804.40
P65C	Neonate, AdmWt 1500-1999g W/O Significant OR Proc/Vent>=96hrs, Intermediate Comp	$16,297.50	8	35	$708.60
P65D	Neonate, AdmWt 1500-1999g W/O Significant OR Proc/Vent>=96hrs, Minor Complexity	$13,858.00	6	35	$725.50
P66A	Neonate, AdmWt 2000-2499g W/O Significant OR Proc/Vent>=96hrs, Extreme Comp	$14,957.80	5	32	$934.90
P66B	Neonate, AdmWt 2000-2499g W/O Significant OR Proc/Vent>=96hrs, Major Complexity	$12,740.80	5	32	$796.00
P66C	Neonate, AdmWt 2000-2499g W/O Significant OR Proc/Vent>=96hrs, Intermediate Comp	$8,829.40	4	25	$712.00

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
P66D	Neonate, AdmWt 2000-2499g W/O Significant OR Proc/Vent>=96hrs, Minor Complexity	$3,538.30	2	9	$786.30
P67A	Neonate, AdmWt >=2500g W/O Sig OR Proc/Vent>=96hrs, <37 Comp Wks Gest, Extr Comp	$9,455.60	4	22	$875.50
P67B	Neonate, AdmWt >=2500g W/O Sig OR Proc/Vent>=96hrs, <37 Comp Wks Gest, Maj Comp	$8,676.60	4	22	$818.50
P67C	Neonate, AdmWt >=2500g W/O Sig OR Proc/Vent>=96hrs, <37 Comp Wks Gest, Int Comp	$6,043.40	3	18	$671.50
P67D	Neonate, AdmWt >=2500g W/O Sig OR Proc/Vent>=96hrs, <37 Comp Wks Gest, Min Comp	$2,506.10	1	8	$696.10
P68A	Neonate, AdmWt >=2500g W/O Sig OR Proc/Vent>=96hrs, >=37 Comp Wks Gest, Ext Comp	$6,833.70	2	12	$1,139.00
P68B	Neonate, AdmWt >=2500g W/O Sig OR Proc/Vent>=96hrs, >=37 Comp Wks Gest, Maj Comp	$3,913.50	1	8	$1,029.20
P68C	Neonate, AdmWt >=2500g W/O Sig OR Proc/Vent>=96hrs, >=37 Comp Wks Gest, Int Comp	$2,572.80	0	6	$918.40
P68D	Neonate, AdmWt >=2500g W/O Sig OR Proc/Vent>=96hrs, >=37 Comp Wks Gest, Min Comp	$966.60	1	7	$306.30
Q01A	Splenectomy, Major Complexity	$11,340.60	2	14	$1,400.00
Q01B	Splenectomy, Minor Complexity	$8,142.60	1	8	$1,400.00
Q02A	Blood and Immune System Disorders W Other OR Procedures, Major Complexity	$13,601.80	4	24	$1,079.70
Q02B	Blood and Immune System Disorders W Other OR Procedures, Minor Complexity	$2,709.10	0	4	$1,202.80
Q60A	Reticuloendothelial and Immunity Disorders, Major Complexity	$7,854.60	3	18	$875.60
Q60B	Reticuloendothelial and Immunity Disorders, Minor Complexity	$3,010.40	1	8	$802.00
Q60C	Reticuloendothelial and Immunity Disorders, Sameday	$506.40	1	1	
Q61A	Red Blood Cell Disorders, Major Complexity	$6,237.10	3	15	$807.30
Q61B	Red Blood Cell Disorders, Intermediate Complexity	$2,360.60	0	6	$839.30
Q61C	Red Blood Cell Disorders, Minor Complexity	$649.90	1	1	
Q62A	Coagulation Disorders, Major Complexity	$4,463.90	2	12	$772.00
Q62B	Coagulation Disorders, Minor Complexity	$689.80	1	1	
R01A	Lymphoma and Leukaemia W Major OR Procedures, Major Complexity	$22,270.20	5	33	$1,274.30
R01B	Lymphoma and Leukaemia W Major OR Procedures, Minor Complexity	$6,981.30	1	8	$1,400.00
R02A	Other Neoplastic Disorders W Major OR Procedures, Major Complexity	$19,164.40	5	29	$1,247.80
R02B	Other Neoplastic Disorders W Major OR Procedures, Intermediate Complexity	$11,582.50	2	13	$1,400.00
R02C	Other Neoplastic Disorders W Major OR Procedures, Minor Complexity	$6,832.70	1	8	$1,400.00
R03A	Lymphoma and Leukaemia W Other OR Procedures, Major Complexity	$20,230.40	7	35	$995.40
R03B	Lymphoma and Leukaemia W Other OR Procedures, Intermediate Complexity	$4,625.80	1	7	$1,253.50
R03C	Lymphoma and Leukaemia W Other OR Procedures, Minor Complexity	$1,711.80	1	1	
R04A	Other Neoplastic Disorders W Other OR Procedures, Major Complexity	$4,993.80	1	7	$1,221.00
R04B	Other Neoplastic Disorders W Other OR Procedures, Minor Complexity	$2,980.70	0	4	$1,241.50

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
R60A	Acute Leukaemia, Major Complexity	$22,560.30	7	35	$1,005.60
R60B	Acute Leukaemia, Minor Complexity	$6,290.40	3	16	$816.80
R60C	Acute Leukaemia, Sameday	$679.60	1	1	
R61A	Lymphoma and Non-Acute Leukaemia, Major Complexity	$15,470.30	6	35	$843.30
R61B	Lymphoma and Non-Acute Leukaemia, Minor Complexity	$4,284.50	2	10	$859.10
R61C	Lymphoma and Non-Acute Leukaemia, Sameday	$515.60	1	1	
R62A	Other Neoplastic Disorders, Major Complexity	$6,754.80	3	18	$764.30
R62B	Other Neoplastic Disorders, Intermediate Complexity	$1,728.20	0	5	$640.20
R63Z	Chemotherapy	$539.20	0	4	$526.90
S65C	Human Immunodeficiency Virus, Minor Complexity	$3,238.00	2	11	$597.00
T01A	Infectious and Parasitic Diseases W OR Procedures, Major Complexity	$26,243.10	7	35	$1,138.70
T01B	Infectious and Parasitic Diseases W OR Procedures, Intermediate Complexity	$10,719.50	3	20	$1,007.20
T01C	Infectious and Parasitic Diseases W OR Procedures, Minor Complexity	$5,857.90	2	10	$1,095.30
T40Z	Infectious and Parasitic Diseases W Ventilator Support	$25,044.90	5	31	$1,400.00
T60A	Septicaemia, Major Complexity	$11,952.50	4	27	$894.20
T60B	Septicaemia, Intermediate Complexity	$6,347.80	2	15	$872.50
T61A	Postoperative and Post-Traumatic Infections, Major Complexity	$7,692.60	4	21	$717.70
T61B	Postoperative and Post-Traumatic Infections, Minor Complexity	$3,820.20	2	10	$797.00
T62A	Fever of Unknown Origin, Major Complexity	$5,038.90	2	13	$817.90
T62B	Fever of Unknown Origin, Minor Complexity	$2,555.30	1	6	$844.70
T63A	Viral Illnesses, Major Complexity	$4,340.90	2	12	$746.30
T63B	Viral Illnesses, Minor Complexity	$2,356.50	0	6	$903.10
T64A	Other Infectious and Parasitic Diseases, Major Complexity	$12,340.00	5	31	$799.20
T64B	Other Infectious and Parasitic Diseases, Intermediate Complexity	$6,978.20	3	17	$850.60
T64C	Other Infectious and Parasitic Diseases, Minor Complexity	$2,856.70	1	7	$822.00
U40Z	Mental Health Treatment W ECT, Sameday	$519.70	1	1	
U60Z	Mental Health Treatment W/O ECT, Sameday	$301.40	1	1	
U61A	Schizophrenia Disorders, Major Complexity	$25,228.30	11	35	$771.40
U61B	Schizophrenia Disorders, Minor Complexity	$13,674.50	7	35	$674.70
U62A	Paranoia and Acute Psychotic Disorders, Major Complexity	$11,713.70	4	25	$944.70
U62B	Paranoia and Acute Psychotic Disorders, Minor Complexity	$12,942.70	6	35	$706.40
U63A	Major Affective Disorders, Major Complexity	$14,548.90	7	35	$662.40
U63B	Major Affective Disorders, Minor Complexity	$13,235.80	6	35	$706.80
U64Z	Other Affective and Somatoform Disorders	$12,267.20	6	34	$735.70
U65Z	Anxiety Disorders	$11,628.60	5	32	$725.70
U66Z	Eating and Obsessive-Compulsive Disorders	$20,331.90	9	35	$746.00
U67Z	Personality Disorders and Acute Reactions	$13,415.20	6	35	$733.40
U68Z	Childhood Mental Disorders	$13,880.60	6	35	$729.90
V60A	Alcohol Intoxication and Withdrawal, Major Complexity	$8,036.00	4	22	$751.40

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
V60B	Alcohol Intoxication and Withdrawal, Minor Complexity	$8,067.80	4	23	$707.70
V61Z	Drug Intoxication and Withdrawal	$10,707.20	5	31	$699.10
V62Z	Alcohol Use and Dependence	$11,892.10	5	33	$733.40
V63Z	Opioid Use and Dependence	$11,262.70	5	33	$695.00
V64Z	Other Drug Use and Dependence	$12,008.90	6	34	$718.90
V65Z	Treatment for Alcohol Disorders, Sameday	$305.50	1	1	
V66Z	Treatment for Drug Disorders, Sameday	$279.80	1	1	
W02A	Hip, Femur and Lower Limb Procedures for Multiple Sig Trauma, Major Complexity	$24,034.20	6	35	$1,211.60
W02B	Hip, Femur and Lower Limb Procedures for Multiple Sig Trauma, Minor Complexity	$15,180.30	3	21	$1,400.00
W04A	Multiple Significant Trauma W Other OR Procedures, Major Complexity	$33,095.20	9	35	$1,133.70
W04B	Multiple Significant Trauma W Other OR Procedures, Minor Complexity	$15,261.20	3	17	$1,400.00
W60Z	Multiple Trauma, Died or Transferred to Acute Facility <5 Days	$2,843.40	0	5	$1,270.60
W61A	Multiple Significant Trauma W/O OR Procedures, Major Complexity	$23,963.50	8	35	$1,032.10
W61B	Multiple Significant Trauma W/O OR Procedures, Minor Complexity	$3,727.90	1	9	$847.00
X02A	Microvascular Tissue Transfer and Skin Grafts for Injuries to Hand, Major Comp	$5,417.10	0	5	$1,124.40
X02B	Microvascular Tissue Transfer and Skin Grafts for Injuries to Hand, Minor Comp	$3,044.30	0	4	$1,130.90
X04A	Other Procedures for Injuries to Lower Limb, Major Complexity	$9,092.80	3	17	$975.60
X04B	Other Procedures for Injuries to Lower Limb, Minor Complexity	$3,298.50	0	4	$1,327.00
X05A	Other Procedures for Injuries to Hand, Major Complexity	$4,332.70	1	7	$1,049.80
X05B	Other Procedures for Injuries to Hand, Minor Complexity	$2,409.80	0	4	$1,080.00
X06A	Other Procedures for Other Injuries, Major Complexity	$9,357.20	3	15	$1,129.30
X06B	Other Procedures for Other Injuries, Intermediate Complexity	$3,417.40	0	4	$1,295.20
X07A	Skin Grafts for Injuries Excluding Hand, Major Complexity	$12,525.50	4	25	$891.50
X07B	Skin Grafts for Injuries Excluding Hand, Intermediate Complexity	$5,453.00	1	8	$1,151.60
X40Z	Injuries, Poisoning and Toxic Effects of Drugs W Ventilator Support	$11,618.40	2	10	$1,400.00
X60A	Injuries, Major Complexity	$7,864.80	4	22	$739.90
X60B	Injuries, Minor Complexity	$2,829.00	1	8	$727.50
X61Z	Allergic Reactions	$1,811.20	0	4	$941.60
X62A	Poisoning/Toxic Effects of Drugs and Other Substances, Major Complexity	$5,990.10	2	14	$852.10
X62B	Poisoning/Toxic Effects of Drugs and Other Substances, Minor Complexity	$2,353.40	0	5	$937.90
X63A	Sequelae of Treatment, Major Complexity	$6,359.10	3	17	$759.70
X63B	Sequelae of Treatment, Minor Complexity	$2,275.50	0	6	$760.40
X64A	Other Injuries, Poisonings and Toxic Effects, Major Complexity	$7,923.30	3	21	$763.30

Item no.	Description	Max fee (excl. GST)	Lower trim point days	Upper trim point days	Max per day rate (excl. GST)
X64B	Other Injuries, Poisonings and Toxic Effects, Minor Complexity	$2,387.20	1	6	$794.50
Y02A	Skin Grafts for Other Burns, Major Complexity	$12,229.30	4	23	$924.00
Y02B	Skin Grafts for Other Burns, Intermediate Complexity	$0.00	0	4	$0.00
Y02C	Skin Grafts for Other Burns, Minor Complexity	$4,435.20	0	5	$1,347.20
Y03Z	Other OR Procedures for Other Burns	$3,845.80	1	7	$930.40
Y61Z	Severe Burns	$10,768.70	5	27	$797.70
Y62A	Other Burns, Major Complexity	$8,394.80	3	21	$804.10
Y62B	Other Burns, Minor Complexity	$5,790.20	3	15	$772.00
Y62C	Other Burns, Sameday	$156.80	1	1	
Z01A	Other Contacts W Health Services W OR Procedures, Major Complexity	$3,840.70	0	5	$1,400.00
Z01B	Other Contacts W Health Services W OR Procedures, Minor Complexity	$1,416.60	1	1	
Z40Z	Other Contacts W Health Services W Endoscopy, Sameday	$778.00	1	1	
Z60Z	Rehabilitation	$294.20	0	4	$294.00
Z61A	Signs and Symptoms, Major Complexity	$4,111.30	2	10	$816.10
Z61B	Signs and Symptoms, Intermediate Complexity	$410.00	1	1	
Z63A	Other Follow Up After Surgery or Medical Care, Major Complexity	$8,346.60	5	30	$571.40
Z63B	Other Follow Up After Surgery or Medical Care, Minor Complexity	$2,934.60	2	10	$597.00
Z64A	Other Factors Influencing Health Status, Major Complexity	$2,668.10	1	7	$760.00
Z64B	Other Factors Influencing Health Status, Minor Complexity	$398.70	1	1	
Z65Z	Congenital Anomalies and Problems Arising from Neonatal Period	$913.30	0	4	$590.50
Z66Z	Sleep Disorders	$1,049.60	0	6	$386.80

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.	$421.90
PR420	Band 2: including procedures other than Band 1 performed under local anaesthetic with no sedation. Theatre time less than 1 hour.	$502.20
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.	$586.60
PR440	Band 4: including procedures other than Band 1 performed under general or regional anaesthesia or intravenous sedation. Theatre time 1 hour or more.	$621.90
	Theatre fee bands	
The band into which services fall will be determined in accordance with the Group Accommodation and Theatre Banding Schedule produced by the Commonwealth Department of Veterans' Affairs, as in force at time of service.		
Where more than 1 service is provided in a single theatre session, the theatre charge is?		
(a) the theatre charge for the service with the highest theatre charge; plus		
(b) 50% of the theatre charge for the service with the next highest theatre charge; plus		
(c) 30% of the theatre charge for each of the other services so provided.		

Item no.	Description	Max fee (excl. GST)
PRT01	Theatre fee band: 1	$484.60
PRT02	Theatre fee band: 2	$618.40
PRT03	Theatre fee band: 3	$859.80
PRT04	Theatre fee band: 4	$1243.70
PRT05	Theatre fee band: 5	$1596.10
PRT06	Theatre fee band: 6	$2101.70
PRT07	Theatre fee band: 7	$2875.20
PRT08	Theatre fee band: 8	$3068.80
PRT09	Theatre fee band: 9	$4093.80
PRT10	Theatre fee band: 10	$5359.10
PRT11	Theatre fee band: 11	$7604.90
PRT12	Theatre fee band: 12	$8165.30
PRT13	Theatre fee band: 13	$7721.20
PRT1A	Theatre fee band: 1A	$242.20
PRT50	Theatre fee band: Dental minor	$458.00
PRT55	Theatre fee band: Dental major	$826.20
PRT9A	Theatre fee band: 9A	$3569.10

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